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"Informal Specialisation".

The aim of the research was to test out assumptions about the bias on a selection of social workers' caseloads. It was commonly believed in Hampshire Social Services Department in 1985 that most qualified social workers specialised in child care work and that the idea of a "generic" worker was fast disappearing. It was also believed that work with the elderly, the physically handicapped and the mentally handicapped was dealt with largely by unqualified staff. Another assumption was that although the Mental Health Act of 1983 tightened up standards with regard to compulsory admission to hospital, work with the mentally ill was given a low priority and was still reactive to emergencies and crises.

Information was achieved by using a questionnaire which was completed during interviews with team managers. The questionnaire recorded data about social workers and their caseloads, including sections on qualifications, grades, previous experience, size of caseload, and primary and secondary biases. Information was also requested on specialisation by method, issues surrounding inforaml bias, and on whether the member of staff was an "identified" worker in the fields of mental health or adoption. The first part of the study involved interviews with team managers from 8 generic teams spread across 7 Area Centres. The teams were chosen in order to represent a mix of city and rural areas, and Intake and Long Term teams. They were also chosen for their geographic proximity with regard to time constraints in undertaking the research. The second part of the study involved research into 4 specialist teams in the same Area Centre, which at the time was the only Area to be organised in this way.

The conclusions showed that, indeed, the majority of the social workers in the study did have a bias on their caseloads, but there was a far greater interest in genericism than had been assumed. It did seem to be the case that most child care work was allocated to qualified social workers, but this was not so much at the expense of other client groups as had been assumed. It also seemed to be true that work in mental health and mental handicap was accorded a lower priority. Although unqualified workers did tend to specialise in adult client groups, this was by no means an exclusive area of work for them, and they were involved in some child care and statutory work.

As regards the differences between the 8 Generic and 4 Specialist teams, it emerged that the latter showed less capacity to experiment with methods of intervention other than "casework". However, they also showed a greater capacity to target staff time than their generic colleagues, who, for example, seemed to have more Approved Social Workers (Mental Health Act, 1983) than they needed.

The thesis finishes by leading on from the conclusions to look at implications for Hampshire Social Services Department's new structure (April, 1990), The Children Act, 1989, and The National Health Service and Community Care Act, 1990.

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CONTENTS.

CHAPTER ONE: INTRODUCTION.

Challis and Ferlie (1988) open the discussion of their research into Specialisation in Area, Hospital and Specialist teams with the following comment:

> "There has been continuing debate ever since the reorganisation of social serivces following the Seebohm Report as to the most appropriate mode of organising field social work. At different times various models have been proposed with more or less enthousiasm, some of which expect fieldwork caseloads to be of a generic kind and others which demand a greater degree of specialisation" (Pg. 1).

It was this tension between the generic and specialist approach to social work in Area Teams which led to an interest in researching the subject in Hampshire Social Services Department. At the time, there were many assumptions about how work was shared between qualified and unqualified staff. It was assumed that the latter, consisting in Social Service Officers and Social Work Assistants, were left to deal with predominantly elderly and physically handicapped clients, whilst the higher risk, and, therefore, higher status work with children and families was allocated to qualified workers. There were also assumptions about differences in the allocation of work between staff at different levels or grades, eg. that Level 3 social workers were particularly skilled in child care work and more likely to have a bias in this direction.

Interest in the subject had been kindled for the author by the following influences:

1. Experience as a formally designated "Specialist" worker, in this case, as an Area Fostering Officer in a neighbouring Local Authority. It was clear that there are considrable differences in the way that job satisfaction can be enhanced by building up resources rather than by the constant demands of a caseload, where it is difficult to guage progress.

2. Experience of managing a generic social work team in which the workers had particular areas of interest covering the whole field of Social Services activities, i. e. child care, the elderly, the physically and visually handicapped, and the mentally-ill and the mentally handicapped. The issue

for management was how to foster and utilise these special areas of interest but at the same time meet the responsibilities of providing a generic service.

3. Experience as a generic social worker.

The objective of the research was to assess the situation in Hampshire and to see how far these assumptions were correct. As will be seen from the chapter dealing with "Methodology", there was an ambitious beginning, and it was inevitable that this had to be curtailed. It would have been interesting to have looked in detail at how the formally designated specialist posts impacted on social work teams, and at how effective these workers were in terms of the overall productivity of Area Centres. It would have been intersting to look at any clash in attitudes between the "caseworkers" on the one hand and the "resource providers" (or Specialists) on the other. However, it seemed that the root of the problem lay in a discussion of the issues about social work practice itself, in what social workers actually do, and in the types of client groups in which they become involved. This seemed to be the priority, and the questions about how this all relates to the generally accepted notion of the "Specialist" worker will need further research.

The relationship between informal specialisation and specialist posts was never more relevent than in the period between 1980 - 1985. This was a time of expansion of specialisation in Hampshire, with a number of posts added to the staff groups in Area teams. This began with the development of Intermediate Treatment as an alternative to custody and the subsequent appointment of Intermediate Treatment Officers to each Area Centre. At the same time, the Adult Placement service was created, with the objective of maintaining mentally handicapped people in the community, placed with carers. It was not long before part-time Adult Placement Social Workers were recruited to Area Centres. Mental Handicap specialists followed, and soon after, in 1985, Child Care Strategy social workers became available to help Areas put into practice new ideas about preventive work with children and families. Parallel with these developments, generic social work teams continued to provide the direct service to clients and their families, with a seemingly concomitant growth in informal specialisation by client group.

This research begins by looking at the literature on the subject. Firstly, there is a consideration of some general issues surrounding specialisation. Secondly, there is some discussion on what the literature has to say about informal specialisation, particularly by client group. Thirdly, there is a more detailed look at some previous research into social workers' caseloads and informal bias on caseloads. A description and discussion on the methods used in the research follows, with an emphasis on the questionnaire and the range of information which needed to be gathered. The next two chapters present the research findings, firstly for the 8 Area Teams or Generic Teams, and secondly, for the 4 specialist teams. The findings contain information not only about informal bias on caseloads, but also on qualifications and grades, previous experience, caseload numbers, specialisation by method, reasons for informal bias, and data on particular forms of specialisation, usually relating to Mental Health and Adoption work. Finally, the chapter on Conclusions draws out some general trends and makes some comparisons between the two groups of social work teams.

The last chapter also goes back to the original hypothesis and how far this has been proved by the research, together with comments on a list of issues raised through a discussion on the literature. It is implicit in much of the discussion that there is very much a management role in drawing together the needs of social workers in terms of their individual interests and the needs of the Department in meeting its responsibilities. David Jones (1980) sums this up by the following:

> "The personal social serivces require many different kinds and levels of worker and there is undoubtedly a place for various types of specialisation. . . . . The knowledge, skills, past experience, preferences and concerns of staff will usually lead to some degree of concentration and division of labour and it is surely the duty of whoever is responsible for the work overall to mobilise the individual and collective resources of staff to meet the needs of clients in the most effective way" (Pg. 102).

The "implicit" issues in the study are based primarily on the fact that all the information on social workers and their caseloads was provided by first line managers, ie. team-leaders. However, the first step towards an understanding of this lies in a consideration of the literature.

CHAPTER TWO: INFORMAL SPECIALISATION - THE LITERATURE.

This chapter will deal with some of the material which has been written on both Specialisation generally, and on Informal Specialisation. Broadly, the chapter falls into three main parts. Initially, there is a review of general considerations on Specialisation. Secondly, there is a discussion of the views of various writers on Informal Specialisation. Thirdly, there is a more detailed look at a small number of research projects on Informal Specialisation. Although the major part of the discussion is on specialisation by client group, there are also references to issues about "method" and "task". The chapter finishes by raising a number of questions which will be the subject of comment within the research data in this study, particularly where the chapter on Conclusions is concerned.

Specialisation - General Considerations.

Stevenson and Parsloe (1978) introduce their chapter on "Specialisation" with the following:

> "The issue of specialisation in the provision of Social Services generally, and of social work in particular, is one of the most important raised in this report" (Pg. 169).

Stevenson (1981) emphasises the crucial nature of this issue still further. She opens the discussion by referring to the debate about specialisation in Social Services Departments and refers to the history of the "generic/specialist controversy" (Pg. 13). She quotes from E. Younghusband (1978):

> "This debate, lively in the interwar years in the U. S. A. and the U. K. since the 1950's, has profoundly influenced the development of British social work" (Pg. 13).

There is no doubt that the subject of specialisation seems to raise strong feelings. K. Woodroffe (1962) quotes from an earlier Younghusband report (1959):

> "There is always a risk in any type of specialisation of concentrating on a particular aspect at the expense of the whole. . . this can lead to a

focusing of effort on a particular need or handicap rather than on the effect of these on the individual in his family or social setting" (Pg. 211).

Brewer and Lait (1980) express even stronger feelings about this. They quote from an advertisement in the journal Community Care (3rd, May, 1979), for a number of specialist posts. They mention the salaries, which they consider to be too high. They suggest that since the Seebohm reorganisation, large numbers of specialist posts have been created in Social Services Departments. They go on to say:

"We have heard much grumbling about top-heavy bureaucracies in our contacts with Social Services Departments. The complaints have come from field-level social workers, who have expressed doubts about the necessity and usefulness of the various posts created" (Pg. 62).

Brewer and Lait also quote from the Parsloe/Stevenson study (1978), with remarks in a similar vein.

"We think that of many superfluous appointments in Social Services Departments, specialist advisers are the most useless, since the specialisms they purport to advise upon have no knowledge base" (Pg. 62).

They finish by suggesting that bureaucracies tempt Directors of Social Services to acquire staff for prestige reasons, and these are unsuitable for the delivery of a sensitive personal service.

It is clear that these comments beg the question of a definition of specialisation and of specialist posts. Before moving on to this, however, it would seem right to balance some of the strong views mentioned above with some positive statements about specialisation.

Sainsbury (1977) writes about the misuse of the word "generic", which he feels should have been applied to training, but has instead been applied to practice with the appointment of "generic social workers" with "generic caseloads" (Pg. 77). He goes on to say:

> "What this has meant in practice is the partial loss of specialised skills and an unrealistic expectation that all social workers should be professionally competent in dealing with every kind of human problem and need" (Pg. 77).

Booth, Martin and Melotte (1980) preface a collection of essays on "Specialisation" and describe the latter as "one thread that has wound unbroken through the tangle of problems and dilemmas facing Local Authority social work" (Pg. V). They suggest that the loss of specialised practice was one of the principle results of the Local Authority Social Services Act (1971), but that now, although in a different context, ". . . . . specialisation seems to be enjoying a come-back, as an idea and in practice" (Pg. V).

In a discussion of team-work, Martin Davies (1981) talks about a group of social workers having uniform objectives, for example, encouraging a community into self-help, or sharing the pressures of an urban environment through an Intake Team. He goes on to say:

> "More ambitious is the idea of allocating specialist functions to each member of staff, so capitalising on their respective strengths - rather in the style of a football team in which each player has a slightly different role to play although flexibility is expected as circumstances change. In social work, this leads to a form of specialisation. . . . . " (Pg. 191).

Sainsbury (1977), in the same study mentioned above, says that some Social Services Departments are reintroducing specialisation as a way of providing a compromise between managerial and professional needs. He goes on to say that other forms of specialisation could be encouraged so as to foster career opportunities for staff who want to remain in practice rather than going into administration when looking for promotion. He finishes by saying:

> "But a case could also be made for permitting some specialisation in the immediate post-training period in order to encourage the growth (and experience) of competence in a field of particular interest to the social worker before he is required to undertake more general responsibilities" (Pg. 138).

Although this study is looking at Informal Specialisation within Area teams in Hampshire Social Services Department, it is difficult to consider this without a brief discussion of the major issues in the general debate on the subject. It is also difficult to look at specialisation without also focusing on "genericism". There are further issues about the development of thinking in social work about specialisation by "setting" and by "skill". Although these particular issues do not form a major part of the study, they seem to occupy such a significant position in the debate that they warrant some attention.

The major part of the chapter, however, will be devoted to the literature on "Informal Specialisation", particularly since the Local Authority Social Services Act (1971). The various quotes at the beginning of this chapter beg the question of a definition of and the meaning of the words "generic" and "specialist" as applied to social workers. Perhaps the most oft-quoted definition is the one given by Timms (1968):

> "If, for example, we take "generic" to mean "general" then the complementary term would be specialised. Adopting this definition has particular implications. It involves us, for instance, in thinking in terms of the general social worker, on the one hand and the specialist on the other. If, however",generic" is used in the sense of genus, we are led to think in terms of a common name covering a number of species. In this use of the "generic/specific" idea, a "general social worker" as a kind of person like the "general social worker" mentioned above would not be conceivable; the term "generic" would refer to those characteristics which make it sensible and convenient to call social workers in different fields by a common name" (pp. 27-28).

Anthea Hay (1979) sets out the problem in a less confusing way when writing about the Seebohm Committee's use of the word "specialist". She says that usually the word "specialist" is used to describe a person who devotes her or himself to a single branch of the profession or subject, and in other professions, such as law and medicine, the term is also used to convey "distinctive competence". She goes on to say:

"The Committee sometimes used the term variably to imply either/and or concentration on some particular kind of social work and expertise (Bromley, 1978), and also to describe other non-social work functions, administration and training" (Pg. 165).

Hay concludes that there are three different aspects of specialisation which need to be considered within social services departments.

"First, to distinguish social work from other kinds of social services work in order that the basic parameters of the social work profession can be determined. Second, within the boundaries of social work, to distinguish the "branches" or "subjects" which lend themselves to concentration in practice. Third, to consider what level of work is intrinsic to each" (Pg. 166).

As far as the word "generic" is concerned, Sainsbury (1977) suggests that this was originally used to describe common training before specialisation in practice, but was then applied to (their) fieldwork and took on the meaning of "general". He goes on to say:

". . . . . social workers were expected to work within an unlimited range of human needs and social problems, and to achieve professional competence in all aspects of their work" (Pg. 138).

Zofia Butrym (1976) offers perhaps a more integrated definition of the generic/specialist conundrum. She stresses the difference, particularly in the educational context, between "generic" as meaning "general" or "genus". She states:

"The former interpretation might encourage the acceptance of an emphasis on the "lowest common denominator". In order to ensure that everybody learns the same - a practice which is bound to have disastrous results on the intellectual standards of social work. The view that "generic" means "in common" must result, on the other hand, in a recognition that there is no inherent incompatibility between the "generic" and "specific",but that, on the contrary, the two are complementary and interdependent" (Pg. 75).

Olive Stevenson (1981) develops this argument still further in discussing the views of both Butrym and Timms. She believes that there are common elements which underpin social work practice and which make the job the same, enabling movement between different fields of practice. She suggests that the "processes and objectives of the task are basically similar" (Pg. 14). She goes on to say:

> "If there is a "genus" or "species", called "social worker", this means they have something in common. Unlike herbivores or aphids, their commonality lies not in what they eat but what they do. Thus, up to a point (and this is an important qualification), they are able to "do the same" in respect of a wide variety of persons and situations, that is, the "genus" can perform as "general" social workers" (Pg. 15).

Stevenson continues by saying that although the specialist will often have knowledge and skills not possessed by the generalist, client problems and needs do not necessarily fit neatly into specialist categories. It is the task of the generalist to use skills in assessing those aspects of a client's which require a specialist service and it is the responsibility of the organization to meet these needs. In this sense, the generalist skills in assessing and diagnosing are as specific as a General Practitioner in medicine.

The distinction between "generic" and "specialist" is also apparent in the development of social work practice and thinking as described by Bartlett (1970). In her discussion of social work as a profession, she feels that social workers tend to think of their practice in terms of "agencies, fields, and methods" (Pg. 132). They start by thinking about the profession as a whole, but then focus on a particular segment of practice, because this is familiar and well known to them. There is a danger that the "common base" can be taken for granted, without any attempt to discuss or examine its nature. She charts the idea of a rise of the idea of a common base in social work, and suggests that consideration of this for all practice is "the next logical and urgently needed step for the profession" (Pg. 132).

Bartlett makes some interesting comments about how the profession deals with limitations in its thinking.

> "In their practice, teaching and writing, social workers have been influenced by ideas that are divisive rather than integrative. Furthermore, they have used ideas that are not necessarily opposites as if they were alternatives and as if choices must be made between them. Examples would be "cause and function", "generic and specific", "individual and community", and "person and environment". Such an approach may temporarily clarify specific entities in comparison with each other, but it tends to block movement towards broader concepts because of its divisive effect" (Pg. 132).

Bartlett goes on to say that this "bipolar" approach has been used in social work particularly in relation to concepts of "person-situation" and "person -environment" (Pg. 133). She feels that there has been little attempt to examine the connection between them despite the professional preoccupation with both. The parallel with Hampshire Social Services and with this particular study would be that these "polarities" echo the potential divide between social workers with caseloads, whether generic or not, and those appointed to specialist roles, which usually have a "resource-finding" component. In this sense, the generalist worker looks at the "person-situation", and identifies needs which the specialist hopes to meet through the "person-environment", eg. practical resources. Despite the complexity of the arguments and the definitions considered so far, the position for the "formal" specialist posts in a Social Service Department such as Hampshire is reasonably clear. The pragmatic issues surrounding the provision of, for example, the Adult Placement Service, (Recruiting and supporting "Carers" for mentally handicapped, mentally ill and elderly people in the community), seem to transcend the difficulties expressed in the arguments put forward by Stevenson, Timms, Butrym and Bartlett.

Before going on to look at more specific literature on Informal Specialisation, it may be interesting to consider some early thoughts from Perlman (1949), particularly with reference to specialisation by "setting". Perlman described the young social work student's view of himself as a specialist worker albeit in terms of setting and task rather than by client group. She mentions the National Conference of Social Work at Ohio, June 13th. 1949, and the question posed then as to whether social work is to be an "aggregate of specialties or a unified

service" (Pg. 293). She goes on to talk about schools of social work "factoring out" the generic elements in casework knowledge and skill which transcend specialisation. She writes about the attempt to find a common base of social work method, irrespective of whether it is found in casework, research, groupwork or community organisation. Perlman says that her paper sprang from a wish to find greater unity in the profession. Although she eventually confines her discussion to casework, she puts forward some ideas about the basic elements which unify the apparent separateness within a number of settings, eg. medical, psychiatric, family, children's work, courts, and school. She lists these as follows:

> " 1. A philosophy which sees human welfare as both the purpose and the test of social policy.
>
> 2. A professional attitude which combines a scientific spirit with dedication to the people and purposes that one serves.
>
> 3. A knowledge of the major dynamic forces in human beings and the interaction between them and social forces.
>
> 4. A knowledge of methods and skills whereby the person with professional interest and understanding can help persons with social problems better utilise their own powers or opportunities in their social situations" (Pg. 294).

Perlman goes on to suggest that it is only by understanding thoroughly the community within which casework is being practised, and this involves a knowledge of the purpose, structure, organisation, authorities and responsibilities, its mores and traditions. She divides the settings mentioned into groups",primary settings", and "secondary settings" (Pg. 295). The first group are the traditional social agencies, with the objective to meet problems and needs of "individual social adjustment" (Pg. 295). The second setting are those agencies which meet problems dealt with by professionals other than social workers - medical, educational, or legal, and casework is the method by which individuals can better use the agency's basic service. It is probably true that social work in the 1990's has now achieved a tradition of a separate identity, but these arguments remain

a useful attempt to clarify some confusing issues. Perlman continues by saying that the common denominator for both settings quoted above have the objective of "promoting individual well-being" (Pg. 296).

The paper continues with some thoughts on how the problems of "separation" can be the same in whatever setting",a problem of understanding and helping people to deal with the emotional complexities of leaving the known and going to the unknown" (Pg. 299).

She says this could be the same for a person entering a home for the aged, or going into a sanatorium, an adolescent entering a correctional school etc. . It is interesting that this discussion is followed up by Stevenson (1981) in a later study on "Specialisation".

Perlman finishes by stating that it is a loose conception to equate setting with specialty, and can lead to a social caseworker's loss of professional identity, or the social worker becoming "handmaiden" to other professionals. She makes some pertinent comments about the confusion between the "generic" and "specific" within the profession.

> "This is a problem, but it is difficult only when we make it so. We make it an obstructive problem when we jealously guard specialty from the encroachments of general practice or when, on the other hand, we assume that everything is equal to everything else. We make it a divisive problem when we pose "generic" against "specific" as if one existed versus the other" (Pg. 300).

Perlman believes that a profession evolves by a process of the increasing division of labour, and this is effected through specialisation", and the process of increasing coordination is the process whereby specialisation feeds back into the corporate body" (Pg. 300). She says that a "specialty" cannot exist on its own, but has to be in touch with its roots to avoid "fragmentation" and "sterility" (Pg. 300). The reference to "roots" is interesting in the light of subsequent discussions in Social Services Departments about whether formal specialist workers, eg. Area Fostering Officers, Adult Placement Social Workers, Intermediate Treatment Officers, should be qualified social workers or not. One school of thought within

Social Services felt strongly that it was the previous experience of the worker that mattered rather than a qualification. Others felt that specialist knowledge and skills could only be developed from a generic social work base, which would give the specialist worker credibility among his peers in a social work team.

However, it is not within the scope of this study to pursue the issues in the relationship between formal specialist workers and their generic colleagues. Even within generic teams, there are issues about specialisation in terms of the particular types of work undertaken by social workers". Informal Specialisation" still begs the question of the nature of generic teams or social workers as envisaged by the Seebohm Report and the Local Authority Social Services Act (1971).

Anthea Hay (1979) says that the chapter in the Seebohm Report (1968), "Specialisation in Social Work", dealt more with organisational issues, with only four out of the nine recommendations being concerned with specialisation. It is interesting that the word "generic" is used only once in the Committee's discussion, and then in relation to training rather than the organisation of work. Sainsbury (1977), suggests that the Seebohm Committee recommended a redefinition of "specialisation" rather than its demise, and there was concern that a specialist approach may lead to services being withheld or to a "blinkered view of the social worker's responsibility to meet clients' needs" (Pg. 77).

Hay refers to Bromley (1978), who felt that the Seebohm Committee used the term "specialist" to imply a focus on a particular kind of social work and expertise, and also said that the term was used to describe other "non-social work functions, administration and training" (Pg. 165). Hay feels that the problems in Social Services do not stem from the Seebohm model of generalism/specialism, but in the way the model has been implemented. She suggests that all the recommendations have been instituted in practice, but that more evolution needs to take place. The slowness of evolution is contingent on "the expectation that new bases of specialisation would emerge, and that a career structure would develop for practitioners" (Pg. 166).

Informal Specialisation.

It could be argued that part of the process of evolution has hinged upon attitudes to "Informal Specialisation". This process has involved a shift from a more purist view of genericism within social work teams, where the traditional post-Seebohm approach was for each social worker to take on a variety of client groups within their caseloads. Informal Specialisation meant that social workers began to specialise in certain client-groups, usually within a generic team. The research data in later chapters in this study deals exclusively with the caseloads of a number of social work teams, first of all with 8 generic teams and then with 4 specialist teams. At this stage, however, it seems appropriate to look at the literature on Informal Specialisation.

Bamford (1982) hints at the importance of this kind of specialisation within the team structure. He suggests that the Local Authority Social Services Act (1970) was the beginning of the growth of team-work as the means by which services are delivered. One of the factors influencing this was:

> ". . . . . the range of specialisms drawn together in the Social Services Departments was such that no single practitioner could be expected to encompass them all with equal competence" (Pg. 70).

Later in the same study, Bamford states that new patterns of specialisation began to emerge after an enthusiastic attempt at total genericism, which was marked by a great deal of confusion.

> "But by the end of the decade the range of tasks no longer held the terrors that it had for unprepared child care officers, psychiatric social workers, and welfare officers".

Bamford quotes Parsloe and Stevenson's research (1978), in that specialisation was a preoccupation of the social work teams which they studied. Their particular study is referred to later in this chapter, but at this stage it seems important to mention that they found formal specialisation by client group difficult to operate in small teams. They also found that specialisation was influenced by the type of staff employed, for example, a large number of social work assistants dealing

with the elderly inhibited this as a specialism for the qualified staff. The use of occupational therapists had a similar impact on the development of specialist social work skills with the handicapped. The issue of unqualified staff and work with the elderly will be dealt with in the research data later in he study.

Bamford describes how Intake Teams have been instituted in areas of high referral rates, but says that it is rare to find Intake workers describing themselves as specialists. He goes on to say:

> "Nevertheless the designation of specialist worker has tended to remain associated with primarily those specialising in work with a particular client group".

Bamford suggests that most social workers have some bias in their caseloads irrespective of how their teams are organised. He suggests that this bias may be caused by personal preference of the worker or by his or her previous experience, or by the propensity of particular kinds of problems within a locality, eg. unemployment. These are some of the factors explored within the research later in this study.

Bamford goes on to say that the client group attracting most specialist roles is "children and families". He feels this is partly due to the importance of statutory work and also to the impact of the enquiries into child care tragedies. This has led to a demand for "fire-proof managements" (Pg. 101), with a framework of procedures and guidelines quite unlike those afforded to other client groups. The specialisms which have evolved often relate to sub-groups within child care, eg. fostering and adoption, intermediate treatment, children in care, groupwork with lone parents, and pre-school work. Although he is referring here to more formal specialist roles, the research data in this study shows these sub-groups as informal specialisation, and develops this idea further in terms of the number and type of sub-groups within child care.

Bamford finishes by making some general comments about the subject. He says that although the entire workload of a department is broadly based, social workers cannot be expected to be competent in all area of practice. However, he feels that "multiple visiting" (Pg. 102) should be eliminated", as long as this is

"consistent with skilled and knowledgable service provision" (Pg. 102). The common base of practice in assessment and relationship skills should be acknowledged, and where there are common factors, these skills should be transferable from one "complex of social problems to another" (Pg. 103). He suggests that the basis of practice in area teams should be generic but at the same time it should enable opportunities for staff to specialise within the team.

Perhaps the most significant quote on the need for informal specialisation comes from Sainsbury (1980), also quoted by Bamford (1982):

> "the development of specialisation needs to be preceded by the development generic teams and team caseloads whereby, although one worker would continue to orchestrate the inputs of work for each case, and would provide continuity of expertise for all clients, all workers would be encouraged to develop personal areas of expertise relative to specific tasks and skills within the total range of work responsibilities allotted to the team" (Pg. 66).

However, John Cypher (1980) takes a different view of informal specialisation. He writes about specialisation by "stealth and by design" (Pg. 77). He refers to Goldberg's studies in Southampton (1978) as demonstrating that child care problems formed a predominant part of social workers' caseloads, even though these problems were numerically smaller than those presented by the elderly and the handicapped. He says that the British Association of Social Workers' own study (1978), Social Workers and Volunteers, showed a hierarchy of clients and a hierarchy of workers. This study showed that child care cases are allocated to qualified and experienced staff, and elderly people are allocated to social work assistants and/or volunteers. He states that the Parsloe/Stevenson study (1978) showed that many caseloads were biased towards child care problems. He writes:

> "Invariably, there was no official agency policy which sought to ensure some concentration, within caseloads, by social workers at different stages in their professional careers" (Pg. 81).

Cypher attributes this policy of allocating child care cases only to qualified social workers to a combination of public concern over child abuse, the risk

management posture of senior agency staff and the "expressed preferences of many social workers" (Pg. 81). He feels that a pre-Seebohm specialisation by client group has persisted. He questions whether this bias towards children and families achieves anything for social workers, unless it is related to training and a consequent enhancing of skills. Cypher suggests that other client groups, e. g. the elderly and the mentally-handicapped, may not receive social work help unless there are designated social workers offering this service. He quotes from the Seebohm Report (Paragraph 521):

> "On first entry to the service, the range of work of the newly qualified social worker would normally be limited. However, he would be expected as soon as possible to undertake a wider range of social work functions, and to develop skills in them. He might develop interests in particular aspects of the work of the department, and it would be right for him to pursue such concentrations of interests, always provided this did not conflict with the primary objective of giving people the help they required at the right time".

Cypher feels that there is a "hint of disquiet" (Pg. 85) in this paragraph, in that the Seebohm Committee were alive to the possibility of specialised practitioners being prescriptive about the interventions they do well. Seebohm suggests a concentration of interest within the context of the whole range of tasks usually expected of the social worker. Cypher questions whether newly qualified are ever restricted on the range of tasks available and this interferes with the consolidation of skills.

Cypher's main point in this part of his essay is that there has been a move towards specialisation by "stealth" which has consisted in an over-emphasis in informal specialisation in child care. In discussing the BASW research, Social Workers and Volunteers, (1978), he says:

> "It is evident that some social workers do not see a professional role for themselves in working with elderly people" (Pg. 81).

Cypher also refers to the Parsloe/Stevenson study (1978) and says that they found that many "social workers caseloads, for a variety of reasons, contained

a bias towards or a concentration on child care problems" (Pg. 81). It is precisely this problem which is the foundation of the research in this study. The popular view in Hampshire Social Services Department is that Level 3 social workers spend all their time engaged in child care work, and the research was undertaken to find out just how much this is the case.

Informal Specialisation - Research.

Sainsbury (1980), however, takes a different view to Cypher about informal specialisation, although this is linked more to task and skill. His paper",A Professional Skills Approach to Specialisation" (1980) is based on research between 1975 - 1977 involving 112 families being dealt with by the Local Authority, the Probation Department, and social workers in a Family Service Unit. He makes the point that specialisation in itself was not a concern within his study, but it threw up various issues in social work practice, whether successful or not, and where there were different levels of expertise among the social workers. He writes:

> " Specialisation by client group and by social work method reflects an over-simplified view of clients' needs and of the skills necessary to help - but undifferentiated genericism has even less to be said for it" (Pg. 62).

The objective of the research was to study the influence of organisational and administrative practices upon the way social workers and their clients perceive social work help. The information was gathered at four-monthly intervals by the use of guided interviews and questionnaires. One of the issues which emerged during the research was that there were a wide range of functions collectively called "casework".

> "To speak of "casework" as if it were made up of a single theoretical system, a single approach to intervention, and an agreed package of skills is naive. . . . . (but) the research reminded us of the immense range of skills and tasks which the word "casework" now embraces, and which may be exercised within, but are not defined by, agency function" (Pg. 63).

Sainsbury casts doubt on the efficacy of developing "specialisation" by either client group or by method. As regards client groups, he feels that this may be useful in that social workers can gain increased knowledge of the particular sub-group, and it also serves to provide a "sponsor" so that classes of deprivation can be represented. The disadvantage, he feels, is that there is a risk of a return to the inequalities of provision prevalent in the pre-Seebohm era. As regards method, Sainsbury feels that the philosophies, skills and approaches which make up "methods" are more germane to what social workers actually do than the boundaries between them, eg. groupwork, community work, casework. He suggests that "specialisation" by client-group and "method" offer a limited understanding of the skills involved, and that this kind of specialisation is no guarantee of a better service, precisely because they do not address the issues of the variety of skills inherent in each.

These ideas are important to this study in so far as they counsel a cautious approach. However, the most significant point Sainsbury makes is concerned with the generic approach of the team rather than that of the individual social worker.

> "In my view, the development of specialisation needs to be preceded by the development of generic teams and team-caseloads whereby, although one worker would continue to orchestrate the inputs of work for each case. . . . . . all workers would be encouraged to develop personal areas of expertise relative to specific tasks and skills within the total range of work-responsibilities allotted to the team" (Pg. 66).

As far as Hampshire in 1986 is concerned, the issues about the overall work of an Area team is relevant to Sainsbury's research. Although the emphasis is still on specialisation by client-group, and to a lesser extent, method, these factors may have a bearing on how social workers develop special interests and how this affects the work of the team. Sainsbury finishes his article on the research by saying that he does have sympathy towards specialisation by client group, but this should be developed in conjunction with ad hoc specialisation based on "task" and "skill". He writes:

> "Central to the effective development of both kinds of specialisation is the need to discard the notion of "generic worker in favour of a "generic team",

without which the task/skill dimension of specialisation cannot become fully operational" (Pg. 75).

O. Stevenson (1981) surveys the whole scene on Specialisation and it would be difficult to describe the literature on the subject without spending some time on her study. As regards informal specialisation, she refers to her own research with Parsloe (1978) and echoes the feelings of Sainsbury et al mentioned above:

> ". . . . . the composition of caseloads showed a considerable degree of informal specialisation, first, in the concentration on children and families - a point also noted in the 1972 Goldberg and Warburton survey, that is, before the inquiries into the deaths of children gained momentum. Secondly, the extent of the dominant interest . . . . . was shown by informal specialisation within that client grouping, for example, in work with adolescents, intermediate treatment, and so on, whilst it was conspicuously lacking in other client groups" (Pg. 45).

These sub-groupings have particular relevance to this study. It will be seen from the questionnaire described in the next chapter on "Methodology" that information was requested and received from a number of child care sub-groups but none under adult client group headings. This seems to be an issue more in generic teams. The data in this study also looks at a comparison with specialist teams, ie. teams working solely within child care and adult client groups.

However, Stevenson offers a useful definition of Informal Specialisation as applied to her research with Parsloe (1978), as follows:

> "This refers to the special interests of workers. It may be in relation to client groups, methods of social work, or certain projects or tasks assigned to team members. In our study the first of these was by far the most common and , within it, sub-groupings of children and families, for example, work with adolescents or one-parent families" (Pg. 46).

Later in the same study, Stevenson goes on to warn against the dangers of formal specialisation. Within this section, she suggests that even informal specialisation reduces the mobility of an organisation, in that a particular service,

eg. groupwork, may have to be withdrawn if the social worker in the team who is skilled in this decides to leave, and there is no-one to take his or her place. This echoes Sainsbury plea for a generic team, since this would be a management problem in the determination of priorities and the need to provide a continuity of service. As far as Hampshire Social Services is concerned, the position in 1986 was that a skill such as "groupwork" would have been seen as an optional extra within a team. It would have been far more serious if there was only one member of the team specialising in, for example, child abuse work, and it would be the manager's responsibility to make sure this service continued from another worker if that "informal specialist" left the team.

Stevenson moves on from specialisation by client group to other issues about the organisation of the work. She suggests that there are five factors which determine specialisation and which have to be balanced against each other, and are additional to the notion of specialist expertise. A summary of these is as follows:

1. The value ascribed to service by the same individual (s) to a particular geographical area.

2. The value ascribed to "Communication, co-operation and collaboration" between social workers and other workers.

3. More efficient organisation of the work to the client's advantage, e. g. Intake Teams.

4. The Social Services Department's perception of the need for specialisms due to unusual skill requirements, eg. services for the deaf, or for developing skills and resources, eg. foster parent and adoptive parent recruitment.

5. The freedom for "individual staff members to develop special interests, which may not be formally described as specialisms but which have implications for the allocation of work" (Pg. 63).

Clearly, it is the fifth and last which concerns this particular study, although reference needs to be made to the third factor at a later stage in terms of the specialist teams in Chapter 5.

As regards the special interests of social workers, Stevenson states that they have not raised particular objections in principle, and have been largely accepted. She says that many advertisements for generic posts guarantee an encouragement towards "concentrations of interest", although Stevenson has found in her own research (1978) that these were mostly within child care sub-groups. Stevenson believes that it is necessary for the profession and to the benefit of clients that social workers are encouraged to acquire "greater knowledge and skill in areas of work which fire their imagination" (Pg. 102). The caveat is that this type of specialisation must not detract from the core generic work and team-managers must be aware of the impact on the overall responsibility of the team. However, the author feels that these interests cannot be a substitute for the formal specialisation needed for team-functioning, and they cannot guarantee knowledge and skill "of sufficiently high quality".

In an earlier study, Stevenson and Parsloe (1978) address the issues of specialisation within their research into social work teams in 8 Local Authorities between 1975 and 1977. It is particularly relevant to this study that they make the following comment:

> ". . . . . our study shows that, although it is seldom spelt out at higher levels, the elderly are accorded a low priority for social work provision (as distinct from social service provision), whilst children are given a high priority" (Pg. 169).

This is an issue which will be raised within the study of the teams in this research. The Parsloe/Stevenson study engendered comments from social workers which echo Sainsbury's views discussed earlier in this chapter.

> "I never believed in a generic social worker, that's nonsense, but in a generic social work team" (Pg. 171).

As regards informal specialisation, the authors say they were interested to discover what were the determining factors to these interests. They found some evidence that previous work had some effect on caseload bias, and there could be some relationship between this and pre-Seebohm experience. They give the example of an unqualified worker, who had trained as psychiatric nurse, specialising in mental health within a social work team.

The authors found that "informal specialisation" usually meant to the social workers concerned a bias in caseload towards particular client groups. This was also within a framework of a generally mixed caseload . . . " but most social workers seemed to welcome bias within genericism" (Pg. 172). There was reluctance to describe themselves as "specialist workers" because of this concentration of interest, and if they saw themselves as "specialists" it was only because there were a considerable number of people on their caseload who fall into a particular client group. The authors suggest the following reasons for this:

1. Social workers did not want to devalue "generic" work.

2. A reluctance to assume greater responsibility when opportunities for skill and knowledge development were limited.

3. Guilt at the possibility of relinquishing the Seebohm ideal.

4. A fear of elitism.

It was more common for social workers to describe their colleagues as "specialists" if they possessed knowledge of particular client groups, and rare for them to describe themselves in this way.

It emerged in this study that where a bias existed, it was more likely to be in one of the child care sub-groups. There were examples of special interests in adolescents, one-parent families, children at risk, children in care, and adoption and fostering. There was only one instance of a caseload biased towards mental handicap, and none with a bias in work with the sick and disabled. There were a few examples of specialisation with mental illness and in Scotland instances of specific work with offenders.

As regards the concentration on child care issues, the following were identified as factors:

1. Child care was seen as the priority by social workers, although not accepted openly by senior management, in all departments visited.

2. Child care cases are more likely to be allocated.

3. Child care situations are more likely to be accepted by Duty Officers and to be referred for social work help.

4. Child care cases were considered to be more difficult and were therefore allocated to qualified and experienced workers.

The authors combined this with the practice of allocating elderly clients to social work assistants and the disabled to Occupational Therapists, and then it becomes clear why qualified workers' caseloads become biased towards child care and there is a consequent sub-dividing into groups within this. The research showed that this was not welcomed by all workers, some of whom felt that there was no option but to have a child care caseload because they were qualified. Others felt that children were more vulnerable and dependent and needed to be more of a priority.

Social workers also expressed the view that a generic caseload was essential to the newly qualified worker in order to gain experience. One response to this was as follows:

> "You should not specialise until you've gained full experience generically. Everything intertwines - therefore you can't be an expert in one field without a sound generic base" (Pg. 173).

This issue is addressed in this study with a discussion of Level 1 social workers and the bias on their caseloads. The comments in the same section on the reasons for informal specialisation are also germane to this study:

> "After some general experience, the development of informal specialisation seemed, within the general constraints already discussed, to depend upon the inter-relationship of the social worker's wishes, the team-leader's views and sometimes chance or even on a laissez-faire policy within the team" (Pg. 174).

It was found that in some circumstances, team leaders had considerable control over bias on caseloads. It was also discovered that social workers could influence the shape of their caseloads, although in allocation meetings, they had to withstand group pressure. There was some opposition to these developments because of the gaps left in the team when social workers changed job. Sometimes social workers found that their caseloads had developed a bias without this being their intention, it "just happened" (Pg. 174). It was also true that if a social worker showed success in dealing with a particular type of case, others of a similar kind were allocated to them.

Stevenson and Parsloe's research on informal specialisation by method and by task will be touched upon later in this chapter. It would seem appropriate now to look briefly at other research into the subject.

Challis and Ferlie (1988) developed some views on this following their research based on a national survey of fieldwork organizations. They suggest that there has been a continuous debate ever since Seebohm about the most appropriate method of organising field work.

> "At different times, various models have been proposed with more or less enthusiasm, some of which expect fieldwork caseloads to be of a generic kind and others which demand a greater degree of specialisation" (Pg 1).

The authors examine the extent of specialisation in the offices taking part in the survey, and look at reasons why specialisation is an issue, even where there is a strong commitment to community based services. They isolate two problems with the debate on the distinctions between client and community centred models, and, by inference, the specialist/generic debate. They mention Stevenson's views (1981) that

"terms generic and specialist have been used exclusively in relation to focus of individual workers on client groupings or problems" (Pg. 45).

Secondly, the argument is how much social work can be defined as a "specialist" expertise.

As regards specialisation both at a formal and informal level, the authors suggest that this should have disappeared after Seebohm. However, the contrary seemed to be true, with a sudden proliferation in the 1970's of specialist structures, which were organised around client groups. This coincided with an increase in the bombardment rate at Area Centres, and the rise in the number of Intake Teams in order to cope with the referrals. The long-term teams were organised on a client-group basis. Other factors leading to more specialised practice and organisation were as follows:

1. The attraction of emergent sources of external funding, eg. joint finance. These were often used to fund small specialist teams.

2. Child Abuse scandals pressurised SSD's into specialisation in work with children and families and led to a questioning of the robustness of generic social work.

3. Dominance of pre-Seebohm Children's Dept. staff in positions of influence.

4. There were doubts about the efficacy of generic training.

Challis and Ferlie sought general information from a large number of social work teams. They used basically the same questionnaire but varied this slightly for three categories of teams, as follows:

1. Specialist teams - defined as serving such groups as the mentally-handicapped and fostering and adoption.

2. Area teams - those providing a front-line, primary service, even when organised on a client-group basis.

3. Hospital teams.

They achieved a satisfactory response rate and acquired detailed information on 278 teams and 2, 982 fieldworkers. They were able to address two issues of concern about the organisation and deployment of social workers:

1. The extent of formal and informal specialisation at individual practitioner level.

2. The relationship between specialisation and a hierarchy of work within the social work profession.

To summarise their research findings -

1. It emerged that three quarters of the teams studied retained a generic label, the remainder being specialist.

2. Respondents in area teams were asked to indicate presence of caseload bias for each of their fieldworkers, and this was defined as 75% of cases coming from one or two of the five main client groups, eg. child care, elderly, mental illness, mental handicap and physical handicap.

3. 80% of social workers were found to have biased caseloads.

4. The degree of bias was highest amongst social work assistants and lowest amongst new entrants - Level 1 workers.

5. Client group bias was aggregated into the three main categories: children and families, elderly and physically handicapped and mental health and was related to grade information.

6. 71% of staff had a caseload biased solely towards one of these main client groups - 9% had a bias which spanned all three.

7. With the exception of social work assistants, higher grade staff had a greater degree of bias towards children and families.

8. Social work assistants had a pronounced bias in favour of work with the elderly.

The authors refer to Pritchard (1983) who found that 69% of basic grade staff and 71% of team-leaders favoured specialisation by client group. They suggest:

> "He (Pritchard) noted that, although a preference for this form of specialisation is often seen as a product of pre-Seebohm work experience, many staff are now too young to have experienced such a pattern of socialisation. Its continuing existence may therefore reflect new workers' preference for the felt competence, greater specificity, work satisfaction and opportunity to acquire knowledge which comes from specialisation" (Pg. 16).

David Howe (1980) takes these issues even further in his study of "Divisions of Labour" in Social Services Area teams. His research into three Local Authorities and 18 Area teams was designed to provide information on the following:

> "1. The extent to which work has become differentiated in the area teams of Social Services Departments;that is the degree to which individual fieldworkers' caseloads are biased, in which directions, and in what numbers.
>
> 2. The distribution of different types of fieldworker amongst the various client groups" (Pg. 135).

The study involved social workers and social work assistants being invited to complete a questionnaire asking for details about both the composition of their caseloads and their personal biographies. 285 questionnaires were returned - a response rate of 74 per cent.

The background to this study is the debate about how Social Services Departments have fared in pursuing the generic principles of the Seebohm

reorganisation in 1971. Howe writes:

> "Work with children and their families, and work associated with the elderly and physically handicapped forms the greatest part of fieldwork practice".

He quotes Goldberg (1977) as noting that the young and the elderly and the disabled are the two groups most likely to be receiving long-term social work involvement. But the author goes on to question how each client group appears to hold a different value to Social Services Departments at fieldworker level. He says that the initial attempts to interpret the philosophy of Seebohm meant that most Social Services Departments saw Social workers as "generic" practitioners.

> "The fate of this early "generic" interpretation became the subject of the present study, the aim of which was to discover how both the work and the workers in area teams were distributed seven years after the creation of the new Local Authority Social Services Departments" (Pg. 135).

The caseload of each fieldworker was analyzed in terms of three major client groups, as follows:

1. Children and their families.

2. The mentally ill and the mentally handicapped.

3. The elderly, frail and physically handicapped. (Including work with the deaf and visually-handicapped)

Equal weight was given to each case, and if the proportion of any one of the categories rose above 70 per cent of the total caseload, it was said that there was a marked bias.

To summarise Howe's findings:

1. 70 per cent of fieldworkers had a marked bias on their caseload.

2. 43 per cent had a bias towards children and families.

3. 63 per cent of workers in metropolitan authorities had a child care bias.

4. 5 per cent had a caseload biased towards the mentally-ill and mentally-handicapped.

5. 30 per cent of fieldworkers had no marked bias, ie. a generic caseload.

6. Generic caseloads are more common in the following workers:
   a. Social workers with less than 2 years experience.
   b. Intake/short term/Duty workers.
   c. Rural social workers.

7. The total caseload for all fieldworkers in the study - 12, 825. These were in the following groupings:
   a. 6413 (50%) - Children and families.
   b. 1539 (12%) - Mentally-ill and mentally-handicapped.
   c. 4873 (38%) - Elderly and Physically handicapped.

Howe concludes that there must be some mechanism at work which encourages certain types of cases to be allocated to certain fieldworkers, often at the expense of other categories of client groups. This is most prevalent in relation to child care cases.

However, the author was also able to comment on other factors which were shown up through the information he achieved. A summary of the findings relating to qualifications and caseloads is as follows:

1. Qualified social workers are more likely to have a marked bias towards child care, eg. in the metropolitan areas 77 per cent showed children and families, whilst only 2 per cent had a bias with the elderly and physically handicapped.

2. Unqualified workers were more likely to show a child care bias than social work assistants.

3. 19 per cent of unqualified workers in the county authorities had caseloads biased in child care, but 24 per cent showed a bias towards the elderly and physically handicapped.

4. 91 per cent of social work assistants showed a bias in work with the elderly physically handicapped.

Howe feels that although this makes a strong comment on the distinction between workers and child care and elderly and physically handicapped in terms of hierarchy, there is also the issue of work with the mentally ill being given a low status.

Fieldworkers were asked by Howe which client groups or problems they prefer to work in. A summary of the results is as follows:

1. 98 per cent stated a client group rather than a problem area, eg. "child care" rather than "people with financial problems.

2. 50 per cent preferred work with children and families.

3. 60 per cent of qualified workers preferred child care work.

4. 17 per cent preferred work with the elderly and physically handicapped.

5. 14 per cent wanted to work with the mentally ill/handicapped.

6. 18 per cent - no preference stated. (This last group included those new to social work)

7. 65 per cent of those expressing a preference wanted to work exclusively in that client group.

8. It was found that any bias coincided with the expressed preference.

9. The majority of social work assistants (25 out of 32) said that they preferred work with the elderly/physically handicapped.

It was also discovered that there was a relationship between the pre-Seebohm experience of fieldworkers and current caseload bias. This can be shown by the following categories:

1. 81 per cent of workers in the pre-Seebohm Children's Dept. had caseloads biased in children and families.

2. 47 per cent who had worked in the former Welfare Dept. had caseloads biased towards the elderly and physically handicapped.

3. 29 per cent who had worked in the former Mental Health Dept. had caseloads biased towards the mentally-ill/handicapped.

In the case of the elderly/physically handicapped, this figure compares with 24 per cent of the general population of fieldworkers. As regards mentally ill and mentally handicapped clients, this figure compares with 5 per cent of fieldworkers.

There was also an influence on the areas of work preferred by social workers, as follows:

1. 84 per cent of former Child Care Officers still preferred to work with children and families.

2. 81 per cent of ex-Mental Welfare Officers expressed a preference for work with the mentally ill and handicapped.

3. 53 per cent of former Welfare Dept. workers expressed continued interest in the elderly and physically handicapped.

Howe suggests that in theory the modern day Social Services Department genericist would hold a caseload the proportions of which would reflect the caseload carried by the team. However, in practice, the minority of workers hold generic caseloads (30 per cent), whilst the majority have a marked bias, the most common of which is towards children and families and work with the elderly and

physically handicapped. Sometimes the bias is so strong that the caseload could be described as "specialist", eg. social workers in urban areas sometimes had caseloads entirely made up of children and families.

Howe goes on to say that the child care work is allocated to those qualified workers who, because of their status, have the most power to influence the content of their caseloads. Child care was shown as the greatest area of preference. The elderly and handicapped, however, are allocated to social work assistants, unqualified workers, and non-graduate workers",whose power to acquire a child care caseload is limited" (Pg. 144).

The author takes this further with a discussion of hierarchies and "Dirty Work". (Pg. 144). He suggests that child care work is at the top of the "hierarchy", with the elderly and physically handicapped lower down, and for the purposes of his discussion, the mentally ill and mentally handicapped come at the bottom. He quotes from Scott (1970):

> "Throughout history, the mentally ill, the crippled, the mentally retarded, the maimed, the poor, and others who were similarly stigmatised as morally inferior have occupied an unenviable status in most societies of the world. Traditionally, such persons have been viewed as helpless dependents, incapable of mastering the elementary skills essential for engaging in productive social and economic activities" (Pg. 145).

The author also refers to the views of Pinker (1971) who alludes to the value of individuals according on their economic dependence on others, and their future economic potential being critical to the value placed on them within the group in which they belong. Children have the capacity to become future producers, whilst the elderly and mentally handicapped do not, and are therefore subject to more stigmatisation.

The author makes the point that this is often reflected in the relative value of resources made available to these groups. He makes the comparison that low status in medicine and nursing is to be located in services for geriatrics and mental "retardation" rather than in paediatrics or obstetrics.

Informal Specialisation - Methods.

Of specialisation by "method", Sainsbury (1977) says the following:

> "Social workers may become accepted therefore as specialists in work with a defined client group. . . . or in such skills as the development of groupwork, the understanding of welfare benefits, the problems involved in marital breakdown" (Pg. 185-186).

At the same time as looking at informal bias on caseloads by client group, there was an opportunity in this research to consider "methods". Parsloe and Stevenson (1978) make some interesting comments about this in their particular study:

> ". . . . . our social workers overwhelmingly used "casework", loosely defined, as their method of intervention. However, they did not identify this as a specialism since alternatives had not usually occurred to them" (Pg. 174).

The authors go on to say that there was very little evidence of the use of other methods apart from casework. This was attributed to the practice of allocating work by case rather than by task, and that social workers would not be able to find on their caseloads a clientele suitable for groupwork or families for a Family Therapy approach.

Stevenson (1981) only relates "method" to community work in her study, and suggests that

> "the unitary approach may offer a way of utilising community work which is more effective than the attempt to place specialists within Area teams dominated by caseworkers" (Pg. 120).

She refers to Sainsbury (1980) and a point of view already mentioned earlier in this chapter. Sainsbury feels that each "method" contains a variety of philosophies and assumptions, and doubts the appropriateness of the word. He says:

"Specialisation. . . . . by the "method" of social intervention misses the point that, within any client group or method the specialist worker may decide to exercise a broad and complex range of skills and tasks, some of which may lie beyond his personal competence" (Pg. 65).

Although the author of this current study would in many ways agree with this, it was still considered valid to try and gauge how much social workers were able to think in terms of a broader application of intervention than just "casework". It seemed reasonable to test out whether the same situation would occur in this research as with Parsloe and Stevenson (1978), when it was found that there was little evidence of any other method apart from "casework".

Informal Specialisation - Issues for the Research.

From the literature, it is possible to extract a number of questions or issues which this research needs to address. These are as follows:

1. Qualifications and grades have a significant impact on the types of client groups allocated to social workers.

2. Previous experience will determine caseload bias on a worker's caseload.

3. Child Care cases are usually allocated to qualified social workers.

4. Child Care, work with the elderly and work with the physically handicapped are the most common biases on caseloads, with a low priority given to the mentally-ill and the mentally handicapped.

5. Work with the elderly and physically handicapped is allocated to unqualified staff.

6. The majority of social workers have a bias on their caseloads, usually in child care, and generic workers are in the minority.

7. Intake and Short-term workers are more likely to see themselves as generic workers.

8. Informal specialisation by method is rare in social work teams, with a continued emphasis on casework as the principle method of intervention.

These issues will be discussed again in the chapter on "Conclusions" after the methodology and research data have been considered.

CHAPTER THREE: METHODOLOGY.

As explained in the Introduction, this research involved the study of eight Area teams across the southern half of the county of Hampshire, and four teams from the same Area Centre in Basingstoke. The information was gathered by using questionnaires and interviews with team-leaders. However, before describing and considering in detail the methods employed in the study, it may be useful to set this into a framework of social research generally.

M. Stacey (1969) outlined five types of social research as follows: "Problem solving Research", "Study of Particular Institutions", "Locality Studies", "Studies of Institutions within Localities" and "Theory Testing". The author makes the point that these types are not mutually exclusive and" clearly overlap and do not form a logically consistent pattern" (Pg. 13). For example, the study of a particular institution could be concerned with a "problem" and "problem-solving" research could test a particular hypotheses. "Nevertheless", the author concludes, "these five types will form a useful basis of classification" (Pg. 13).

As regards the first, it was not the intention to begin by believing that informal specialisation is necessarily a "problem" in itself, although it was anticipated that the study would show up a number of difficulties. M. Stacey suggests that this type of "research is done because some person or authority feels that something is wrong and ought to be put right, or that something could be done better than it is being done at the moment" (Pg. 12). Whilst it was accepted that there could be elements of this in the results, the intention was to survey the situation.

The second type, "Study of Particular Institutions", does have some relevance to this research. Referring to the study of social inequality, M. Stacey says:

> "sociologists have been concerned with the way in which society is stratified: how it is divided into status or class groups or categories. General observation showed that some kinds of people felt themselves inferior or superior to, or the same as, other kinds of people" (Pg. 20).

In considering the Social Services Department as an institution, it is clear that the study of specialisation raises issues of status. The questionnaire that was used,

as will be seen, specifically asked for information about grades of social worker, details of qualifications and previous experience. It is also generally assumed that certain kinds of work, eg. adoption, child protection, carry a higher status than other kinds of work.

Thirdly, there are "Locality Studies", where the focus is on the "interrelations of one set of institutions to another within one society, to see its constituent parts, and how these are articulated to each other" (Pg. 25). There could have been arguments to examine a smaller number of teams in more detail and to compare these, or to look in detail at one Area Centre. However, it was felt that there was such a lack of information on informal specialisation that the priority was to gain a much broader view of the situation. The research came close to this was with study of all four teams in one area, Basingstoke. However, this was carried out because Basingstoke was the only area in Hampshire at the time which was organised into "specialist teams", ie. child care, disability, elderly care.

The study of "Institutions within Localities" is a combination of the previous two approaches. As with the previous type, there could have been arguments to look at one particular Area Centre in some detail. Issues concerning caseload bias could have been discussed in relation to factors influencing the work of the Area. These would have included referral rates, caseloads of specialist staff, eg. Area Fostering Officers, and the work of other agencies involved in similar client groups in the area, such as Child Guidance, Probation, and Hospital Social Work Departments. However, this again would have distracted from a broad view of informal specialisation. A narrow focus on one Area would have produced some information on issues about caseload bias, but it was felt that the priority was to achieve considerable data across a number of teams which would lead to some more general conclusions.

Lastly, M. Stacey talks about "Theory Testing. She says that:

> "Sociological Theory. . . . is concerned with a series of propositions which explain social relations and social processes as they are, and since they explain, can also predict" (Pg. 28).

Although the chapter on "Literature" (Chapter Two) deals with a number of theoretical issues about "Specialisation", this research rests more on testing out a hypothesis and on an "Area of Study" Stacey says that "some people consider that a piece of social research is not scientific unless it has a clearly defined hypothesis which it sets out to test" (Pg. 6). She goes on to say that viable hypotheses can only be developed in areas where empirical data has already been collected. As far as my study is concerned, there is a body of data available, and it was a question of building on this in more detail. As far as Hampshire Social Services was concerned, I wanted to test out commonly held assumptions about the work of both qualified and unqualified social workers. The hypothesis I started with was as follows:

> Generic work in social work teams in Hampshire is subordinate to the necessity for qualified staff to take on child care and mental health clients, leaving unqualified staff to deal with the majority of cases involving elderly and disabled people.

M. Stacey quotes Goode and Hatt(1952) as taking

> "the view that it is essential to have an hypothesis to guide research, ie. a statement of the object of research which may be deduced from existing theory and which will lead to an empirical test"(Pg. 8).

She goes on to explore arguments between "Areas of Study" and "Hypotheses". Sellitz, et al. (1959) accept the value of research of an "Area of Study" in order to reach a hypothesis. This particular research is as much an Area of Study, and I was open to the fact that the hypothesis may well develop as more data became available.

The Area of Study.

The initial objectives of this research were far more concerned with "Specialisation" as a general topic. However, it soon became apparent that this is a vast field. Early thoughts on possible areas of research were as follows:

A. A survey of specialisation by "Setting", eg. comparison of the methods of work in Area Centres, Hospital Social Work Departments, Child Guidance Clinics.

B. A survey of specialisation by method, eg. group-work, community work, casework, family therapy, task-centred approach etc.

C. A comparison of the efficacy between "generic" and "specialist" workers.

D. Research into the relationship in Area Centres between "generic"and "specialist" staff, eg. Area Fostering Officers, Day-Care Officers for the Under-Fives, Intermediate Treatment Officers.

E. A survey of "Identified Workers", eg. social workers who have a designated specialist role alongside or as part of their normal role in a social work team, and which usually requires extra training, eg. Approved Social Workers (Mental Health Act 1983), Adoption work, Guardian ad Litem and Reporting Officers.

F. Research into "Informal Specialisation", ie. case-load bias. This would focus on the potential conflict between the "special" interests of social workers and the need for team-leaders to ensure an even delivery of service from their teams.

G. A study looking at comparisons between specialist workers responsible for creating resources eg. Fostering Officers, Day-Care Officers, and those responsible for providing specialist services, eg. Adult Placement Social Workers, Mental Health and Mental Handicap social workers.

H. A survey of specialist workers "out-posted" from Head-quarters at Winchester, eg. Adult Placement Officers (who are responsible for recruiting "carers", as opposed to Adult Placement Social Workers, responsible for supporting "carers"). This group of specialists would also include social workers for the Deaf, and the Programme Co-ordinator for the Teenage Family Care Programme, which recruits "professional"

foster-parents for adolescent children.

l. A general survey of specialist workers across Area Centres in Hampshire, looking issues concerning professional support, use of specialists in different Area Centres, vacancy levels and recruitment.

It was obvious that it would be impossible to focus in any depth on all of these. Initially, it seemed as though they fell into three main groups, as follows:

a. Research primarily into "generic" social workers within teams. This could cover issues about "informal specialisation", "identified workers" and specialisation by "Setting", and specialisation by" Method".

b. Research into specialists in Area Centres who have client-groups as a focus, eg. Area Fostering Officers, Day-Care Officers etc. . This could include a general survey as well as comparisons with "generic" staff.

c. A survey of specialist workers, with a focus on the distinction between "client-group" and service provision, incorporating both Area based and out-posted H/Q staff.

Firstly, it was decided to limit the study to Area based specialisation, which would make the collection of data more manageable and lend a more unified approach to the task. As regards specialists in service-provision, I felt that there were an insufficient number of these to warrant a great deal of concentration. In addition, the idea of social workers specialising in mental health or mental handicap was at the time still fairly new, and I did not consider that enough experience had been built up to have an impact on the general situation regarding specialist workers. For these reasons, I discounted proceeding with the field of study shown in C. above.

A major decision was required about whether to focus on a. or c. as shown above. At the time, a particular interest and priority seemed to be issues surrounding specialisation by client-group and its effect on an otherwise "generic" service. However, it seemed to be difficult to launch into this without first considering how social workers saw themselves as specialists in their own right.

This would surely influence, it could be argued, how they used "formal"specialist workers and lead to some ideas of how tensions were created between them. A focus on social workers and their caseloads would also make it possible to gather information on specialisation by method and on "identified" workers. It was also apparent that there was little information within Hampshire on "informal specialisation". There were a number of assumptions amongst staff in Areas at the time that most Level 3 social workers, and, indeed, most qualified social workers, specialised in child care work. This was because it was seen as the area of work carrying the most risk. There was also the assumption that most of the work with the elderly and disabled was left to unqualified social workers, ie. Social Service Officers and Social Work Assistants. I felt that it would be interesting to test out these assumptions.

Having decided that a survey of caseloads was the priority, I wanted to link this with some data on formal specialists(by client-group). I planned to achieve this by a series of interviews with specialist workers, who would be "key informants. As the research progressed, the volume of data gathered made this more and more impossible, and there was a further decision to limit the study to "informal specialisation".

The Data.

Once the decision had been made about the particular area of study within the field of specialisation, there seemed to be three further decisions which needed attention:

A. The nature and amount of information needed in order to prove the hypothesis.

B. The selection of and number of Area Teams which would take part in the study.

C. The method for collecting the information.

The Information.

It seemed that it would be necessary to link biases on caseloads with a number of other factors which could influence how and why social workers pursued their interests in particular client groups. In addition, other kinds of information would be necessary to establish links between grades of social worker and the type of work in which they were engaged, ie. emphasis on particular client groups. it was felt that information would be needed on social workers and their caseloads as follows:

1. Grade or Level, eg. Level 1, 2, 3, Social Service Officer, Social Work Assistant, Family Aide, Specialist Worker.

2. Qualifications.

3. Previous Experience.

4. Number of cases on case-loads.

5. Primary and Secondary biases on caseloads.

6. Information on whether they were "identified workers".

It seemed important to gain information about "previous experience" to see if this led to particular forms of specialisation, eg. whether someone with a background in residential child care would specialise in work with children and families in an Area Team. As regards "primary" and "secondary " biases, experience of managing teams had shown that social workers often have a "sub-specialism" on their case-load. This may often be a particular category within a client-group, eg. children under five, the elderly mentally infirm, mentally-handicapped children.

It also seemed important to gauge how much specialisation was a problem, either to the worker, to the team or to the team-leader. This led to a further category of information:

7. Issues and attitudes to Informal Specialisation.

One of the objectives in the hypothesis was to test out how generic a sample of social workers were, and information was originally specified on "genericism" within caseloads. The pilot project, as will be seen in later in this chapter, showed this to be unnecessary, since the sections in the questionnaire on primary and secondary biases covered this issue.

It was decided that the teams taking part in the study should include at least two Intake Teams. In addition, some of the teams would deal with their own crisis and short-term work, and this led to a further category of data:

8. Short-term, crisis and Intake specialisms.

This rested on the belief that social workers operating in this kind of team could develop specific skills in certain areas, eg. welfare rights, fuel debts, financial problems.

Other categories in the questionnaire will be covered in the relevant section later in this chapter.

The Selection and Number of Area Teams.

The selection of Area Teams was based more on accessability and the need to limit travelling time rather than on any true "sampling" basis. It was important to get a cross-section of teams in different geographic areas. As a basis for comparison, it was also important to look at an Area which was also divided into specialist teams. It was felt that it would also be interesting to look at two generic teams within the same Area Centre. In terms of numbers and considering the amount of information to be collected, it was decided that a manageable number would be twelve social work teams, which would also include four specialist teams within the same Area Centre. The teams selected for the project were as follows:

Alton Area- Alton team

Petersfield team.

Portsmouth Area 2 - Intake Team.

Test Valley Area - Romsey Team.

Portsmouth Area 3 - Portsea Team.

Eastleigh Area - Intake Team.

Havant Area - Southern Team

Fareham Area - Portchester Team.

Basingstoke Area - Child Care Teams (2)
Elderly Team
Disability Team.

The advantages with the first eight teams on the list were that they were within easy travelling distance of Portsmouth, which was the base for the research. Secondly, they represented a good cross-section of Area Centres in the South of the County. Thirdly, six of the teams were part of a "patch" structure, which meant that they had to operate on a thoroughly "generic" basis within their geographic areas. This was seen as essential with regard to meeting the objectives of the research, rather than using" long-term child care" teams, where specialisation has already begun to take place. It seemed important to do a comparative survey of an Area Centre which had organized itself into specialist teams. This would show whether there would be similar issues in social workers developing "sub-specialisms" within their case-loads, even though broadly their specialisation would be in either child care, or with the elderly or disabled.

The Method.

The methods needed to gather the information presented further challenges. It would have been possible to design a questionnaire and send it to all social workers involved. However, a high response rate could obviously not be guaranteed. It would also have been necessary to design a separate questionnaire

for the team-leaders, since some of the information, eg. " attitudes and issues", needed to come from them. In terms of time, it was not considered feasible to interview all the social workers (including Social Service Officers and Social Work Assistants), since a rough count numbered these at about eighty members of staff in all. It was also important to be able to consider the information by "team" as well as by social worker so that the impact of informal specialisation could be seen in terms of its effect on team-members. An individual approach to social workers could have detracted from this.

Considering the need to gather a large amount of information on this number of social work case-loads and the need to see this in terms of teams, it was decided to adopt the following methods:

1. To design a questionnaire which could succinctly contain the information needed.

2. To complete this questionnaire through interviews with the team-leaders of the teams selected. The team-leaders would be seen as "key-informants".

The disadvantages of this approach were that the research would only reflect the views of one person with regard to the entire team. However, the need for an overall view of case-loads within each team and the need to collect the data in a manageable way seemed to outweigh these disadvantages. It seemed that the most important factor would be the information on primary and secondary biases, and it seemed reasonable that attitudes and issues about these could be expressed by the member of staff who has management responsibility. To achieve this from all the staff involved would have increased the scale of the survey to unmanageable proportions, or would have meant a much more detailed look at a smaller number of teams.

It was decided to approach the team-leaders directly by telephone to explain the objectives of the research and to seek their permission for interviews. It was further decided that the pilot project would provide some information on the probable length of interviews, as well as testing out the questionnaire.

The Questionnaire.

The design of the questionnaire had to take into account the need to collect a large amount of information on each team. It also had to be manageable in practical terms so that it could be easily filled in during the course of an interview. Having experimented with various lay-outs on A4 paper, I discovered that the only size suitable would be A3. I decided to use vertical columns for the types of information and horizontal columns to show the position for each social worker. (See specimen questionnaire in Appendix 1). The types of information requested was as follows:

1. *Name of Social Worker.* This was included for ease of discussion during the interview, but it was recognised that names would not be needed for the analysis of the information.

2. *Grade of Social Worker.* This would include the following, and at the time reckoned to embrace most grades and levels of staff.

Social worker - Level 1
Level 2
Level 3

Social Service Officer

Social Work Assistant

Family Aide

Specialist Worker

Other.

3. *Qualifications.* The intention was to examine professional qualifications, but it was also decided to include academic qualifications, first degrees and higher degrees. The list was as follows:

C. Q. S. W. / Diploma in Social Work.

C. S. S. (Certificate in Social Service).

Degree

Other.

No qualification.

4. *Previous Relevant Experience.* This was designed to see if there were any links between previous experience and areas of specialisation. "Experience" could be either within Social Services or any job or career. Types of experience considered most likely to precede working in social work were as follows:

a. Nursing.

b. Teaching.

c. Residential work.

d. Police.

e. Youth Work.

f. H. M. Services.

g. Other.

5. *Size of Caseload.* Experience of managing teams had shown that case-load numbers can vary depending on the level or grade of social worker, and whether formal specialists carry case-loads. The range, therefore, was set as follows:

9 or under.

10 - 19.

20 - 29.

30 - 40.

41 and over.

6. *Generic Caseload* (ie. no bias). As explained previously, the pilot project showed that this section was superfluous, as this information was contained in the section on case-load bias.

7. *Primary and Secondary Biases.* This section of the questionnaire would clearly be the most crucial in terms of information, and its design needed careful consideration. It would not be possible to show on the questionnaire every possible sub-specialism within each client group, eg. child care, elderly, mental health, mental handicap, physical disability. However, practice experience had shown that there were fewer sub-specialisms in client groups other than child care, and the pilot project could be used to test out initial categories.

In addition, the categories specified at the top of the questionnaire, (See Appendix A - Specimen questionnaire), need only be considered as a guide, and under "Other", different sub-specialisms could be shown. Clearly, there would have to be a set number of groupings in order to analyze the findings. The categories at this stage were set as follows:

1. Elderly.

2. Mental Health.

3. Mental Handicap.

4. Physical Handicap.

5. Blind.

6. Child Care - Voluntary Supervision.

7. Child Care - Delinquency.

8. Child Care - Non-accidental Injury.

9. Child Care - Sexual Abuse.

10. Child Care - Family Placement.

11. Child Care - Under Fives.

12. Other.

It was felt that these categories represented the majority of client specialisms. Information on these would lead to a picture of each social workers case-load in terms of" bias" towards particular specialisms. It was envisaged that these categories would be shown at the top of each questionnaire and the information relevant to each social worker written in the space across the page.

8. *Attitudes to Informal Specialisation.* Although it was recognised that it would only be possible to gauge the team-leaders attitudes, this section could also cover "issues", and include social workers views as reported by the team-leader. The various options concerning informal specialisation were seen as follows:

1. Not encouraged.

2. Encouraged, but within the constraints of the overall priorities of the team.

3. Encouraged for reasons concerning professional development.

4. Other issues.

It was hoped that this section would throw up some of the problems in this kind of specialisation. Practice experience has shown that some social workers only wish to work with certain client groups, and have quite some proficiency in this. The problem for the team-leader is that he or she has to ensure that other client groups are given equal attention by other team-members. There are also teams which are committed to a generic approach from each social worker and any kind of specialisation is actively discouraged. Thirdly, it has long been recognised that social workers recently qualified need a range of experience in a team before taking on any kind of specialisation.

9. *Identified Workers.* At this time in Hampshire Social Services Department , certain areas of work were seen as carrying the need for specialist expertise and needed to be given to Level 3 social workers. Area Centres were asked to "identify" these workers, and decisions were made by team-leaders and Area Managers in terms of a worker's grade, experience and future development. It was expected that training would be offered in these areas of work, and no other social worker would become involved unless they had been "identified"

At this time, the following were "Identified Workers"

1. Approved Social Worker - Mental Health Act, 1983.

2. Reporting Officer - 1975 Children's Act.

3. Guardian ad Litem - 1975 Children's Act.

4. Social Work - Mental Handicap.

5. Court Officer.

6. Other.

10. *Types of Teams.* This section asked whether the team was one of the following.

1. Generic team.

2. Long-term team.

3. Intake/ Short-term team.

The pilot project showed that this information could be more easily achieved at the beginning of the questionnaire.

11. *Intake, Short-Term, Crisis Specialisms.* This information was particularly relevant to the Intake Teams, but it was also considered viable for other teams where social workers were on "Duty" rotas. The categories in the questionnaire under this heading were as follows:

a. Welfare Rights.
b. Fuel Debts.
c. Homelessness.
d. Advocacy.
e. Family Crises.
f. "One-Off" Assessments.
g. Telephone work.
h. At Risk work.
i. Resource finding.
j. Legal Sanctions.
k. Other.

12. *Specialisation by Method.* It was felt that it would be useful to gain some information on the various methods which could be used and to see how widespread differing methods were. The repertoire was seen as follows and set out in the questionnaire.

1. Groupwork.

2. Community work.

3. Casework.

4. Family Therapy.

5. Modelling.

6. Task-Centred Work.

7. "Support and Practical" approaches.

8. Others.

For the purposes of this study and this particular questionnaire, the following definitions were used:

A. Groupwork - Any work with clients on a group rather than on an individual basis, which could include "support" groups run by Area Fostering Officers, for example, as well as therapeutic groups initiated by social workers as an alternative to traditional one-to-one interventions.

B. Community Work - Initiatives in the community where the focus is on a service or a neighbourhood rather than on the participants becoming "clients" of the Social Services Department.

C. Casework - One-to-One work, with the expectation that the case is "allocated" and joins the caseload of a social worker.

D. Family therapy - This is specifically defined within the social and clinical methodology of the discipline and involves further training for social workers. It is unlikely to be within the brief of unqualified staff.

E. Modelling - This was defined as an approach which depends upon a worker showing a client how to perform certain tasks or develop skills and on engaging in these tasks alongside them. It is often used by "Family Aides" working with families with parenting problems.

F. Task-Centred work - An approach where the worker agrees specific goals or objectives with a client and works towards achieving these.

G. Support and Practical - This was intended mainly for Social Service Officers and Social Work Assistants, and rested on the belief that their work can (but not always) represent the more "service-giving" aspects of the social work task rather than casework or more therapeutic methods of intervention.

H. Others - This was included to cover any other methods not covered in the list above.

The definitions are not intended to be more than a rough guide to different approaches. It was known that there would not be time during the interviews to go into these in too much detail, but reliance was placed on the team-leaders knowledge of how their workers used the various theoretical and practical models available to them.

13. *Caseload Numbers.* As has been explained earlier in the chapter, it was considered useful to include the size of social workers' caseload, and to see how this relates to both types of team and to their grade. As regards the specialist teams, it was felt to be necessary to gauge any differences between child care and adult caseloads. The range was set out as follows:

9 and under
10 - 19
20 - 29
30 - 40
41 and over.

The Pilot Project.

The questionnaire was tested out on 4 teams - a generic long-term team in the Southampton area, and in 3 generic teams in the researcher's own Area Centre. This involved a preliminary study of 33 social workers.

The information was achieved through interviews with the team-leaders of these teams. The interviews took between an hour and an hour and a half. The details concerning Levels and Grades was straightforward, as was the information on qualifications, although there was a tendency to go into some detail and mention "A" levels as well as Degrees and Professional qualifications. The team-leaders seemed to have a good grasp of their workers' previous experience. "Probation" was added to the list, as this came up on 4 occasions in the pilot project.

Information was requested on caseload figures, but there seemed little relevance in separating this into groups of numbers, eg. 9 and under, 10-19, etc. It was much easier to write the actual figure, as the team-leaders had records available of up-to-date numbers on caseloads.

Similarly, the section asking for a comment on whether the worker had a generic caseload seemed irrelevant, since this information became clear in the next section on primary and secondary biases. There was some experimentation in the section on caseload bias. To begin with, it seemed easier to write in the space provided the number representing the particular client sub-specialism, eg. Elderly was No. 1, Mental Health -2, right up to "Other", which was No. 12. However, although this was a speedier way of completing the questionnaire, it did not necessarily show enough detail any of the particular quirks apparent in some caseloads, particularly where specialisms under "Other" were concerned.

As a result of this piloting, a number of changes were made to the list of sub-groups. Firstly, the list was extended to include "Mental Health Support" and "Mental Health Statutory" to distinguish between work with the mentally-ill which could be undertaken by any grade or level of worker, and that which could involve a Section under the 1983 Mental Health Act, which would need a qualified and "Approved" social worker. Similarly, work with the elderly was divided into "Elderly-Support" and "Elderly-At Risk" because there seemed to be

distinction here.

As regards Child Care, "Delinquency" proved to be too narrow a category, and this was expanded to "Statutory Work - Care and Supervision Orders" as this embraced both delinquency issues and other children in care subject to compulsory orders. "Adoption/Guardian ad Litem" work was also added owing to the number of responses in the pilot project. There were in addition some responses which were concerned with work with families and the use of "Refuges for Battered Wives", so "Family Violence" was also included in the sub-groups. Lastly, some of the social workers were involved with families where there were severe relationship and parenting problems, and this led to the inclusion of a further category, "Family Functioning".

As regards the category, "Issues and Attitudes surrounding Informal Specialisation, " the pilot showed that the list of 4 questions on the questionnaire needed to be expanded. Firstly, there were a number of responses showing that bias was in the nature of the work undertaken by the social worker. This led to the inclusion of a further heading, "Defined by Role" This often applied to formal specialist workers. Secondly, it was felt there needed to be a comment about a generic caseload, so "Not Encouraged - Committed to Genericism" was added. Thirdly, there was no way of indicating disagreement between social worker and team-leader on the loading of bias on a caseload. "Conflict between Social Worker and Team-leader" became the next category to be added. Intake workers and those involved in Duty work were not specifically covered by the previous headings, nor was there any mention of methods of intervention. "Encouragement of Specialist Methods or Short-term/Intake specialisms" was then included. Lastly, the pilot also did not show up whether a worker was pushed into an informal specialism because his/her colleagues all had biases in particular areas of work, eg. social work assistants with the elderly because no-one else wanted this kind of work. "Specialist by Default" was the final category to be added.

As has already been mentioned, the information on the type of team came next in the questionnaire, ie. Generic, Long-term, or Intake, and whether the individual worker acted as a Duty officer. The pilot showed that it was more relevant to gain this at the beginning of the questionnaire, and there was really a clear idea about this when the interview was actually arranged with the team-leader.

The categories for sub-specialisms and Intake workers were actually written down on the questionnaire when the research was carried out. For the pilot project, 4 categories were used, ie. Financial problems, accommodation, welfare rights, and "at risk" work, but these were given as examples. It was felt that the list ought to be more specific.

Information on methods of work was gained without any apparent difficulty, with the team-leader having a clear knowledge of styles and methods of intervention. The pilot showed a limited range of methods, with "casework", "groupwork", "modelling", "task-centred work", "Family Therapy", and "Practical Support", all appearing as response.

General Comments - The Pilot Project.

It became clear that the questionnaire was going to carry a considerable amount of information. The pressure points seemed to be the sections on primary and secondary biases, which involved team-leaders most in terms of looking up their records on caseloads and thinking about the work of the particular members of staff.

It was evident that thought had to be given to what constituted "bias" and how to determine this. Primary bias was described as areas of work which the member of staff was mostly engaged in and as the priority on the caseload. This was usually co-terminus with a priority for the team. A secondary bias was seen as areas of work with less volume and time, but not necessarily less of a priority. Sometimes this could reflect a particular interest or perhaps a piece of project work, e. g . groupwork.

Howe (1980) in his research of social work staff and caseloads gained information about the composition of caseloads. He analyzed the data in terms of three large categories of work: Children and families;the mentally-ill and mentally handicapped; the elderly, frail and physically handicapped(including work with the deaf and visually handicapped.) He defines bias as follows:

> "The proportion which each client category assumed in a caseload varied from fieldworker to fieldworker. If the proportion. . . . . rose above 70 per cent of the fieldworker's total caseload, that caseload was said to have a marked bias in the direction of that category. In some instances, the proportion approaches 100 per cent" (Pg. 136).

Challis and Ferlie (1988) included caseload bias in their study of Area, Hospital and Specialist teams. Their definition of bias was as follows:

> "Respondents in Area Teams were asked to indicate presence of caseload bias for each of their fieldworkers. This was defined as 75 per cent of cases coming from one or two of the five main client groups (Child care, elderly, mental illness, mental handicap, and physical handicap. This was a tighter definition of bias than that used by Howe (1980)" (Pg. 14).

The definition used by Challis and Ferlie is closest to that of this research. Firstly, it depended on first line managers to provide this information, albeit by postal questionnaire. Secondly, this method looked at a percentage of "one or two" of the five main groups constituting caseload bias. Thirdly, there is the same use of the five client categories. The data in this current study depended on the team-leaders knowledge of the major groupings of client categories on their workers' caseloads. In the case of child care, this was often a case of a number of sub-groups, eg. preventive work, child abuse, adolescents. If the major proportion of the sub-groups were in one client category, this worker was said to be an "informal specialist" If they covered 3 or more of the main client groups, the worker was deemed to be "generic" If the sub-groups were made up of work with the elderly, mentally ill, mentally handicapped or physically handicapped, the worker was described as an "informal specialist with adults", and similarly for child care. There was one further category which acted as a bridge between "generic" and the "child care informal specialists", which hinged on child care sub-groups appearing equally with adult. This was termed "Child Care/Adult Mix". Clearly, in some cases, the dividing line between these and truly "generic" workers was narrow.

In many ways, this research goes further than that conducted by Howe (1980) and Challis and Ferlie (1988) in that it looks in some detail at a smaller number

of social work staff, and tries to link various other elements with issues of caseload bias, eg. previous experience, methods of work, numbers on caseloads, whether the staff are "identified workers", and the nature of the informal specialisation.

As the questionnaires were completed through interviews with the team-leaders, points could be clarified on these sub-groups and information on caseloads was ready to hand. The chapters on literature (Chapter Three) and on the Conclusions (Chapter Six) both look again at the research undertaken by Howe (1980) and Challis and Ferlie (1988) and some comparisons are made with findings.

CHAPTER FOUR: INFORMAL SPECIALISATION- RESEARCH FINDINGS.

Introduction.

In discussing the Parsloe/Stevenson study (1978), Michael Hill (1980), makes the following observation,

> "Specialisation is rarely total, rather a bias in workload".

He goes on to say that much specialisation consists in the worker devoting part of his/her time" to some special task or to the development of some special expertise" (1980). The Parsloe/Stevenson study (1978) showed that informal specialisation was common within the social work teams studied. The responses by social workers indicated biases in caseloads towards particular client groups rather than specialisation by tasks or methods of work. They found that most social workers seemed to welcome "bias within genericism", and they rejected the notion that a biased case-load implies special knowledge or skills. It was found that a bias for qualified workers was more likely to focus on a sub-group within a wider client category, eg.children and families.

> "We found, for instance, many examples of special interests in adolescence, single-parent families, children at risk, children in care or under statutory supervision, and, adoption and fostering, which were reflected in caseloads. This was sometimes accompanied by tendency for the elderly to be allocated to assistants or the unqualified and for the disabled to be allocated to occupational therapists".

In this study, it was felt to important to look at the situation in Hampshire, particularly to what extent social workers were operating as "generic" workers. It was also considered important to test out the assumption that the elderly and disabled were dealt with by unqualified workers. It also seemed pertinent to link this with a worker's previous experience and to gain information about other specialist roles they might have (see Chapter on Methodology). Information on the genericism of social workers would be gathered by focusing on biases on caseloads, and issues surrounding these would be explored through interviews with the team-leader of each team studied. I will repeat in the following the

headings under which information was gathered in the questionnaires.

The Questionnaire.

1. Level or Grade of social worker.
2. Qualification (If any).
3. Previous experience.
4. Number of cases on caseload.
5. Identified worker (If appropriate).
6. Primary bias on caseload.
7. Secondary bias on caseload.
8. Issues about Informal Specialisation.
9. Intake/Short-term specialisms.
10. Specialisation by method.

The findings or outcomes have not been presented in the same order as they appear on the questionnaire. It was felt that there should be a priority in which the information is discussed. Firstly, the scene is set by looking at levels, grades, qualifications, and previous experience. Secondly there is the main body of the research findings on primary and secondary biases on caseloads and a discussion on issues about these as described by team leaders. Thirdly, specialisation by method is dealt with, as this links closely with the activities of the social workers and has a bearing on informal specialisation. This is followed by the information on Intake or Short-term specialisms, limited since this was only a focus in two of the teams studied. Fifth, there is a discussion on Identified Workers, and, lastly, numbers of cases on caseloads.

A similar format is used to look at the data on the Basingstoke Area Centre in Part 2 of the Chapter.

The Data.

1. *Qualifications.*

Full details of the qualifications of all the Social Services Department staff involved in the study are shown in Appendix A. In this part of the study, i.e.

excluding Basingstoke, information was requested about a total of 58 Area Centre staff. Of these, 45 were qualified as social workers, and 13 were unqualified. Of the 45 qualified staff, 22 were also graduates. The majority of staff in each team were professionally qualified as social workers, with some teams having between 1 and 3 Social Service Officers or Social Work Assistants. One of the Level 3 social workers had the Home Office Letter of Recognition in Child Care. One of the Social Service Officers had achieved the Certificate in Social Service, and a Social Work Assistant had undertaken the In-Service Training Course in Social Care. None of the other 11 unqualified staff were shown to have any other qualifications. One of the Level 3 workers was not professionally qualified - she had gained this status on the strength of her long experience. An Intermediate Treatment Officer had a Teaching qualification, and was paid on a scale equivalent to a Level 3 social worker. The other "specialist" workers in this part of the study, ie. 3 Adult Placement Social Workers, 2 Area Fostering Officers, were all qualified.

In terms of the balance of qualified workers throughout the 8 teams, 7 had no less than 5 C.Q.S.W. holders (1 Home Office Letter). One of the teams had 4 qualified staff, of whom 1 was a specialist worker, and another of the teams had 3 qualified staff, the remainder being made up with Social Service Officers (2), and a Social Work Assistant.

2. *Grades.*

Amongst the qualified staff, 22 were at Level 3, 14 at Level 2, and 7 at Level 1. There were 10 Social Service Officers in the study, and 2 Social Work Assistants. Three of the qualified staff were Adult Placement Social Workers, one of whom also combined this with a further part-time job as a Level 2 social worker. In terms of posts, this gives an overall majority of 59 members of staff. Two of the Level 3 posts were occupied by Area Fostering Officers, one of whom was part-time. As can be seen in Appendix A, none of the teams had less than two Level 3 social workers, and the norm was 3 in each team. Five of the teams had two Level 2 social workers, and only 1 team had none at this grade. The Level 1 social workers were more thinly spread amongst the teams, with 3 teams with none, and the rest with at least 1 in each.

As regards, unqualified staff, 2 of the teams had no Social Service Officers or Social Work Assistants. Four of the teams had 2 SSO.'s each, 1 had 3, and the remaining team had 1. Two teams had 1 Social Work Assistant each. It is perhaps not surprising that the team with the lowest number of qualified staff (3), had the largest number of unqualified workers (2 SSO's & 1 SWA).

3. Previous Experience.

This section in the questionnaire looks at the possibility of links between a worker's previous experience and their current informal specialisation or bias, if any. A full breakdown of the responses on the questionnaires is shown in Appendix B. As explained in the Chapter on Methodology, the categories listed were as follows:

1. Nursing - General
   Psychiatric
   Mental Handicap.
   Children's Nursing
2. Teaching
3. Residential Social Work
4. Police
5. Probation Service
6. Voluntary Organizations
7. H.M.Services
8. Youth Work.
9. Home-Help Service.
10. Other.

Some responses included "No previous experience" and these have been included in the description of the results. To begin with, it would seem helpful to show the number of different types of response. This is greater than the number of social workers in the study because some members of staff listed more than one type. Following this, the information is shown by grouping the social workers into Levels 1, 2, 3 and Social Service Officers and Social Work Assistants. The specialist workers are dealt with according to their grade. Previous experience has

been linked with what was stated as their primary and secondary bias, or whether they were described as generic social workers. A number of staff were described as having general "Social Services" experience, and a further category has been added."Not known" or "Not recorded occurred on 3 occasions.

However, the number and incidence of responses is as follows:

			Total.
1.	Nursing -	General	2
		Psychiatric	2
		Mental Handicap	2
		Children's	-
2.	Teaching		1
3.	Residential Social Work -	Adults	6
		Children	3
4.	Police		11
5.	Probation Service		1
6.	Voluntary Organizations		8
7.	H.M.Services		1
8.	Youth & Community Work		2
9.	Home-Help		-
10.	Other:	Church Ministry	2
		Industry	3
		Administrative/Clerical	2
		Personnel	1
11.	Not Known		3
12.	Social Services Department		19.
13.	No previous experience		3.

Level 1 Social Workers. As can be seen in other sections of the study (Issues and Attitudes Surrounding Informal Specialisation), the trend with Level 1 social workers seems to be keep them 'generic' during their first year back from

training. This is to enable them to build up a broad spectrum of experience and to consolidate training. Of the seven Level 1 staff covered in the study, six were described as 'generic' in their primary bias. Only one showed a different response - a social worker who had trained as a teacher and had also worked for voluntary organizations. She specialised in work with children and families on a primary bias, but with no involvement in sexual abuse cases. Her secondary bias was in adoption. Another showed child care as a secondary bias, particularly work in child abuse and adoption. This social worker was shortly to move onto Level 2 status, and had considerable experience in Social Services Department before qualifying. This may account for her involvement in child abuse situations, which was unusual for this grade of social worker.

Three out of the seven had previous experience in Social Services, two of them in residential work with children. There was no particular links between the other four, showing experience in teaching, psychiatric nursing, youth work, and no previous experience. Because of the tendency to insist on 'generic' work for Level 1 staff, it is difficult to draw any conclusions about their previous experience. However, the mix of experience in this group can be compared with other groups of staff, and this will be dealt with later in the chapter.

Level 2 Social workers. A full breakdown of this group of staff showing previous experience and primary and secondary biases is set out in Appendix B. There were 14 Level 2 workers in the study. In terms of bias, these fell broadly into three groups as follows:

Informal Specialists - Child Care. Four out of the fourteen had primary biases in child care, and could be described as 'informal specialists. 'Their secondary biases were a mixture of generic and child care sub-specialisms. One showed work with the elderly as a secondary bias. Mental Handicap, Day-Care support to mothers and Under-Fives, and 'No secondary bias' were also shown. One of the social workers was also a part-time Adult Placement Social Worker, specialising in mental handicap. It is interesting that the other half of her job as a Level 2 social worker was specialising entirely in child care work. In terms of previous experience, it is interesting that three out of these four all had a background in residential care of children. One of them also had experience of teaching and working in pre-school playgroups. The fourth was described as having had 'No

previous experience.'

Generic Workers. There were six people in this group who were described as generic workers. These included three who were termed 'generic' with no other comment, and three whose primary biases spanned both adult and child care sub-specialisms, eg. elderly and children and families, with the comment, "excellent social worker across the board", meaning, with all client groups. Another had a very diverse range of work, covering children and families, adoption, children under 5, children subject to Care Orders and Supervision Orders, elderly support, and the physically handicapped.

In terms of previous experience, again a variety was shown, featuring Personnel work, residential care of the elderly, the Probation service, clerical and administrative work, and Social Services Department experience. One social worker's previous experience was 'Not Known'. There was no obvious pattern to this, and their previous experience seemed as diverse as the generic work in which they were engaged.

Informal Specialists - Adults. The third group of Level 2 social workers all showed primary biases in adult sub-specialisms, eg. elderly support and 'at risk', mental health, and psychogeriatric work. Five out of the eight primary sub-specialisms were in work with the elderly. The secondary biases were interesting in that they showed 'children and families' in all three cases, with the third being described as a 'reluctant genericist' and had child care work imposed on him.

As regards previous experience, Voluntary Work, psychiatric nursing, and a mix of Social Services Department/Theology/Engineering were shown. It is not known whether the voluntary work referred to included work with the elderly, but it was inferred that this was the case. It would seem that all three social workers had had some experience of working with the elderly before qualifying as social workers.

It is clearly difficult with such a small group of workers to draw any firm conclusions. However, it is possible to suggest the following:

a. Three out of the four informal specialists in child care had considerable previous experience of working with children.

b. All three of the informal specialists with adult client groups had previous experience of this work, with a bias towards working with the elderly.

c. The previous experience of the 'generic' group was as diverse as the work they were engaged in.

d. It is perhaps more interesting to look more generally at previous experience, as follows:

Experience in Social Services before qualifying - 7 out of 14.
Experience in a Caring profession before qualifying - 10 out of 14.
Other types of experience - 2
No experience - 1
Not Known - 1.

Although these numbers only relate to the Level 2 group at this stage, similar conclusions about the whole sample of social work staff will be drawn at the end of this section.

Level 3 Social Workers. Appendix B shows a full breakdown of the responses in this group, which consisted of 23 social workers. As with the Level 2 group, the primary and secondary biases on caseloads led to the possible categorisation into the following four types:

Informal Specialists - Child Care. There were 7 social workers in this category. Four of these showed both primary and secondary biases in child care, covering the whole range of specialisms, eg.Children and families, adoption, voluntary supervision, non-accidental injury, Guardian ad Litem work, etc. .There were 3 others whose primary biases were in child care, but showed a range of client categories as secondary interests. For example, two had involvement in work with mentally and physically handicapped clients. Another showed 'Physically handicapped young adults as a secondary bias, together with, 'Work with Special Schools. 'Lastly, a social worker showing a wide range of child care specialisms as a primary bias had involvment in mental health support as a secondary, together with child placement.

In terms of previous experience, two had backgrounds in residential child care, for whom one had involved looking after children under the age of 5 years. She showed this as one of her primary biases. One had experience of voluntary work, and another came from a clerical/administrative background. Naval Officer was shown for one of this group, and there were two instances of 'None shown. 'Apart from the temptation of an obvious link between the two former residential workers specialising in child care, there was no pattern to the previous experience in this group.

Specialist workers. The specialist workers really form a separate group. Although it is not possible to view their workload in terms of bias, since this is defined by their specialist role, it is still useful to look at their previous experience. Firstly, there was an Intermediate Treatment Officer, who carried a small caseload of teenagers subject to statutory orders, eg.Care Orders and Supervision Orders under 1969 Children and Young Persons Act. This caseload was in addition to his responsibility to provide groupwork for teenagers at risk of delinquent behaviour. His background was as a teacher in Secondary education.

Secondly, there were two Area Fostering Officers in this group, one of whom was part-time. The part-time worker had a background in residential child care(Under 5's) and as a social worker in the Welfare Department before the Local Authority Social Services Act reorganization in 1971. The second was a part-time Area Fostering Officer and worked a further 18 1/2 hours per week as a Level 3 social worker. Her primary bias, therefore, was in assessing and supporting foster-parents, a task defined by her role. The secondary bias constituted the other part of her job as a Level 3, and consisted entirely in dealing with children subject to Care Orders and Supervision Orders. She had many years of experience previously in both the Children's Department and the Social Services Department, mostly working with children.

It is clear that this group were too small in numbers to make any comments. It is interesting that they were all "formal" specialists and had considerable experience in the client group for which they were responsible.

Generic Workers. Out of the total of 10 social workers in this category, 5 were described as 'generic' in their primary bias. One, who had previous experience in church and community work, showed Court work with children as a secondary bias, together with work with the elderly. The other 4 were from the same Intake Team, and showed a variety of secondary biases in Adoption, a carer's group for elderly and physically handicapped, mental health and child care. A variety of previous experience was also shown, including, Auxiliary Nursing, Hospital Social Work, Management, and Social Services Department .One of these had a variety of experience in Voluntary Service, Intermediate Treatment, and as a community worker. There were a further group of 5 social workers who dealt with a range of client groups within their primary and secondary biases. One had a background in Social Services, dealt with child care and elderly cases, but preferred working with children. A second worked equally well with both elderly and child care, and had previous experience as a volunteer organizer and in residential work.
Another had experience in Social Services already, and dealt with elderly, children and families, and 'Family Functioning', (See Chapter on Methodology.)A social worker with previous experience as a Child Care Officer before the L.A.S.S. Act 1971 specialised in Mental Health, and all client groups. Lastly, a worker with previous experience in Social Services specialised in Child Care, Mental Health, and running a Mother and Toddler Group.

As with the Level 2 group, the previous experience was diverse. However, there did seem to be large proportion of workers with Social Services (or Welfare/Children's Department before 1971) experience, ie. 7 out of the 10. In terms of working in the Caring professions, all of these, 10 out of the 10, had this type of previous experience in the Generic group.

Informal Specialists - Working with the Elderly. There were 3 social workers who specialised in working with the elderly on an informal basis. One was a part-time worker with a background in teaching, whose primary bias was with the elderly with a small amount of child care as a secondary bias. Secondly, a worker with experience in residential work and housing for the elderly, whose secondary bias was shown as 'generic' work. Thirdly, a member of staff who had experience in a Hospital Social Work Department and who worked part-time, was shown as specialising in "elderly completely" Again, this group was too small to draw any conclusions. It is interesting that 2 out of the 3 had considerable experience of

working with the elderly, but the third had changed direction completely from involvment with young people to work with the elderly.

Out of the total of 23 social workers in this group, it is possible to make only the following general comments:

a. There was no specific link between previous experience and caseload bias in the Informal Specialists in Child Care. It was shown that 2 out of the 7 had former child care experience.

b. There was also no specific links between types of experience in the Generic group. It was interesting that 7 out of 10 had Social Services or Local Authority experience, and all 10 had a background in the Caring professions.

c. The 3 specialist workers all had considerable experience in the client groups with which they were working.

d. The Informal Specialists with the Elderly were a small group(3 workers), and it is not possible to make any useful comments.

In terms of overall experience before qualifying, it may be useful to note the following from this group:

Previous experience in Social Services/Local Authority	13
Previous experience in other Caring professions	4
Other previous experience	4
No experience shown	2

The total of workers showing previous experience in the Caring professions, therefore, was 17 out of 23.

Unqualified Staff - Social Service Officers and Social Work Assistants. There were 9 Social Service Officers in this part of the study, and 2 Social Work Assistants. The SSO's fell roughly into three groups. Firstly, there were 4 workers who could be broadly described as 'generic' in that their primary and secondary biases

covered a number of client groups, including child care cases. One showed a broad range of client groups, including non-accidental injury, Under 5's, elderly, and children subject to Care and Supervision Orders. This worker had a background in voluntary organisations. Another worked primarily with the elderly but showed a secondary bias in children and families, and was described as having had numerous years of experience in Social Services.

There was another staff member who specialised primarily with the elderly but was also involved with teenagers and sexual counselling. She had a wide range of experience, including teaching, residential child care, and nursing the mentally-handicapped. Lastly, a worker who had been in residential child care specialised in the elderly and psychogeriatrics, mental handicap and child care. Because she was part-time, all of these were shown as primary biases.

A second group of 3 workers seemed to be generic within a range of adult client groups. One, who had a background in both General and Geriatric nursing showed working with the blind, and the elderly as primary biases, with mental handicap and physical handicap as secondary interests. Another, who had been in the Police Force, showed primary interests in working with the elderly, the blind, the physically handicapped, and the elderly 'at risk' as a secondary bias. Lastly, a member of staff who came from an administrative/clerical background, showed primary interests in work with the elderly, the mentally handicapped and the physically handicapped. She had been an Occupational Therapy Assistant (Social Work Assistant Status) with Social Services before taking up her current post.

Lastly, there were 3 SSO's who specialised much more in work with the elderly.but this was not exclusive. One used to work as a Good Neighbour Organiser with Social Services, and she was involved entirely with the elderly. A second was shown as having no previous experience, and she worked mostly with the elderly but also the blind. Thirdly, a worker who had considerable experience within Social Services was also entirely concerned with the elderly.

There were 2 Social Work Assistants. One of them carried a large and difficult caseload of elderly, mentally-handicapped, Under 5's, children and families, mental health, and teenagers on Care Orders and Supervision Orders. These were spread across primary and secondary biases. He was a draughtsman with a major

electronics firm before joining Social Services and had no other experience. The second SWA had a background in voluntary organisations and residential care of the elderly. She was mostly involved in elderly clients, but took on the physically handicapped and the blind as a secondary interest.

It is clear that this is a small group of staff and it is difficult to draw any firm conclusions. There is a further problem in that it is more difficult to use the word "Previous" in describing experience since there is no cut-off point for professional training as there is for qualified staff. Some of the unqualified workers had been in their posts for many years and had no experience before this. Others were able to show previous jobs or areas of experience before working for Social Services. However, it is possible to make the following general comments:

a. There was no pattern of previous experience which could be linked to caseload bias.

b. Seven out of the 12 had previous experience of Social Services, either in an Area Office or in residential work.

The overall picture in terms of previous experience is as follows:

Previous experience in Social Services	7
Previous experience in Caring professions (including Social Services)	9
Other experience	2
No experience	1

The information on the responses concerning previous experience has been presented by discussing the groups of social work staff involved in the study, ie. social workers at Levels 1, 2 and 3, and Unqualified staff. Comments on the data have been made at the end of each section, but more general conclusions about the whole group of 58 staff will be presented in the chapter on 'Conclusions' later in the study.

3. Primary and Secondary Bias on Case-loads.

The information on this section is presented in 3 parts. Firstly, there is an examination of the number and type of responses, with a comparison between primary and secondary biases. Secondly, it will be necessary to refer constantly to the tables 1, 2, 3 and 4 in Appendix C, which show a complete breakdown of the primary and secondary biases on the caseload of each member of staff. Thirdly, there is a description and a discussion on the findings. As indicated at the beginning of the chapter, the information on the remaining sections of the questionnaire will be covered after this section.

Number and Type of Responses. Firstly, the category Generic has had to be added, (see Chapter on Methodology) to reflect the large number of responses. Secondly, there were a number of responses about social workers who covered the whole range of child care work rather than a combination of specific groups as requested in the questionnaire. These have been shown as a separate figure.

As can be seen in Appendix C, most social workers show primary bias in groupings of 2 or more client categories. The exception to this is where they are described as 'Generic.'Secondary biases tend to be, though not always, one client category. Some discretion had to be applied in grouping these responses. For example, where the response was just shown as 'elderly', this has been categorised under 'elderly at risk' and 'elderly support and day-care', since a worker specialising in this kind of work would be involved in both. There were 2 instances of Area staff involved in 'Psychogeriatric' work. These were grouped under 3 headings, ie. elderly support, elderly at risk, and mental health support, and thus counted as 3 responses. Area Fostering Officers have not been shown to deal with fostering assessments as a primary bias, since this task is defined by their role. However, small caseloads attached to their role or forming part of a further part-time post attached to their A.F.O. hours, have been included as a secondary bias. To a certain extent, formal specialist workers are dealt with separately.

The Responses.

Client Category	Primary	Secondary
1.Elderly - Support, Day Care Services	25	6
2. Elderly - At Risk	21	5

3. Mental Handicap	8	5
4. Physical Handicap	4	7
5. Mental Health - Support	5	5
6. Mental Health - Statutory	1	1
7. Blind/Partial Sight	3	2
8. Children and Families - Voluntary Supervision	7	7
9. N.A.I./Child Abuse	2	4
10.Sexual Abuse	0	2
11. Child Placement	0	3
12. Under 5's	4	1
13. Care Orders/Supervision - Statutory work	8	6
14. Children Leaving Care	0	0
15. Adoption/G.A.L./Reporting Officer work	3	8
16. Family violence	0	0
17. Family Functioning	1	1
18. Children and Families - all types of Child Care	9	4
19. Generic Work	16	3
Total	117	70

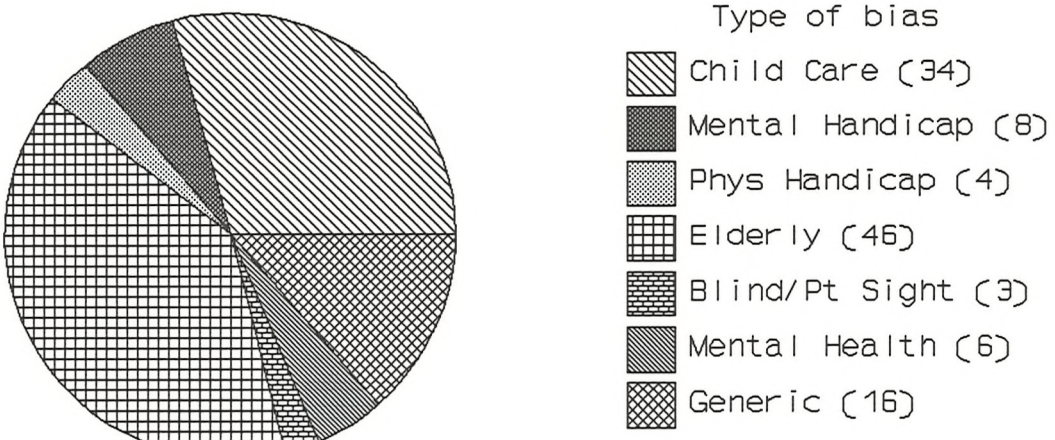
As can be seen, there were fewer responses for secondary as opposed to primary biases (70 - 117). In the case of 15 social workers, there was no response under Secondary Bias, and these included 7 social workers described as Generic. The low numbers for some of the Child Care categories could be misleading, since there was a larger number of Child Care sub-specialisms than those relating to work with the elderly, ie. 11 as opposed to 2 in the latter group. If the Child Care responses are added together, a clearer picture emerges. For simplicity, I have also added together the Elderly and Mental Health categories:

Client Category	Primary	Secondary
1. Elderly (Support & At Risk)	46	11
2. Mental Handicap	8	5
3. Physical Handicap	4	7
4. Mental Health (Support & Statutory)	6	6
5. Blind/Partial Sight	3	2
6. Child Care (Questionnaire No.s 8-18)	34	36
7. Generic	16	3
Total	117	70.

These figures are shown as pie charts over the page.

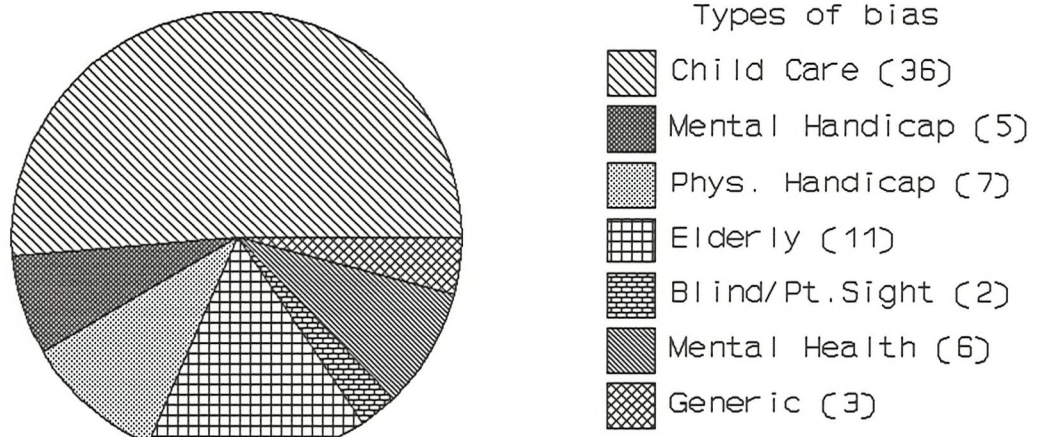
Primary Bias

8 generic teams



Secondary Bias

8 generic teams



As can be shown, the combined number of responses for Child Care is 70, as opposed to 57 for work with the elderly, although the latter features more numerically as a primary bias(46 for elderly as opposed to 34 for child care.) The next highest figure is for Generic work - a total of 19 responses. Although there was insufficient time during the interviews to ascertain what proportion of cases involving mental handicap, physical handicap, mental health, blind and partial sight were also concerned with children, it is reasonable to suppose that the majority of these clients were 'Adult' rather than 'Children'. At this time, the specialist services in Hampshire were divided into 'Adults' and 'Children and Families', with an Assistant Director responsible for each. Using these categories, along with Generic, the responses are as follows:

Client Category	Primary	Secondary	Total
Adults	67	31	98
Children & Families	34	36	70
Generic	16	3	19

It is interesting that responses for Adults score so highly, particularly work with the elderly. These figures do cast some doubt on the assumption that the majority of work in the department is directed at Child Care. Other comments and general conclusions can be found in the chapter on 'Conclusions' later in the study.

Primary and Secondary Bias. As with the section on 'Previous Experience', the information and findings in this section will be presented by grouping the social workers in terms of their grade, ie. Levels 1, 2 and 3, and Unqualified staff. Specialist workers will be dealt with within their grades.

Level 1 Social Workers. Out of the 7 Level 1 workers in this part of the study, primary bias was shown only for 1 member of staff. This consisted of a totally child care caseload, with the comment, "excluding sexual abuse". Her secondary bias was in Adoption. This seemed to indicate a greater level of experience than most of the others in this group.

The other 6 were all described as Generic. Only 1 of these showed a secondary bias, and that was in "Child Care - All Types, particularly Child Abuse and Adoption". Again, that seemed to indicate a good level of experience before

qualifying. The comment in all cases was that it is important for social workers to consolidate their experience with a generic caseload during their first year back from professional training.

This group was representative of 4 out of the 8 teams studied, and also represented 4 out of the 7 Area Centres involved.

In summary, the Level 1 social workers were classified as follows:

1. Informal Specialists (Child Care)	1
2. Generic workers	6

Level 2 Social Workers. As previously shown, there were 13 Level 2 social workers in the study. In terms of informal bias, they could be grouped under the following headings. (For full breakdown of primary and secondary biases, refer to Appendix C):

1. Generic	6
2. Child Care/Adult Mix	6
3. Informal Specialists/Child Care	1.
Total	13

Generic Workers. Out of the 6 workers in this group, 4 were actually described as "Generic", but 1 of these had a bias towards children and families, and showed "Adolescents" as a secondary bias. Another was identified as Generic, but with the comment, "including all types of child care, " but no hint as to whether this constituted a bias of any kind. The secondary bias was shown as work with the elderly. A third was called Generic but had secondary interests in Mental and Physical Handicap. Two social workers in this group had a wide range of sub-specialisms and were thus deemed to be generic workers. In one case, these included children and families and elderly support as a primary bias, and Under 5's, the physically handicapped, and children subject to Care and Supervision Orders (CYP Act, 1969) as secondary interests. A second specialised in work with the elderly and in mental health, and showed children and families as a secondary bias.

Child Care/ Adult Mix. This is a difficult group to quantify (See chapter on Methodology), since there is little difference at first sight from a 'generic' caseload. The common denominator is that Child Care features highly as either a primary or secondary bias and in almost equal proportion to other client groups. For example, one worker showed Mental Handicap and Child Care(particularly Adoption and Adolescent Work) as primary biases and Elderly as a secondary bias. Another(part-time) worker just showed Elderly and Children and Families, with no secondary bias at all. A third specialised in psychogeriatric work as a primary bias, along with mental health, and was described as 'generic' as a secondary bias, with "imposed child care". Four out of the 6 showed considerable child care involvment as a primary interest. One worker, particularly, was involved in a Mother and Toddler Support Group and Intermediate Treatment groups for teenagers, but was described as 'generic' mostly. Her secondary bias was with children and families and with sexual abuse. Another predominantly child care specialist, showing children and families and children subject to statutory orders under the Childrens & Young Persons Act 1969, had mental handicap as a secondary bias. There were 6 social workers in this group.

Informal Specialist - Child Care. There was 1 social worker who specialised completely in child care work.She showed "Children and families -all types of preventive work" as a primary bias, and "Day care support - mothers and young children" as a secondary. It is interesting that in the team in which she was based there were 2 other qualified staff with caseloads, both specialising either with the elderly or in generic work. The other team members were specialist workers, 2 Area Fostering Officers, and an Intermediate Treatment Officer. From discussion with the team-leader, it emerged that although child care was the preference of this particular worker, the needs of the team demanded that she should specialise in this type of work.

It is interesting that there were no social workers specialising in Adult/Elderly work on an informal basis. Even though there was a general bias towards child care in 'Child Care/Adult Mix group, it is also interesting that 12 out of the 13 workers were 'broadly generic'. The major difference from the Level 1 group is that the sub-specialisms were shown more distinctly and were spread across both primary and secondary biases. Only 1 staff member was described as 'generic'

with no other comment as opposed to 6 social workers in the Level 1 group. In addition, 11 out of the 13 Level 2 workers showed 1 or more secondary sub-specialisms, as opposed to 2 out of 7 in the Level 1
group. This seems to indicate that even though there was a generic feel to the caseloads, social workers are beginning to be identified with particular sub-groups within the client categories.

Level 3 Social Workers. Similar to the Level 2 group, the Level 3 social workers seemed to fall into the following categories. The number in each category is also shown.

1. Informal Specialists - Child Care	7
2. Generic workers	6
3. Child Care/Adult mix	6
4. Informal Specialists - Elderly/Adult	1
5. Formal Specialists	3
Total	23

Informal Specialists - Child Care. The primary biases of all 6 showed child care sub-categories only. In the secondary biases, there were 2 references to other client groups, 1 in younger physically handicapped and the other in mental health support, and these applied to two members of staff respectively. Three out of the 7 came from the same Area Office, but were spread across 2 teams. "Child Care- All Types" was mentioned for 3 social workers, as was "Children and Families - Voluntary Supervision". Four of the staff showed "Statutory work- Care and Supervision Orders". "Child Abuse" was given only once as a primary specialism, as was Adoption/G.A.L work. It is difficult to make any comment about the number of sub-specialisms given, as the response, "Child Care - All Types" covers all of these.

As regards secondary bias, all 6 showed at least 1 sub-category. "Sexual Abuse" came up once, as did "Adoption/G.A.L." work. "Child Abuse" was mentioned twice, as was "Child Placement". The latter did not feature at all in the primary biases. One social worker was unusual in being engaged in a Mother and Toddler Support Group as a secondary bias - the only example of group-work in this

section.

Generic Workers. Four out of the 6 workers in this section were described as Generic in their primary bias, with no other comment or sub-group mentioned. The secondary biases for these were varied. One showed 'Court-work', the elderly, and "Marital Counselling". Another showed "Adoption" as the only sub-specialism. A third was shown as dealing with Adoption work and a Carer's Group for the elderly and physically handicapped. A fourth showed no secondary bias at all.

The 2 remaining staff in this group included a social worker with a wide range of primary and secondary biases across all client categories, eg. "Elderly", Family Functioning", and Voluntary Supervision" (Children & Families) as primary specialisms, and "Statutory work - Care and Supervision Orders", "Blind", and "Physically Handicapped" as secondary interests. Lastly, a social worker was described as 'Generic, basically, but Child Care bias", as a primary, and "Mental Health" and "Child Care" as secondary interests.

Four out of this group of 6 came from the same(Intake) team, where there was clearly a strong commitment to generic work.

Child Care/Adult Mix. As has been mentioned before this group only differs from the Generic workers in matters of emphasis. Out of the 6 involved, 3 showed work with the elderly in their primary biases. Two, from the same Area team, showed their secondary interests as "Generic, including all types of child care."The third showed "Child Care - All Types" as a secondary interest. Two of the remainder showed "Child Care" and "Elderly" as primary interests, with" Adoption" and "Mental Handicap" respectively as single secondary interests. Lastly, a social worker had primary biases in "Child Care- All Types" and "Mental Health", and secondary interests in a Mental Health Support Group and a Mother and Toddler Support Group.

Three out of the 7 Area Centres were represented in this particular group. Three of the social workers came from the same Area, as did the 2 mentioned above with the same primary and secondary interests.

Informal Specialists - Elderly/Adult work. There was only 1 social worker who specialised entirely with the elderly. This was a part-time worker who showed the "Elderly" as a primary bias and no secondary bias at all. This social worker was based in an Intake team where the 2 Social Service Officers specialised in work with the elderly, and where there was an emphasis on generic and child care/adult mix on caseloads.

Formal Specialist Workers. There were 3 formal specialist workers at Level 3 in this group. Two were Area Fostering Officers, and, as can be expected, they both showed "Foster Parent Assessment" as a primary bias. One of these was part-time, and showed no secondary bias. The second also combined her role with a further part-time job (18 1/2 hours) as Level 3 worker. She showed secondary interests in children subject to Care and Supervision Orders(Statutory Work). The third specialist was an Intermediate Treatment Officer, whose primary role was in groupwork and court work with children and young people. He showed a secondary interest in "Adolescents" and "Care Orders and Supervision Orders."

Social Service Officers. Appendix D shows the full position for the 9 Social Service Officers in the study. Not one of them showed responses which could classify them as informal specialists in child care work. However, one of these could be described as carrying a generic caseload. He showed primary biases in statutory work(Care & Supervision Orders 1969 CYP Act), child abuse, Under 5's, and "elderly at risk." His secondary biases were in "Family Functioning", "Mental Health Support" and "elderly support."His work was said to have evolved from a specialisation with the mentally-handicapped and the elderly, and now includes the whole range of child care work. The only sub-groups he did not deal with were the blind and the mentally-ill. This worker was in a team with 2 full-time qualified staff, a part-time social worker, and 2 other unqualified staff. This team had the lowest number of qualified staff in the study, and it was not surprising that the team-leader pointed out the necessity of his taking on this kind of caseload.

There were 2 further SSO's who came into the category of Child Care/Adult Mix in terms of their biases. One had a primary bias with elderly work, and showed secondary interests in children and families under voluntary supervision. She had a number of years experience of working in a Social Services Department and was

described as "gentle and supportive." The second dealt mainly with the elderly and with mental handicap. Her secondary interest was in child care, particularly adolescents, but she was also skilled in sexual counselling and ran a Divorce Support Group. She was an experienced worker in the 'helping' professions, with a background in teaching, residential child care, and working with the mentally handicapped.

However, 6 out of the 9 staff in this section were involved to a great extent in working with either elderly or adult client groups. Each of the 6 showed either "Elderly Support" or "Elderly at risk" or both as a primary bias. Apart from one, these primary biases were combined with such sub-groups as the visually-handicapped, the physically handicapped, mental handicap, and psychogeriatric work. There was only one instance of a secondary bias, and that was in "elderly at risk" from a worker whose primary biases were in elderly support work, the blind and physical handicap. One worker showed only work with the elderly and no other sub-specialism. Two of these workers were part-time and from the same (Intake) team.

The overall position for the Social Service Officers can be summarized as follows:

a. Generic workers	1
b. Child Care/Adult Mix	2
c. Informal Specialists/Elderly/Adults	6

Social Work Assistants. Appendix E shows the full position for the 2 Social Work Assistants in the study. One came from the same team as the only 'generic' Social Service Officer described above. This SWA dealt with a wide range of client groups on a primary basis, and included the elderly, children and families, the mentally and physically handicapped and the Under 5's. Secondary biases were in Statutory work with children and families, voluntary supervision(children and families), and mental health support. The same comments apply here about the number of qualified staff in his team and the need, therefore, for him to take on such a wide variety of work. His background was in Industry. He also took on the role in the team as a specialist in aids and adaptations for the physically-handicapped.

The second SWA showed biases in working with the elderly - both "support" and "at risk". Secondary biases were in physical handicap and with the Blind. He had a background in residential work with the elderly and with voluntary organisations. He was based in a team in which 3 other members of staff specialised to some extent in work with the elderly, and the remaining 4 concentrated more on children and families. He was the only unqualified worker in his particular team, which consisted of three workers at Level 3 and three at Level 2.

Specialist Workers. The complete picture for Specialist staff is shown in Appendix G. There were 7 formal specialist workers in the study. These consisted of 3 Adult Placement Social Workers, 3 Area Fostering Officers, and one Intermediate Treatment Officer.

The Adult Placement Social Workers were all part-time, except that one combined this with a further 18 1/2 hour part-time role as a Level 2 social worker. The team-leader said that this arrangement had caused problems in the past. Another Adult Placement worker had a background in psychiatric social work. Her primary biases were in three of the adult client groups, ie. elderly, physical and mental handicap. The team-leader said that there was some informal specialisation at work, and cases were being taken on that were not strictly Adult Placement work. A part-time Adult Placement worker had many years experience(previously in the Children's Department in a London Borough). Her primary bias was definitely with the mentally-handicapped, with secondary biases in elderly support and elderly at risk. This was said to be 'defined by her role' and consistent with Adult Placement policy.

The Intermediate Treatment Officer was based in a team with 5 other qualified workers, and no unqualified staff. His primary interest was in groupwork with children, and he held a caseload as a secondary bias with Adolescents and children subject to Care and Supervision Orders(CYP Act, 1969). It is interesting that 2 of his colleagues in the team were also specialist workers - part-time Area Fostering Officers.

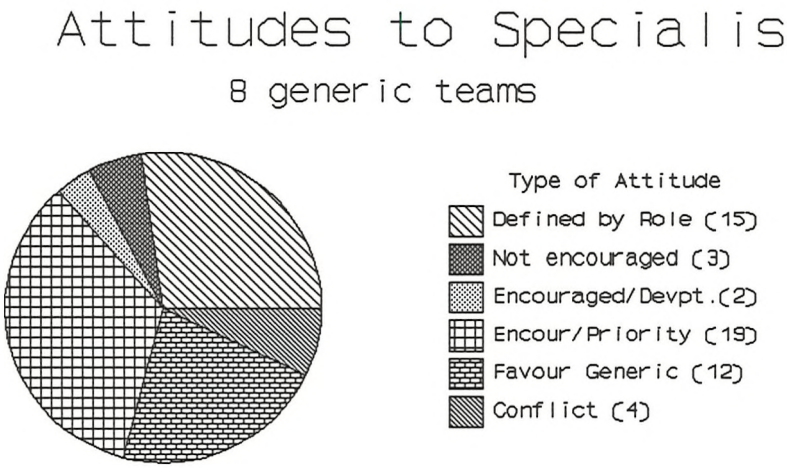
These two Area Fostering Officers operated differently within their team. One was full-time and combined her role with that of a Level 3 worker. Her secondary bias showed a caseload entirely devoted to child care, particularly with more complex

situations, eg.child abuse, sexual abuse, and adoption. Her primary bias was in foster-parent assessment and support, which constituted her Area Fostering role. The second was part-time, and showed a primary bias in foster-parent assessment and support, with no other primary or secondary biases. She had many years experience in both Social Services and in the Children's Department, particularly in the residential care of young children. Lastly, a third Area Fostering Officer from one of the City teams combined his role, which was full-time, with a small caseload of children and adolescents on statutory orders under the 1969 Children and Young Persons Act.

It is difficult to draw any conclusions from such a small group of staff. The only comment that could be made is that where there is any informal bias either within the sphere of work covered by the specialist or within a caseload additional to the role, this is likely to be in the same client group, The one instance where this was different, ie. an Adult Placement Social Worker who combined this with a Level 2 role with children and families, was said to cause problems. The bias on the caseloads could also be influenced by the needs of the team, which could conflict with their role of serving all the other teams in the Area. This is very much the author's view, and substantiated by comments from any of the team-leaders.

Issues and Attitudes Surrounding Informal Specialisation. Firstly, it would seem useful to set out again the headings in the questionnaire in this section, and to show the number of responses for each one. Each of the headings will then be discussed in turn. The chapter on 'Methodology' contains a full description of these headings and reasons for their use.

Heading.	No. of Responses.
1. Defined by role	15
2. Not encouraged	3
3. Encouraged for Professional Development	2
4. Encouraged subject to priorities within the team	19
5. Not encouraged - Commitment to Genericism	12
6. Specialist by default	0
7. Conflict between social worker & team-leader	4
8. Encouragement of specialist methods/short-term/Intake Specialisms	0
Total Responses	55.



Defined by Role. This category applied mostly to staff carrying generic caseloads, whose role dictated this, as seen by their team-leader. This included Social Service Officers, Social Work Assistants, and Specialist workers. One exception to this was a social worker in an Intake Team, who was described as 'generic' because that fitted best the type of work undertaken within Intake. There were 2 Social Service Officers in this group, both of whom dealt with adult client categories, eg. elderly,

blind, physically handicapped. One of these was described as a 'specialist by default' because of the needs of the team for him to do this work. The 2 Social Work Assistants fell into this category. One of them had dealt exclusively with the elderly but was now being encouraged to take on child care work as part of professional development. It was said that there had been conflict in the past about this, but was now more resolved, ie. agreement about an extension of role into child care work. This worker's primary and secondary biases covered a wide range of sub-groups, eg. elderly, children and families, Under 5's, mental handicap, physical handicap, children subject to Care and Supervision Orders (CYP Act, 1969).

The specialist workers included 3 Adult Placement Social workers, an Intermediate Treatment Officer, and 3 Area Fostering Officers. Their primary biases, with the exception of one, were all in the spheres of work dictated by their specialist role. The exception was an Adult Placement Social Worker who took on cases involving other tasks, eg. Part 3 assessments for admission to elderly persons homes.

This was as much a case of 'seeing through' situations which were originally referred for Adult Placement but were then unable to take this up. There seemed to be no other instances in this group of specialist workers not working to the brief which was defined by their role as 'Specialists.'

Not Encouraged. This section was included to show up any issues of Area policy with regard to informal specialisation. The responses in this group could equally well have applied to the section, 'Not Encouraged- Commitment to Genericism'. There were 4 responses, and 3 of these were about Level 1 workers who needed a broad range of cases in order to consolidate learning during their first year back from professional training. This group also included a Level 2 worker, about whom the same comments were made, but on the grounds of the need for experience. She was in the same Area Centre as 2 of the Level 1 staff just mentioned, and it seemed that the Area believed strongly in this approach.

Encouraged for Professional Development. There were 2 responses to this section. One involved a Level 2 worker whose primary bias was exclusively with the elderly, both 'support' and 'at risk', and whose secondary bias was in 'adoption'. The actual comments by the team-leader were that these biases represented, "partly team needs, partly encouraged for professional development, and his wishes, too."It was not clear whether these biases could be changed to accommodate other aspects of professional development, and it seemed as though the adoption work was a way of providing complex child care experience to offset the heavy emphasis on the elderly. In the same team, another Level 2 worker showed child care sub-groups as a primary bias(children and families, children subject to Care and Supervision Orders). The secondary bias was in work with the mentally-handicapped. The actual comments were, "Her wishes ... encouraged for professional development." It was not clear how this was being managed or how it fitted with a longer term plan. Both workers were soon to be

assessed for their Level 3 status. It was assumed that the variation in client groups and the informal specialisation in their primary groups would give them more experience and depth of knowledge with which to approach this assessment.

Encouraged subject to priorities within the team. This section, which attracted 19 responses, showed the most clearly the agreement between social worker and team-leader in the matter of informal specialisation. There were 6 Social Service Officers in this group, 5 of whom were entirely involved in work with the elderly. One also dealt with the blind, whilst another added mental and physical handicap to her caseload. Only one of these dealt with children and families, and that was in equal proportion to her work with the elderly. She was described as "gentle and supportive."Comments about the Social Service Officers ranged from, "personal preference and team needs", "what she is good at - needs of the team", "genuinely interested - suits team and her", "what she wants to do, is capable of, needs of team" and, "her choice, what the team needs, no experience of child care."

There were 10 level 3 workers in this category. Six of these specialised entirely in child care work, 2 specialised to an extent in elderly clients, and 2 were described as 'generic'. Comments about these were similar to those expressed about the group mentioned above. These included, "A happy coincidence, " "Team needs and social worker's preference, " "primarily wants this kind of work, " and "needs of the team, her wishes and skills."One Level 3 worker specialised in work with the elderly, and the comment was, "wishes to work in this way because of her background", which was in residential care of the elderly. Another was described as "generic" by "personal preference mostly, "but she also had to work with the elderly more because of the needs of the team. Two other Level 3 workers both specialised in child care and this was encouraged within priorities, but there was no other comment about their preference.

Three Level 2 social workers came into this group. One had a part generic and part child care caseload, and this was "encouraged within priorities, "but there was no other comment. Another, who was just coming off a protected caseload after professional training, specialised in adolescent work and with families, and the comment was, "Her choice and needs of the team". Lastly, a worker at this

grade had primary biases in elderly work and mental health, with a secondary interest in children and families. The comment about him was: "He enjoys this kind of work, it is what the team needs, and also for his own professional development."

Not Encouraged - Commitment to Genericism. There were 12 responses in this section, which included those from three Level 1 workers, three at Level 2, and six at Level 3. One in the first group was described as "truly generic" and this was because he was not long returned from professional training. Another at this grade was described as needing a "broad experience."Lastly, another newly qualified worker was also said to need a broad experience, although his main interest was in community work.

Three Level 2 workers invited such comments as, "Genericism encouraged" and "Committed to genericism." These comments did not necessarily preclude the worker from being described as dealing with a range of client groups, rather than just the word, 'generic.'One showed primary biases in preventive work with children and families, the elderly, and Reporting Officer work in Adoptions, whilst her secondary interests were in the elderly at risk, the physically handicapped, and statutory work with children (CYP Act, 1969). Another Level 2 worker had a generic caseload, but also did work on a primary basis with a Mother and Toddler Group and an Intermediate Treatment Group. Her secondary biases were in child care sub-groups. She was described as having to be generic because of the needs of the team, but her preference and her own bias was towards child care work. Thirdly, a worker at this grade in an Intake team was said to want to be generic, and this suited the needs of the team. His secondary bias was in working with the physically and mentally handicapped.

Within the Level 3 group, one worker was said to be committed to generic work, but there was another comment that it was difficult to develop informal specialisms as a part-time worker. There was some effort to encourage this for her with regards to professional development by a bias towards Schedule 2 reports in Adoption work. Another team member was described as a good social worker "regardless of the type of case."In this situation, generic work was essential for the needs of the team, although she did manage to hold a 50% child care caseload, which was her main interest.

The remaining four Level 3 workers all came from the same Intake Team. Three were reported as wanting to stay as generic, and this suited the needs of the team. It is interesting that no sub-groups were mentioned with any of these three - they were described by the single word, 'generic'. The fourth Level 3 worker in this team was described as "basically generic", but with a bias towards child care. One of the 3 just mentioned had only joined the team a week before the questionnaire was completed. He had a total of 4 cases, but was already saying he wanted to hold a generic caseload.

As a general comment, the two teams which showed the highest number of generic workers(3 and 5 respectively), were both Intake Teams.

Specialist by Default. There were no responses which gave this as a central comment. The only reference to this was a Social Service Officer already described in the section on 'Defined by Role.'He was in a team with 3 qualified workers and 2 other unqualified staff. The pressure on the qualified was to take child care work, which meant that he had to specialise in work with the elderly and other client groups.

Conflict between Social Worker and Team-leader. There were 4 acknowledged instances between a social worker and the team-leader, although the preferred description was "disagreement" or "agreement to differ."

Firstly, a part-time Level 3 worker showed involvment with the elderly as a primary bias - no other client groups were shown. A secondary bias was in "child care general."The comment was that she prefers to work with children but the needs of the team dictate that she works with the elderly. The position was reversed with another staff member at Level 3 whose primary bias was in working with the elderly and in all types of child care. Her secondary biases was in adoption work. She preferred working with the elderly but the team needed her to work equally with children and families. Another member of staff at this grade showed child care and elderly work as a primary bias, with mental handicap as a secondary. Her team-leader said that her main interest was in mental handicap, and the other work was determined by the needs of the team rather than her own preference.

Lastly, a Level 2 worker had primary biases in psychogeriatric work and in mental health. The secondary bias was in generic work, with "imposed child care."The team-leader said that this was resolved by "rational compromise" so that the worker had a partly specialised and partly generic caseload.

Encouragement of specialist methods or short-term and Intake specialisms. There were no responses under this heading. However, information on responses generally to this section in the questionnaire follows this part of the analysis of the data.

Other Comments. There were 4 social workers about whom comments did not seem to fit any of the categories. These involved 2 Social Service Officers and 2 Level 3 social workers.

One of the "SSO.'s" seemed to take on a wide range of work covering most adult and child care sub-groups. The comment was that this work had developed from an initial interest in the mentally ill and with the elderly, and she was now committed to a generic caseload, but this excluded statutory mental health work and dealing with the blind. Secondly, a part-time "SSO." went through phases of working with the elderly and mentally handicapped and then much more generically, but whose child care was described as "weak."He was mostly interested in working with the elderly and the mentally handicapped but wanted to develop new skills. He wanted to go on a professional training course, and the team-leader could not say where any particular bias lay.

As regards the Level 3 workers, one part-time member of staff showed "child care - all types" as her primary bias, together with responsibility for running a Mother and Toddler Group. The comments were that this was partly the needs of the team, partly because she was good at this kind of work, and also because she was part-time. A second worker in the same team showed "child care - all types" and mental health as primary biases, with involvment in the Mother and Toddler Group and a Mental Health Support Group as secondary interests. The comments indicated that she was interested in working in both these areas, ie. that as an "Approved" social worker under the Mental Health Act, 1983, she was committed to mental health, but also deeply involved in child care work.

Intake, Short-term, Crisis Specialisms. This section was only relevant to the two Intake Teams in the study. One was from a City area, and the other from one of the old "Hampshire" offices with a more rural population. Although some information was gathered on the other 6 teams in the study under this heading, it was not consistent enough to warrant inclusion. As explained in the chapter on "Methodology, " the sub-headings in this section on the questionnaire were set out as follows:

1. Welfare Rights.
2. Fuel Debts.
3. Homelessness.
4. Advocacy.
5. Family Crises.
6. "One-off" Assessments.
7. Telephone work.
8. "At risk" work.
9. Resource finding.
10. Legal sanctions.
11. Other.

It was difficult to achieve detailed comments on all these. In one team, 5 out of the 9 social workers or Social Service Officers were described in general terms, eg. "generally good at all this, " "generally good apart from legal sanctions, " "over all brilliant, " and "good duty officer - responsible, dependable." Another Level 2 worker was described as good at crisis intervention and one-off assessments. Another at Level 1 was said to be good at duty generally, particularly at child abuse, which featured as the secondary bias on his caseload. A Social Service Officer, who worked mainly with the elderly, was described as particularly skilled in assessment work, "homelessness, " "telephone work, " and "resource finding". Another Social Service Officer was said to be a "Duty Worker" - she did duty on 3 days per week. A part-time member of the team, a Level 2, did not do as much duty as the others and was used as more of a "Stand-in."

The second team from the more rural area showed fewer comments. An experienced Level 3 worker was seen as a "good all round duty worker, but

particularly skilled in one-off assessments and crisis situations." Another at Level 2, who specialised in psychogeriatric work and mental health, was skilled in "resource-finding."Another at Level 2, described as generic worker, was good at "resource-finding, " and "welfare rights."There were no comments at all about 4 of the team-members. Finally, a second part-time Social Service Officer only did a half day on duty per week, and a third SSO, working full-time, was said to have "no duty commitment at all."

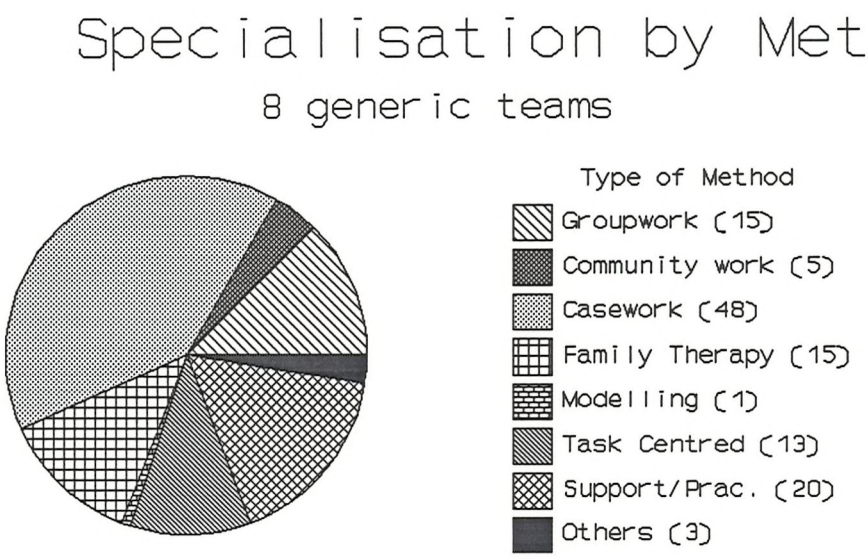
Across the 2 teams, therefore, there were few detailed comments as set out on the questionnaire. There seemed to be an overall pride in the way the work was carried, with little indication of informal specialisation within the headings shown.

Specialisation by Method. This section was designed to gain information on possible varieties of methods of intervention. It was difficult with some of the headings, eg. family therapy, to discern whether this was an 'interest' or whether this was actually being practised. As will be seen, some of the headings referred directly to a specialist worker's role, eg. an Area Fostering Officer and the expectation that there will be "groupwork" with foster-parents. Others referred to project work, often undertaken as a secondary bias, eg. Mother and Toddler Support Group.

To begin with, the headings and numbers of responses are shown so that the overall position can be seen, as follows:

Heading	No. of Responses.
1. Groupwork	15
2. Community work	5
3. Casework	48
4. Family therapy	15
5. Modelling	1
6. Task-centred work	13
7. Support and practical	20
8. Other	3

Groupwork. This was given as a method on 15 occasions. Firstly, there seemed to be a sub-group of specialist workers for whom groupwork was intrinsically part



of their role. These included an Intermediate Treatment Officer who was engaged in groupwork with young offenders. There were also 3 Area Fostering Officers for whom group support and training with foster-parents was central to their role.

Secondly, there were 3 social workers who were described as using groupwork methods, but there was no other information as to how they did this or with which particular client group. These included a Level 1 worker with a generic caseload, a Level 2 with a primary bias in elderly and children and families, and another Level 2 with a "child care/adult mix caseload.

Thirdly, there were 3 social workers who were described as having an "interest" in groupwork, but did not seem to be practising this at the time the questionnaire was completed. These included a Social Service Officer who worked mainly with the elderly and psychogeriatrics, a Level 3 worker who was an informal specialist with the elderly, and a Level 1 worker with a generic caseload.

Lastly, there were 5 social workers who were actively engaged in some kind of groupwork. These included a Level 3 member of staff whose primary bias was

with the elderly, and who used groupwork methods with the physically-handicapped and in a day-care setting with the elderly. There was also a Level 2 worker interested in groupwork in Intermediate Treatment, and "adolescents" featured as a primary bias on her caseload. This group also included a Level 2 worker involved in a Mother and Toddler Support Group. Her caseload was described as generic. Lastly, two social workers from the same Intake Team, both said to be generic, were involved with groupwork, one in a community play group, the other in a Carer's Group for elderly and physically handicapped clients.

It is interesting that one of the teams showed a strong commitment to groupwork. The team had organised a Mother and Toddler Group, a Mental Health Support Group, and a Divorce Support Group. Three members of staff in this team were shown to have involvment in these groups within their primary and secondary biases, but were not shown to be concerned with groupwork under this particular section in the questionnaire. If it was an oversight that these were not included, then the total number of responses for this heading would be 18 rather than 15.

Community work. There were 5 responses to this heading. These included a Level 1 worker with a background in Youth Clubs and Youth Training Schemes, and with a generic caseload. He was described as being interested in community work and "street work." Secondly, a Level 3 worker from the same team was interested in community day-care for elderly and physically-handicapped people. Her primary bias was with the elderly, and the community work was said to be a "developing" interest. Thirdly, a Level 2 worker, whose primary biases were in elderly work, was linked to a G.P. surgery, and saw this as "community" work. In the same team, another Level 2 social worker was described as being interested in community work, but no further details were given. Lastly, a Level 2 worker whose primary interests were in child care, was keen to develop community day care facilities for mothers and young children.

Casework. It is perhaps not surprising that a survey of social workers in Area teams should throw up such a large response under this heading - 49 in all. This was given for the majority of social workers, Social Work Assistants, and Social Service Officers involved in the study. It is perhaps more interesting to note the number of staff who were not said to use casework - 9 in all. There were some

difficulties in seeing "casework" as a separate and distinct method alongside categories such as "task-centred" work, since the latter could be described as part of casework. However, it is important in terms of a "one-to-one"approach, as opposed to groupwork and community work.

Family Therapy. There were 13 responses to this heading. It was difficult to gain an impression as to whether this was just an interest or if it was actually being practised on caseloads.

However, this group included 4 members of staff from the same team, 2 at Level 3, one at Level 2, and one at Level 1. There were few comments on how this was encouraged in practice.It is interesting that 5 out of the 15 workers showed child care in their primary biases. The others were a mixture of generic, and child care/adult mix. This seemed to show that Family Therapy was not necessarily the domain of purely child care oriented workers.

Modelling. There was only one response to this, and no information as to how this approach was effected in practice. This applied to a Level 2 worker with primary interests in the elderly, and secondary biases in preventive work with children and families. She was shown to be using a variety of methods of intervention, eg. groupwork, community work, and task-centred work, but these seemed to indicate areas of interest rather than specific practice.

Task-Centred Work. Thirteen members of staff were said to use this approach. These included a Social Service Officer and a Social Work Assistant from the same team. The former dealt mainly with the elderly, the blind and the physically-handicapped and was described as a "specialist by default."For him, this approach was strongly linked to "Support and Practical"(See following section.)The Social Work Assistant also covered a wide range of client groups in both adult and child care sub-specialisms. Again, this approach was linked to "Support and Practical", and the worker was also shown to have developed considerable casework skills.

Two Level 2 workers from the same team showed this as a method. One had a caseload of child care/adult mix, and linked task-centred work with "Support and Practical."Secondly, there was the member of staff already referred to in the

section on Modelling. Five social workers from the same (Intake) team were also described as interested in this method. In all cases, this was combined with other methods, eg. casework, family therapy, groupwork, behaviour modification, and marital work."Task-centred" work seemed to be regarded as an integral part of an Intake workers skills.

In another of the rural teams, the social worker who was part-time Adult Placement Worker and part-time Level 2 (generic)worker showed this as a method, but it was not clear which "half" of her job this applied to. A Social Service Officer from the same team who specialised in work with the elderly paired this approach with "casework."

It is interesting that in the second Intake Team only 2 out of the 10 workers showed this as a method. One was at Level 2 and was described as "generic." The other was at Level 3 with many years experience, also described as "generic."Both also listed "casework" as a method.

Support and Practical. There were 20 responses to this heading. In one team, this method was attributed to 6 out of 7 members of staff. Four of these linked this method with "casework", and no other methods were mentioned. These 4 included a variety of grades and skills - a social worker at Level 2, a Social Service Officer, a part-time Level 3 worker, and a part-time Adult Placement Social Worker. In one case, that of the Social Service Officer, it was stated that "Support and Practical" was a more significant approach than casework. The only social worker in the team who did not show this method was a Level 3, who was predominantly involved with child care, and who showed "casework" and "Family Therapy" as methods.

In one of the City teams, 5 out of the 7 social work staff identified this as a method. These included a Social Work Assistant, the only unqualified worker, who specialised in the elderly, and who linked this with "casework."There were also two Level 3 workers, both of whom carried predominantly child care caseloads, and who also linked this method with "casework."Lastly, there were two Level 2 workers. One of these combined "Support and Practical" with "task-centred" and "casework". The other has been referred to under previous headings in this section, and showed a large number of methods of intervention

which seemed to be "interests" more than actual methods.

It is interesting to note that the 2 workers not showing this as a method included a Level 2 social worker specialising in both elderly and child care work, and a Level 3 staff member who was also the Area Fostering Officer.

The Intake Team in the City area included 3 out of 8 social work staff with this method in evidence. These included a Social Service Officer whose primary bias was with the elderly - no other method of intervention was shown. There was also a part-time Level 3 worker who specialised completely with the elderly, and who linked this with "casework."Lastly, another Social Service Officer, who specialised mainly with the elderly but on a secondary bias with children, showed this as her only method of dealing with her caseload.

The more "rural" Intake Team produced 4 out of the total of 10 workers said to be using this method. Firstly, a Level 2 worker, described as a "reluctant genericist, "whose primary biases were in psychogeriatric work and mental health, combined this with "casework."Secondly, there were 2 Social Service Officers, both of whom specialised in working with elderly and adult client groups, and who showed no other method of working apart from this. Lastly, an Adult Placement Social Worker, whose primary bias was in mental handicap, linked this with "casework."

The last out of the 5 teams that showed this as a method included only one social worker said to use this approach. This was a Level 3 worker, whose primary biases were in mental health and in generic work. "Casework and "Family Therapy" were also shown.

Other. There were 3 responses not covered by the headings specified in the questionnaire. Firstly, a Level 3 worker from the City Intake team showed "Marital work" as a method. His primary bias was in generic work, with court work, elderly and "marital counselling" as secondary interests. This method was also linked to "casework" and "task-centred". Secondly, a part-time Level 3 worker from another team was particularly interested in "Counselling."She had a caseload biased entirely towards child care and was involved in running a Mother and Toddler Group. Lastly, a Level 1 worker also from the City Intake team was

interested in "behaviour modification" techniques, and this was listed alongside "casework" and "task-centred" approaches.

Identified Workers. The chapter on "Methodology" deals with the definition of "Identified" workers and with issues about their appointment within Area Centres. The term at this time referred to an area of expertise attached to a social worker's role, with Area Centres being asked to identify a small number of social workers who can carry out the prescribed duties, often in addition to their normal caseloads. Sometimes this involved specific training laid down by legislation, eg. Approved Social Workers under the Mental Health Act, 1983. In other cases, training may be provided by in-house or in-unit courses, eg. the Reporting Officer, Guardian ad Litem role as laid down by the Adoption Act, 1976 and subsequent regulations.

In order to make the situation clearer, the categories of "Identified" worker named in the questionnaire will be set out again.

1. Approved Social Worker.
2. Reporting Officer/Guardian ad Litem.
3. Mental Handicap Specialist.
4. Court Officer.
5. Other.

As with other sections in the study, it would seem useful to set out the number and range of responses first, and then to comment on them. Conclusions will be dealt with in the chapter at the end of the study.

Heading.	No. of Responses.
1. Approved Social Worker	13
2. Reporting Officer/Guardian ad Litem	15
3. Mental Handicap Specialist	-
4. Court Officer	3
5. Other	2

Approved Social Workers. Only one out of the 8 teams had no Approved Social Workers at all. However, this team was studied in conjunction with the second

team in the same Area, which produced 2 out of a total of 4 qualified staff. Presumably, these 2 also covered any mental health work in the other team. Neither social worker - both at Level 3 - showed mental health as a primary or secondary bias. One specialised more with the elderly, whilst the other showed child care sub-specialisms.

Another team had one Approved Social Worker out of 4 qualified staff. He had primary biases in child care, with "mental health support" as a secondary bias. There was no mention of "statutory" mental health work. A third team had one Approved worker out of 5 qualified staff. She had primary biases in elderly work, with generic work shown as a secondary bias. Mental health work did not feature in this.

Caseload Numbers. The final part of this chapter deals with numbers on caseloads, although for the purposes of the questionnaire itself, the information was gained towards the beginning of the interviews with team-leaders. Some team-leaders were able to give definite figures from records which were immediately available to them, others had to give approximates.
Initially, it would seem useful to consider caseload numbers by level or grade of worker, and then by Area team.

Level 1 Social Workers.

Area	No. on Caseload.
Alton (Alton Area Team)	15
Alton (Petersfield)	5
Alton (Petersfield)	25-30
Fareham(Portchester team)	18
Portsmouth (Area 2)	19
Portsmouth (Area 2)	20
Romsey	15

From the comments on the questionnaire, the figures for Level 1 workers are mostly dependent on how long they have been in post. At the time the questionnaire was completed, the worker in the Alton Area team had been in post for 2 months. The second worker in the Petersfield team had been there for nearly a year, hence the difference in caseloads. The social worker at Fareham

had been in the team for 3-4 months, whilst the second worker in the team at Portsmouth Area 2 was just about to be regraded to Level 2 and was, therefore, a more experienced member of staff.

Level 2 Social Workers.

Area	No. on Caseload.
Alton (Alton team)	20
Alton (Alton team)	30
Havant (Southern)	24
Fareham	25
Portsmouth Area 3	34
Portsmouth Area 3	22
Portsmouth Area 3	26
Portsmouth Area 2	22
Portsmouth Area 2 (part-time)	15
Romsey	25
Romsey (part-time)	11
Eastleigh	12
Eastleigh	14

As can be seen, there is quite some variation in the caseloads for Level 2 workers. The figures for Eastleigh are consistent with other workers in the same team - the Level 3 social workers carried caseloads of 12 and under, and this seems typical of the Intake style of working. The second Intake team in the study shows a slightly higher figure for the Level 2 workers - 22 and 20 (Portsmouth Area 2.) The highest figure was at Portsmouth Area 3, but this is consistent with overall team caseloads, with the two Level 3 workers carrying 35 and 32 cases respectively (both were informal specialists in Child Care). The next highest in the Level 2 group was in Alton - 30 cases. This was a worker whose primary biases were described as both "generic" and "child care-all types", with a secondary bias in work with the elderly. Her two Level 3 colleagues had caseloads of 30 and 35 respectively - both of whom were informal specialists in Child Care.

Level 3 Social Workers.

Area	No. on Caseload.
Alton (Alton team)	35
Alton (Alton team)	30
Alton (Alton team - part-time)	20
Alton (Petersfield team)	40
Alton (Petersfield team)	40-50
Alton (Petersfield team)	40
Havant (Southern team)	33
Havant (Southern - part-time)	13
Fareham	30
Portsmouth Area 3	35
Portsmouth Area 3	32
Portsmouth Area 2 (part-time)	22
Portsmouth Area 2	20
Romsey	24
Romsey (part-time)	12
Romsey	Not Known
Eastleigh	12
Eastleigh	5
Eastleigh	12
Eastleigh	4

Of the 20 Level 3 social workers, the highest caseload figures were from the Petersfield team at Alton.It may be significant that this team consisted of three Level 3 workers with high caseloads, plus two Level 1 workers, one of whom was very inexperienced and only carried 5 cases.The other had a caseload of 25-30 and had been with the team less than a year. Lastly, there was one Social Service Officer in the team who dealt entirely with the elderly and visually handicapped. These factors may well have combined to push up the figures for the Level 3 workers.

At the other end of the scale, it is clear that the Intake teams in the study had lower caseloads, and the objective was to deal with situations quickly and then hand them on to long-term teams, rather than building up large numbers of cases which would then prevent them from dealing with the crises. The Intake team for Portsmouth Area 2 showed slightly higher for Level 3 workers than the Eastleigh team (20 and 22 as opposed to 12, 5, 12 and 4.) All the other teams were designated "Patch" teams, with Romsey as the largest (sub-office of Test Valley Area Centre), ie. Alton and Petersfield, Southern team at Havant, the Portchester

team at Fareham, and the Portsea team at Portsmouth Area 3. In all of these, caseloads were around the 30 mark, and this seemed to be a consistent figure. It would be interesting to see if this was typical of Patch teams across the County. A significant factor for these teams is that there is no Intake or Duty team acting as a filter for referrals and they have to take everything that comes up on their patch.

Social Service Officers.

Area.	No. on Caseload.
Alton (Petersfield)	30-40
Havant	23
Havant	22
Portsmouth Area 2	14
Portsmouth Area 2	24
Romsey	40
Romsey (part-time)	12
Eastleigh	30
Eastleigh (part-time)	10
Eastleigh (part-time)	18

Alton and Romsey show the highest caseloads for Social Service Officers.In Romsey, this worker specialises primarily in work with the elderly, but also took on some child care cases.She was also involved in a secondary bias in a Divorce Support Group, and was also able to provide sexual counselling.In the Alton team, this worker specialised in work with both the elderly and the visually handicapped.This is an Area of high caseloads generally. It was not a case of the unqualified worker taking on all the cases involving the elderly, therefore pushing up her caseload. There were two other qualified workers in the team who showed primary biases with the elderly, although no-one specialised in this completely.

The workers in Portsmouth Area 2 had similar sized caseloads to the rest of the team. One of them showed a comparatively lower figure(14) but it was also shown on the questionnaire that she did "Duty" three days a week, and this would have naturally restricted her caseload. The rest of her time was entirely devoted to the elderly. One of the Social Service Officers at Eastleigh had a comparatively high caseload - 30. She took on work with the visually handicapped and dealt with all new registrations, as well as showing a primary bias with the

elderly. She had no Duty commitment.

The Social Service Officers in Havant held caseloads of similar size to their qualified colleagues. One took on all types of cases and was really a generic worker. The second, with 22 cases, was involved with adult groups, eg.the elderly, physically handicapped and all new blind and partial sight registrations. He also had an interesting role as an "Identified" worker - that of Deputy Court Officer, which, of course, implies work with children and families.

Social Work Assistants.

Area	No. on Caseload.
Havant	29
Portsmouth Area 3	20

The Social Work Assistant at Havant had a slightly higher caseload than most of her colleagues(eg. SSO.- 22, Level 2 worker- 24, part-time Level 3 worker - 13.) This member of staff had the task of dealing with all the Aids and Adaptations for the physically disabled in the Area. He took on a whole range of client groups, eg. elderly, physically handicapped, mentally handicapped, children and families- under 5's, voluntary supervision, Statutory work - children on Care and Supervision Orders. The Social Work Assistant for the Portsmouth Area 3 team had a more restricted caseload - he specialised in working with the elderly, and had secondary biases in physical and visual handicap. It is interesting that unlike many unqualified workers, he had the lowest number on his caseload in the whole team.

CHAPTER FIVE: THE BASINGSTOKE SPECIALIST TEAMS

The study of the 4 specialist teams in the Basingstoke Area Centre is included both as a contrast to the 8 teams in the previous chapter and also to test out how much informal specialisation is an issue with them. It seemed worthwhile to gain some information about these specialist workers' caseloads to see if they in turn tended to fix on certain sub-groups within their area of specialisation. The same questionnaire was used, and, therefore, the same information was also requested in terms of qualification, grade, previous experience, numbers of caseloads, whether identified workers or not, issues surrounding informal specialisation, if any, intake specialisms, and specialisation by method.

The information, however, will be presented differently to the previous chapter in that it seemed easier to look at the situation as much by team as by the headings on the questionnaire. As explained in the chapter on Methodology, the Basingstoke Area in April, 1986 was split into the following teams:

Child Care Team - South
Child Care Team - North
Elderly Care Team
Disability Team

1. Qualifications and Grades.

The qualifications and grades for all 4 teams are set out in the following tables:

a. Child Care team - South

Level 3 - CQSW/Degree
Level 3 - CQSW/Degree
Level 3 - CQSW
Level 2 - CQSW
Level 1 - CQSW/Degree
Level 1 - CQSW/Degree
Social Service Officer - No qual
Social Work Assistant - No qual

b. Child Care Team - North

Level 3 - CQSW/Youth & Community.
Level 3 - CQSW
Level 2 - CQSW/BSc
Intermediate Treatment Officer - no qual
Level 1 - CQSW
Level 1 - CQSW/MSc
Level 2 - CQSW/BSc

Social Work Assistant - No qual

Social Service Officer -
No qual
Social Services Officer - NNEB

c. Elderly Care Team

Level 3 - CQSW/Degree
Level 1 - CQSW
Level 2 - Diploma,
Social Administration
Social Service - No qual.
Officer
Social Service - No qual
Officer

d. Disability Team

Level 3 - CQSW/SRN
R.N.M.S

Level 3 - CQSW/Degree
Level 1 - CQSW
Level 1 - CQSW
Occupational Therapist - OT
Qualification
Family Service Worker -
No qual
Family Service Worker -
No qual
Care Attendant Scheme - No qual
Co-ordinator.

Some of these workers were "formal specialists," ie. Area Fostering Officers, Mental Handicap specialists, but these designations will be shown in the tables covering primary and secondary biases.

General Comments.

There were 32 members of staff in this part of the study. Of these 19 were qualified as social workers. Out of the 19 CQSW holders, 9 were also graduates. The Child Care teams had the highest number of qualified staff - 6 each, whilst the Disability Team had 4, although there was also a qualified Occupational Therapist. The Elderly Care team had the lowest number - 2 qualified, although one was also part-qualified with a Diploma in Social Administration.

Each team had at least 2 unqualified workers - either Social Service Officers of Social Work Assistants. In the case of the Disability Team, these were Family Service Workers, who are employed to work specifically with a particular client group -in this case, the physically handicapped. Originally, these posts were joint-funded with the Health District.

2. Previous Experience

A table showing "Previous Experience" by team is included below:

a. Child Care Team - South

Level 3 - Education Welfare

Level 3 - Trainee - Social Services Dept.
Level 3 - Clerical Work, Child Care
Level 2 - Social Services work
Level 1 - Industry/Building Trade
SSO - Social Services
SWA - Social Services
Family Service Worker

b. Child Care Team - North

Level 3 - Youth Work, Mission, Welfare Department

Level 3 - None shown
Level 2 - Residential
SSO - Nursery Nurse
I.T. Officer - Residential Level 1 - Missionary Child Care
Level 1 - Residential Work (Adults) & Community Work
Level 1 - None shown
Level 2 Social Services
SWA - Residential Child Care Teacher
SSO - Residential Child Care

c. Elderly Care Team.

Level 3 - Voluntary work, Social Services
Level 1 - Residential work, Elderly, Voluntary work.
Level 2 - Social Services - Generic work.
S.S.O. - Social Services - Occupational Therapy.
S.S.O. - Blind Welfare -

d. Disability Team.

Level 3 - General and Psychiatric Nursing.
Level 3 - Social Services.
Level 1 - Social Services.
Level 1 - None Shown
Level 3 - Residential Child Care, Medical Social Work.
F.S.W. - Residential work, mentally handicapped, Voluntary Org
F.S.W. - Residential work, Mentally handicapped
Care Attendant
Scheme Co-ordinator - Day Centre, Elderly.

General Comments.

Before looking at these responses in more detail, it may be helpful to include the number and incidence of the different types of "Previous Experience."

Experience.	*Number of Response.*
1. Nursing - General	1
- Psychiatric	1
- Childrens'	0
- Mental Handicap.	0
2. Teaching	1
3. Residential - Children	5
- Adults	4
4. Police	0
5. Probation	0
6. Voluntary Work/ Organisation.	4
7. H.M. Services.	0
8. Youth work.	1
9. Home-Help	0
10 Other.	
- Previous Social Services/ Welfare/Childrens' Dept.	10
- Hospital Social work.	1
- Day Care	1
- Education Welfare	1
- Industry	1
- Clerical work	1
- Missionary work	1
- Nursery Nurse	1
11. No experience shown	4
Total 38	

As with the similar section in Chapter 4, some of the staff showed more than one type of "previous experience," and these have been separated out according to type. Given the fewer numbers than in Chapter 4, it would seem sensible to discuss these responses by team rather than by grade or level of social worker.

A. Child Care Team - South.

Five out of the 8 members of staff in this team had previous experience of Social Services, either as a trainee or as a Social Service Officer or Social Work Assistant before qualifying. One of the level 3 workers had experience of clerical work in the Education Dept. Another had been in Education Welfare. The two Level 1 workers both seemed to have unusual experience, one having qualified after doing missionary work, and the other with the background in Industry and

the Building trades. There was one social worker at Level 2 in this team, and she had been a Social Services Officer before qualifying. The Social Work Assistant had been a Family Service Worker before taking up her current post. The Social Service Officer in the team showed "Social Services" as previous experience, implying that she had been in post for sometime. She held a specialist post in the team, in that she was responsible for child minders and playgroups.

In summary, the social work staff in this team can be categorised as follows:

Previous experience in Social Services	5
Previous experience in Caring Professions	7
Other previous experience	1
Total	13

B. Child Care Team - North.

Out of the 10 workers in this team, 2 showed experience in Social Services in the Welfare Dept. (Pre - 1971 and the Local Authority Social Services Act). However, four had a background in residential work with children, and although it was not specified, some of this may well have been in Social Services. A Social Service Officer who had a specialist role in the team dealing with child minders and playgroups, had the N.N.E.B. qualifications, but it was not specified whether her previous experience was in a Social Services Day Nursery. One of the Level 3 workers, who was a part-time Area Fostering officer and a part-time social worker with children and families, had a background in "Youth Work, Mission work, and Welfare Dept." She had the broadest range of experience in the team. A recently appointed Level 1 worker had experience in a "Crisis Centre" and in Community work.

As regards the other unqualified staff, the Social Work Assistant had a background in residential work and teaching, and she specialised within the team in helping with the support to the child minders. The second Social Service Officer also had experience of residential care and children, and he had a large caseload of teenagers, mainly on statutory orders under the 1969 Childrens' and Young Person's Act.

The second Area Fostering Officer in the team, also part-time, was not shown to have any previous experience. Lastly, the Intermediate Treatment Officer was described as having previous experience in residential child care work.

In summary, the previous experience in this team can be categorised as follows:

Previous experience in Social Services	2
Previous experience in Caring Professions	6
No experience shown	2
Total	10.

C. The Elderly Care Team.

Out of the 5 members of staff in this team, 3 were shown to have previous experience in Social Services. These included the only level 3 worker, who also had experience in the voluntary sector, the level 2 worker, and a Social Service Officer. This latter used to work in Occupational Therapy, and it can be assumed she held the post of Occupational Therapy Assistant, equivalent in status to a Social Work Assistant. She also had experience of the Voluntary Sector. A Level 1 member of the team had experience of residential work with the elderly, and also in the voluntary sector. The second Social Service Officer used to be a Welfare Assistant in a voluntary organisation for the Blind.

It may be significant that 4 out of the 5 workers in this team came from the Voluntary Sector. This was the smallest team numerically, although at the time they did have a vacancy for a part-time member of staff.

In summary, the previous experience in this team can be summarised as follows:

Previous experience in Social Services	3
Previous experience in Caring professions	2
Total	5

D. The Disability Team.

Two out of this team of 9 workers were shown to have previous experience in Social Services. These included a level 3 worker who specialised in dealing with profoundly disabled people, and a Level 2 who worked with the younger physically handicapped and the Blind. A part-time Level 3 had a background in the residential care of children and in medical social work. The second Level 3 worker came from a career in both general and psychiatric nursing. She specialised with mentally handicapped and mentally-ill clients. There was no experience shown for the part-time Adult Placement Social Worker.

As regards the unqualified workers, both Family Service Workers were shown to have a background in the residential care of mentally handicapped people - one of them combined her working life with some hours every week at a children's home for special needs children. They both specialised in dealing with the physically disabled. The Care Attendant Scheme Co-ordinator, which was a jointly-funded post with Health District, showed working in a Day Centre for the Elderly as previous experience. Her role was to recruit and support carers and link these with physically-disabled people.

In summary, the previous experience in this team can be categorised as follows:

Previous experience in Social Services	3
Previous experience in Caring professions	5
No experience shown	1
Total	9

General Comments.

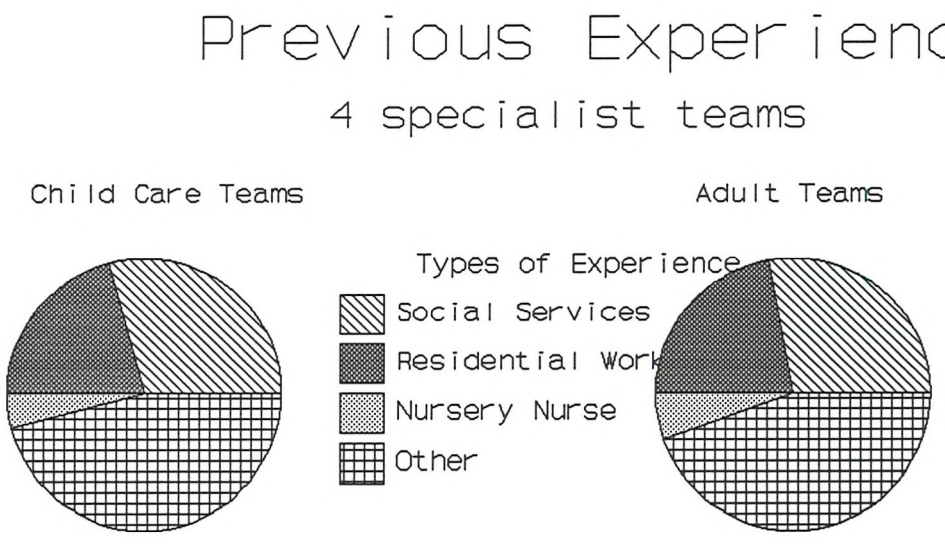
It may be interesting to compare the responses for the Child Care and the Adult Teams, and explore whether there is a possibility of any relationship between previous experience and a specialist role within this type of team structure .

Child Care Teams
(North and South).

Social Services (7)
Residential Child Care (4)
Residential - Adults (1)
Nursery Nurse (1)
Welfare Dept. (1)
Missionary Work (2)
No experience shown (2)
Teaching (1)
Youth work (1)
Education Welfare (1)
Clerical work (1)
Industry (1)
Community Work (1)

Adult Teams
(Elderly Care and Disability).

Social Services (5)
Residential Child Care (1)
Residential - Adults (3)
Nursery (1)
Occupational Therapy (1)
Voluntary Organisations (4)
No experience shown (2)
Day Care (1)



Although at first sight there are more responses for the Child Care Teams, it must be borne in mind that these contained more social work staff - 18, as opposed to 13 in the Adult Teams. (For the purposes of this study, the Occupational Therapist in the Disability Team has been excluded, and only social

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work staff have been discussed.)

It is probably to be expected that the Child Care Teams have the greatest number of former residential child care workers, and the same is true for the Adult Teams and residential work with adults. It is also interesting that they have one each of the opposite client group. Voluntary Organisations are not represented at all in the Child Care Teams, but feature prominently in the Adult Teams. This may throw up questions as to whether there is a predisposition in voluntary work towards adult or elderly client groups. Nursery nursing, teaching, youth work, and Education Welfare are all generally child-centred, so it is not surprising to find them represented in the Child Care Teams. The Adult Teams do not feature this kind of work experience at all. similarly, Day Care and Occupational Therapy are more associated in work with the elderly and adults, and these are to be found in the Adult Teams but not Child Care.

Given that this is a small number of staff from 4 teams in one office, it is still interesting that staff do seem to continue working with a client group in which they have had experience before or during their career with social Services.

3 - Primary and Secondary Bias on Caseloads

A complete breakdown of primary and secondary bias by worker and by team is shown below. Discussion of the biases will follow this, and the information will continue to be looked at by team rather than by grade or level of worker as in Chapter 4.

A. Child Care Team - South

Level/Grade	Primary bias	Secondary bias
Level 3	Care orders/Supervision Custody/Access Child Abuse Family Placement	Sexual Abuse
Level 3	Whole range of child Care work	Juvenile Justice Interest, but no bias.
Level 3	Whole range	Work with foster parents interest but no bias.
Level 2	Whole range	None shown

Level 1	Bias towards preventative work	None shown
Level 1	Preventative work, small amount-statutory	None shown
S.S.O.	Child minders/Playgroups (Specialist Under 5's)	Private fostering
S.W.A	Under 5's Day Nursery attenders	None shown

B. Child Care Team - North

Level/Grade	Primary Bias	Secondary Bias
Level 3 part-time	Foster Parent assessment	Mental Handicap Adoption
Level 2	Child Care general	Adolescents
I.T. Officer	Delinquency/Juvenile Justice	None Shown
Level 1	Child Care general	None shown
Level 1	Child Care general	None shown
Level 2 part-time	Child Care general	None shown
S.S.O. part-time	Child minders & Playgroups	None shown
Under 5's worker	Child care general	Part-time caseload holder
S.W.A.	Help with Child minders	None shown
S.S.O	Adolescent boys (some girls)	None shown

C. Elderly Care Team

Level/Grade	Primary bias	Secondary bias
Level 3	Whole range	Bereavement counselling interest.
Level 1	Whole range	None shown
Level 2	Whole range	None shown
S.S.O.	Whole range	G.P. Liaison
S.S.O.	Whole range	Blind/partial sight

D. The Disability Team

Level/Grade	Primary bias	Secondary bias
Level 3	Mental Handicap	Mental health
Level 3	Profoundly Phys. handicap	Specialist mental Health work (interest)
Level 1	Younger Phys.Handicap?Blind	Physical Handicap
Level 1 Adult Placement Social Worker (part-time)	Mental Handicap	None shown
Level 3 (part-time)	Duty worker - no bias	None shown
Family Service Worker	Physical Disability	Mental Health
Family Service Worker	Physical Disability	Mental Health
Care Attendant Coordinator	Younger Physically Handicapped	None Shown

General Comments

Rather than looking at the total number of responses for child care and adult client groups, as in Chapter 4, it is probably more interesting to compare the teams to begin with, and then discuss the overall types and incidence of responses for all the staff involved. As there were few of the sub-headings used in the questionnaire, only those used will be listed.

Sub-Specialism re. Primary Bias	Child Care North	Child Care South
Voluntary Supervision	0	3
Statutory work - Care and Supervision Orders	1	1
Under 5's	0	1
Child Placement	0	1
Access/Custody (other)	0	1
Whole Range (other)	5	3

The specialist posts are not included in this, since the bias is determined by their role. There were 2 Area Fostering officers in Child Care North.Their primary bias was shown as Foster Parent assessment. Also in this team were a Social Service Officer and a Social Work Assistant who held specialist roles with Child minders and Playgroups. In Child Care Team - South, there was one Social Service Officer who specialised in work with Child Playgroups.

Sub-Specialism re. Secondary Bias	Child Care North	Child Care South
Adoption	1	0
Mental Handicap	1	0
Sexual Abuse	0	1
Private fostering (other)	0	1
Work with Foster Parents (other)	0	1
Child Care - General	1	0
Adolescents (other)	1	7
None Shown	7	4

The overall numbers and types of response for these two teams can be summarised as follows:

	Child Care, North	Child Care, South
No. of Primary Biases	7	10
No. of Sub-specialism	2	7
No. of Secondary Biases	4	4

A more detailed comparison with the 8 teams studied in Chapter 4 will be provided in the chapter on Conclusions. However, it seems clear that workers in specialist teams throw up fewer sub-specialisms in both primary and secondary biases. It seems as though they are more likely to be "across the board" workers within their particular specialisms.

In the Child Care Team, South there were three level 3 workers in this team. Two of these showed "all types of child care" as a primary bias. Their secondary interests were in "Assessing Foster-Parents" and "Juvenile Justice" respectively. The comment for both on their secondary bias was that this is an area of interest and is not reflected in their caseload. The third Level 3 worker was the only one to have a list of sub-specialisms, ie. statutory work. N.A.I. Child Placement, and Custody/Access as primary biases, with Sexual Abuse as a secondary. This social worker had the highest number on her caseload in the team, and was also the only Approved Social Worker.

The one Level 2 worker in this team showed "All types of child care" as a primary bias, with no secondary bias shown. The two Level 1 workers both had a bias towards Preventative work with children and families, and both were recent appointments. One showed a minimal involvement in statutory work as a secondary bias, the other showed no bias in this category. it seemed as though this was a way of building up experience before expecting them to take on more complex work.

As regards the unqualified workers, there was one Social Services Officer who was also the Day Care Officer for the Under 5's. and specialised formally in the registration of Child minders and playgroups. She had a small secondary caseload of 4 privately-fostered children. There was also one Social Work Assistant, who worked four days per week, and specialised in children under 5 years who attend Day Nursery and worked in conjunction with the Day Care Officer.

In the Child Care Team, North there were three Level 3 workers in this team. One was a part-time Area Fostering officer who spent most of her time assessing and supporting foster-parents, but also had a small caseload of 4 cases involving mentally-handicapped and adoption situations. The second was also a part-time

Area Fostering Officer but who combined this with a further 18.5 hours as a Level 3 Child Care Social Worker. She was shown to have a primary bias in "Child Care General" with her secondary bias in assessing and supporting foster-parents. The third worker in this group was just about to be regraded to Level 3 and was part-time, showing "Child Care General" as a primary bias, with no secondary bias shown.

There was one other Level 2 worker in the team, who was described as dealing with "General Child Care" as a primary bias, with "Adolescence" as a secondary interest. This was the only further example of a secondary bias in the team. The two Level 1 workers were described as recent appointments, and both shown to take on a wide variety of child care work. One of them was said to hold one Child Abuse case. This seemed to indicate that the "variety" was to gain experience rather than an exact cross-section of all types of cases.

As for the unqualified staff, the specialist Intermediate Treatment Officer was shown to be involved in "Delinquency and Juvenile Justice" but this was an expectation of his role. One of the Social Service Officers was a part-time Day Care Officer for the Under 5's and a part-time Child Care Worker. Her time was divided on a primary basis between registration of child minders and playgroups and "Child Care General." No secondary bias was shown. Another S.S.O. who had considerable residential child care experience, dealt on a primary basis with an entire caseload of adolescents, described as "teenage boys, with some girls." There was no secondary bias. Lastly a Social Work Assistant, also with residential experience, was shown to be solely involved in "helping with child minders" and worked in conjunction with the Day Care Officer. The second had a primary interest in Profoundly Physically-Handicapped people, with a secondary bias in "specialist mental health work." He was an approved Social Worker. Thirdly, a part-time Level 3 was engaged in Duty work entirely and did not specialise in any of the disabled groups.

There were two Level 1 workers in the team. One was a recent appointment and showed a primary bias in work with the Blind and a secondary bias in the Younger physically-Handicapped. The second was the specialist Adult Placement Social Worker (part-time), and dealt only with the Mentally-Handicapped.

Of the three unqualified workers in the team, two were Family Service Workers, both part-time working 25 hours and 17 hours per week respectively. Both had small caseloads, 5/6 cases each, and both specialised in work with "Physical Disability across the board" as a primary bias, with "Lesser degree, mental Illness" as a secondary. Lastly, there was the Co-ordinator for the Care Attendant Scheme, whose role demanded that she specialise completely in the Younger Physically-handicapped.

As can be seen, the degree to which informal specialisation occurred seemed to depend on the work of the team. As a general observation, the two Child Care Teams were "mostly" involved in "Child Care General" or "Child Care - All Types" with a small number of primary or secondary sub-specialisms shown. Even when a secondary sub-specialism was shown, it was often described as an "interest" only. The most clear areas of specialisation came from the specialist and unqualified workers, who were engaged in work with foster-parents, child minders and playgroups or in juvenile justice.

The Elderly Care Team was perhaps the most clear-cut, with all the workers showing involvement "Across the Board" and only 3 sub-specialism being mentioned as either primary or secondary biases. The Disability team differed from the other 3 teams in that each worker seemed to take responsibility for a specific client group e.g. Mental Handicap, Physical disability, profound Physical Handicap, Younger Physical Handicap, Blind. It was interesting that Mental Health was only mentioned as a secondary bias, and accounted for 3 out of the 45 responses on secondary biases. It seemed as though informal specialisation was actively encouraged in this team, and seen as a more efficient way of coping with the workload than expecting each of the workers to work across the board.

4 - Issues and Attitudes Surrounding Informal Specialisation.

In this section, it seems to be more useful to concentrate on the headings in the questionnaire rather than to discuss the findings by "team". The incidence and types of responses will be shown first.

Heading	*No. of Responses*
1. Defined by role	14
2. Not encouraged (Area Policy)	0
3. Encouraged for Professional Development	3
3. Encouraged subject to priorities within team	17
5. Not encouraged - commitment to genericism	0
6. Specialist by default	0
7. Conflict between social worker and team leader	0
8. Encourage - specialist or short term/intake methods	0
9. Other	0

Defined by role.

This response applied to 3 out of the 8 workers in the Child Care Team - South. Firstly, one of the Level 3 staff, who worked across the board in child care, with some interest in juvenile justice. This was also combined with the response, "Encouraged subject to priorities within the team". It also applied to the Level 2 worker who covered the whole range of child care, and again was linked to the response about "priorities within the team". Lastly, it applied to the Social Service Officer who was also the Day Care Officer for the Under 5's, which was a specialist post.

In the Child Care Team - North, this response occurred 5 times. Not surprisingly, it applied to all the specialist workers, the 2 Area Fostering Officers, the Intermediate Treatment Officer, and the part-time Day Care Officer for the Under 5's. It was also the response for the Social Work Assistant who was solely engaged in helping with child minders and working with the Day care Officer.

The Elderly Care Team did not produce any responses under this heading. The Disability team, however, gave this for 6 out of the 6 social work staff. Firstly, and again, not surprisingly, this applied to workers with a specific role ie. the Family Service workers, the specialist worker in Adult Placement, and the Care Attendant Scheme Co-ordinator. It also applied to the part-time level 3 worker who just did Duty work and did not carry a caseload. However, it was also given as a response for the Level 3 social worker who specialised in mental handicap

and mental health. It was not clear why he should be described thus and not the other social workers in the team with their various sub-specialisms.

Encouraged for Professional Development.

There were 3 responses to this. Firstly, it applied to a Level 3 worker in the Child Care Team - South, who was the only one to show a number of child care sub-groups rather than "general child care". It was not clear why this should have applied to her and not to the other qualified workers in the team. This response was also given for the two Level 1 workers in the Child Care Team - North. They had recently qualified and the intention was for them to specialise in preventative work with children and families, the primary bias for them both, as a way of consolidating experience.

Encouraged subject to Priorities within the Team

This was the most numerous of the responses - 17 in all. this heading denotes a balance between the workers own preference and the needs of the team. In two cases, this was made explicit, e.g. a Level 1 worker where preventative work was described as "a reflection of his own interest," and a Level 3 worker in the Disability Team who specialised in the Profoundly Physically-Handicapped - "by choice and interest and the needs of the team".

Most of the responses, however, were less explicit, and most showed "Needs of the Team" or "Needs of the Area." This applied to 5 out of the 8 workers in the Child Care Team - South, all of whom were dealing with child are work "across the board". It was also given to a Social Work Assistant who was engaged in working with children attending Day Nursery and in this case was described as "deliberate bias".

Three out of the 10 workers in the Child Care Team - North were described in this way - they were the only three not to have a specialist role but who worked with children and families "across the board". The others were either specialist workers, "Defined by Role", or Level 1 workers not long back from professional training, who were encouraged to become involved in general work as part of professional development.

The Elderly Care Team showed this response for each member of the team. There was the same kind of clarity of response and purpose as with the information on primary and secondary biases.

As has been shown in the first category in this part of the discussion, the Disability Team showed "Defined by Role" as the most numerous, 6 out of 8. However, this was linked with "Needs of the Team" in the case of the Level 3 worker who specialised in mental Handicap and Mental Health", and who had a background in general and psychiatric nursing. The second has already been referred to in that he specialised in Profound Physical Handicap and Mental Health "by choice and interest and the needs of the team." The third and last was a Level 1 worker, recently qualified, who specialised in dealing with the Blind and the Younger Physically-handicapped because they were his "own area of interest and because of the needs of the Area."

Specialist by Default.

There was only one response which could come under this category. This related to a Social Service Officer in the Child Care Team - North, he held a caseload of teenage boys, with some girls, and was described as "the only one who can do this kind of work." This was linked with another heading, "Needs of the team."

Other

There was only one response under this heading. This referred to a Level 1 worker from the Child Care Team - South, who had only been in post for 3 weeks. Although he was building up a caseload or preventative work, with a very small number of cases, it was said that it was "too early to tell" in which direction he could go.

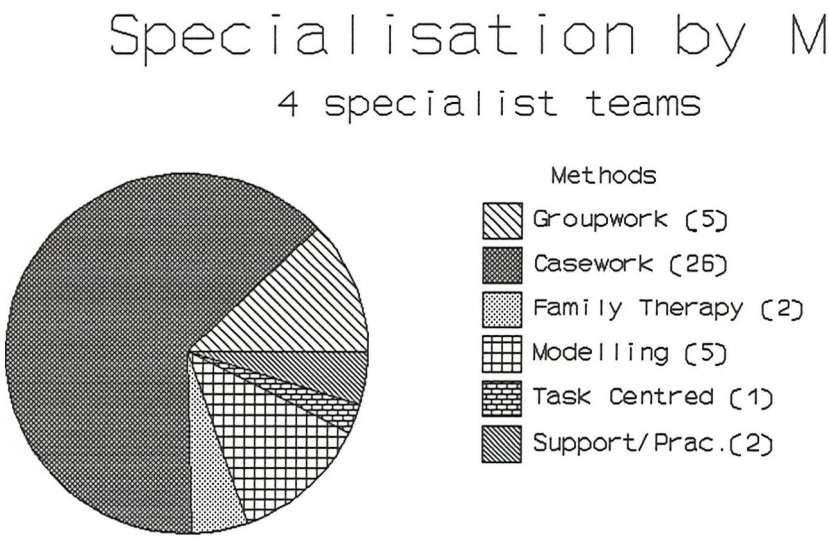
General comments

The results of this part of the study, "Issues and Attitudes surrounding Informal Specialisation", will be dealt with further in comparison with the teams studied in Chapter 4 in the Conclusions.

5 - Specialisation by Method

As with previous sections, it seems useful to set out the complete range and number of responses under this heading in the questionnaire.

Heading	*No. of Responses*
1. Groupwork	5
2. Community work	0
3. Casework	26
4. Family Therapy	2
5. Modelling	5
6. Task-Centred	1
7. Support and Practical	2
8. Other	0



Groupwork

This category included a Social Work Assistant who specialised in children under the age of 5 years attending Day Nursery. The groupwork mentioned was in relation to work with parents and children at the Day Nursery. This heading was also linked with "casework". It also included the 2 Area Fostering officers in Child Care team - North, who worked in groups with foster-parents. They too, linked this with "casework".

The Intermediate Treatment Officer showed this as a response, and this referred to groupwork with adolescents within the Juvenile Justice system. Lastly, a Level 3 worker from the Disability Team was described as using groupwork techniques, but there was no comment as to how or with whom. This worker specialised with mentally-handicapped and mentally-ill clients.

Casework

It is not perhaps surprising that this should score so highly. It would be easier to look at who did not show this as a method, but it may be helpful to review this by team.

a. Child Care Team-South - All 8 workers showed casework as a method.
b. Child Care Team-North - 8 out of 9 showed "casework"
c. Elderly Care Team - All 5 workers showed "casework"
d. Disability Team - 5 out of 8 workers showed "casework"

The above numbers do not show which of these were combined with other methods. These will be dealt with under the appropriate headings, as with "groupwork".

Family Therapy

The 2 responses under this heading included a Level 3 worker in the Child Care Team - South who showed the widest range of sub-specialism out of all the child care social workers. "Family Therapy" was described as "secondary." The second social worker to show this was a Level 2 in the Child Care Team - North

who had "general child care" as a primary bias and "adolescents" as a secondary. This was also linked to "casework" and "task-centred" work.

Task-Centred Work

The only response to this was the Level 2 worker mentioned above in the section on "Family Therapy". There were no comments as to how this was put in to practice.

Support and Practical

The 2 responses to this heading centred on the two Family service Workers in the Disability Team. Their primary bias was in "Physical Disability cross the Board" with secondary interests in mental health. The emphasis in the role of the F.S.W's is essentially practical support rather than "casework" or any of the other methods.

Other

The only response under this heading was from the Care Attendant Scheme Co-ordinator, who was described using management skills in the operation of her project, which provides support to younger physically handicapped people through recruiting "carers".

General Comments

As with the previous section, the findings in this part of the study will be discussed further as a comparison with the 8 Area Team in Chapter 4 later in the study in Chapter 6: Conclusions.

6 - Identified Workers

The number and type of identified workers according to the headings in the questionnaire is shown as follows:

Heading	*No of Workers*

1. Approved Social Worker (Mental Health Act, 1983)	3
2. Guardian ad Litem/Reporting Officer	2
3. Mental Handicap Specialist	0
4. Court Officer	0
5. Other	1

Approved Social Workers.

As can be seen, there were 3 Approved Social Workers amongst the teams. One of these, a level 3, was in the Child Care Team-South. She had a child care caseload, and did not show any mental health sub-specialism. There was no comment on how often she was called upon to exercise her duties under the Mental Health Act.

The other 2 Approved Social Workers were in the disability team. One was a Level 3, with a primary bias in Mental Handicap and a secondary bias in Mental Health. he had a background in both general and psychiatric nursing before qualifying as a social worker. The second, also a Level 3, had a primary bias in the Profoundly Physically Handicapped and secondary bias in what was described as "Specialist" Mental Health - no other comments about this, he had considerable experience in a Social Service Dept before qualifying.

Guardian ad Litem

There were 2 Guardians ad litem, both in Child Care Teams. The first was in the Child care Team - South, and was a Level 3 worker. Her primary bias was in "Child Care General" with a secondary interest in assessing and supporting foster-parents, although this was not reflected in her caseload. The second was in the Child Care team-North, and was a Level 2 worker. Again, she showed "Child Care General" as her primary bias, with "Adolescents" as a secondary. She was also the worker who showed the greatest range of methods ie. casework, Family Therapy and Task-Centred work.

There was no mention of Reporting Officers in the teams, and it can be assumed that general social workers in Child Care carried out these duties, which were less complex than those of a guardian ad Litem.

Other

There was only one response under this heading. A social worker in the Child Care Team - South, at Level 3, was shown as a Practice Teacher. She held a "general" child care caseload, and had an interest in Juvenile Justice, although this was not reflected in her caseload.

General comments

There was no information as whether there were enough Identified Workers to meet the needs of the Area or whether there were too few. The lack of comment seemed to indicate a sufficiency, but seemed to be consistent that there was a G.A.L. in each of the Child Care Teams. It was interesting that the G.A.L. was at Level 2 in the Child Care Team-North. This may have been because the three workers at Level 3 were either part-time or were also Area Fostering Officers.

It also seemed consistent that there were 2 A.S.W's in the Disability Team, as this was the team which dealt with Mental Health work. The Elderly Care Team did not have any Identified Workers at the time that the questionnaire was completed.

7 - Numbers on Caseloads

In this section, it will be clearer if the situation is shown by team. Some comparisons can be made within the Basingstoke Area and the 4 teams. There will be a further discussion of this in Chapter on "Conclusions."

A. Child Care Team - South	*No. on caseload*
Level 3	27
Level 3	24
Level 3	23
Level 2	12
Level 1	16

Level 1	7
S.S.O/Specialist under 5's	4
S.W.A.	18

B. Child Care Team - North	*No. on caseload*
Level 3 (A.F.O.)	18
Level 3 (A.F.O.)'	4-5
Level 2	35
Level 1	15
Level 1	10
Level 2 (part-time)	15
S.S.O/Specialist Under 5's	12
I.T. Officer	0
S.S.O.	44
S.W.A	2

C. Elderly Care Team	*No. on Caseload*
Level 3	45
Level 1	21
Level 2	42
S.S.O.	45
S.S.O.	28

D. Disability Team	*No. on Caseload*
Level 3	40
Level 3	25
level 1	30
Level 3 (part-time)	0
Level 1 Specialist/Adult Placement	30
Family Service Worker	5-6
Family Service Worker	5-6
Care Attendant Scheme Co-ordinator	0

General Comments

As far as the Child Care Team - South is concerned, it is not perhaps surprising that the three level 3 workers have the largest caseloads. The Level 1 staff have smaller numbers ie. 16 and 7 respectively, and it seems as though they are building up on numbers as they become more experienced. It is interesting that the Level 2 worker has a smaller caseload (12) than the first level 1. The Social Services Officer is also the Day Care Officer for the Under 5's, so only carries a

very small number (4).

In the Child Care Team - North, the caseloads are generally smaller, with the exception of the Level 2 worker (35). She seems to have a significant role in the team. Her Level 3 colleagues are all part-time or are specialists (Area Fostering Officers/Intermediate Treatment Officers), and the remainder are Level 1 workers, with caseloads of 15 and 10 respectively. One of the Social Services officers was also part-time, with the other half of her time as the Day Care Officer, and carried 12 cases. The second S.S.O. carried a high caseload (44) of teenagers - this was the highest number in the team. It is not surprising that caseloads are lower in this team considering the number of both part-time and specialist staff. The lowest figures is 2 cases, carried by the Social Work Assistant who helps with the child minders and playgroups and has, therefore, more of a specialist role.

The Elderly Care Team has the highest per capita caseload, with the Level 3 and Level 2 workers carrying 45 and 42 respectively. The Level 1 workers has a lower figure 21, consistent with correspondingly lower caseloads for Level 1's in the child care teams. The unqualified staff have higher caseloads than their child are colleagues - 45 and 28 respectively. One particular feature of this team, however, is that there are no part-time or specialist workers, and this leaves them totally free to take on cases. It was also the team with the most consistence responses on "Methods", with "casework" begin given for every member of the team.

The Disability Team also showed higher figures, with 40 and 25 of the Level 3's and 30 for both Level 1 workers. The high figures may be the result of the rest of the team either not carrying cases at all, e.g. the part-time Level 3 Duty worker, or the Family Services Workers, also part-time, who carried 5 or 6 cases each. This must leave the bulk of the individual casework to the 4 full-time qualified staff.

As far as overall figures are concerned, the following gives some idea of the total caseload of each team:

Team	*Total no. of Cases*
A. Child Care - South	131
B. Child care - North	156
C. Elderly Care	181
D. Disability	137

The situation is complicated further by the number in each team who can carry cases, as follows:

A. Child Care - South	6 full-time
	2 part-time
B. Child Care - North	5 full-time
	4 part-time
C. Elderly Care	5 full-time
	3 full-time
D. Disability	3 full-time
	3 part-time

Numerically, therefore the Child Care teams have a larger number of "case-carrying" staff - 8 and 9 respectively, with the Adult teams with 5 and 6 members of staff. A final comparison might be between the total child care and adult cases in the Area compared to staff numbers, as follows:

A. Child Care - 287 cases - 17 staff (11 full-time, 6 part-time)

B. Adult - 318 cases - 11 staff (8 full-time, 3 part-time)

It is, of course, very difficult to equate "caseload" with "workload", and it is well known that a small number of cases can be more complex and time-consuming than a larger number.

Summary.

The findings and the discussion in this chapter have followed broadly the same headings in the questionnaire and those used in Chapter 4. Information has been

gathered on 4 teams in the same Area Centre on the Following:

1. Qualifications/Grades of Staff
2. Previous Experience
3. Primary and Secondary Bias on Caseloads
4. Issues and Attitudes surrounding Informal Specialisation
5. Specialisation by method
6. Identified workers
7. Numbers on caseloads

Comparisons between the 8 Area Teams and the 4 Basingstoke Teams will be considered in Chapter 6 along with some general conclusions.

CHAPTER SIX: CONCLUSIONS.

The chapter on Methodology (Pg.40) refers to M.Stacey's discussion (1969) on the distinction between an "Area of Study" and an Hypothesis, and she quotes from Goode and Hatt (1952) as taking the "view that it is essential to have a hypothesis to guide research ie. a statement of the object of research which may be deduced from existing theory and which will lead to an empirical test" (Pg.8). It seems important to begin the discussion of the conclusions of this research project by a repetition of the original hypothesis as set out in the Methodology chapter (Pg.40).

> "Generic work in social work teams in Hampshire is subordinate to the necessity for qualified staff to take on child care and mental health clients, leaving unqualified staff to deal with the majority of cases involving elderly and disabled people".

PART A

The second major reference point for the discussion of the conclusions is the list of issues arising out of the Literature survey in Chapter 2, Pg.35. These are also repeated as follows:

1. Qualifications and grades (ie. Levels 1, 2, 3, and Unqualified staff) have a significant impact on the types of client groups allocated to social workers.

2. Previous experience will determine caseload bias on a social worker's caseload.

3. Child care cases are usually allocated to qualified social workers.

4. Child care, work with the elderly and work with the physically handicapped are the most common biases on caseloads, with a low priority given to the mentally-ill and the mentally-handicapped.

5. Work with the elderly and physically handicapped is allocated to unqualified staff.

6. The majority of social workers have a bias on their caseloads, usually in

child care, and generic workers are in the minority.

7. Intake and short-term workers are more likely to see themselves as generic workers.

8. Informal specialisation by method is rare in social work teams, with a continued emphasis on casework as the principle method of intervention.

The discussion of the conclusions will also need to take into account some of the differences between the 8 Generic and the 4 Specialist teams. More general conclusions are drawn at the end of the chapter following the consideration of the research data. This is particularly important in the light of the new legislation on the horizon, ie. The Children Act, 1989, and the National Health Service and Community Care Act, 1990.

The discussion of the research findings will be taken in the same order as in Chapters 4 and 5, but the Generic teams and the Specialist teams will be considered together.

1. Qualifications.

A. The 8 Generic Teams.

There were 58 members of staff involved in the study within the 8 Area teams. These were in the following groups:

Qualified - (C.Q.S.W/Other) - 45 or 78 per cent.
Unqualified - - 13 or 22 per cent.
Graduates - 22 or 38 per cent.
Non-Graduates - 36 or 62 per cent.

B. The 4 Specialist Teams.

There were 31 members of fieldwork staff amongst these teams. These were in the following groups:

Qualified (C.Q.S.W./Other) - 20 or 65 per cent.

Unqualified -	11 or 35 per cent.
Graduates -	9 or 29 per cent.
Non-graduates -	22 or 71 per cent.

It can be seen, therefore, that there was a higher percentage of qualified workers within the generic teams, and a higher percentage of graduates. There also seemed to be a correspondingly greater use of unqualified workers in the specialist teams.

The relationship between caseload bias and qualification will be discussed later in this chapter. There are no references in the Literature survey to comparisons between Generic and Specialist teams with regard to qualification. There is no evidence to suggest that the lower number of qualified staff is linked to team structure. Although this is not within the province of this particular research, it is thought that it is more difficult to recruit qualified staff in the North of Hampshire, ie. Basingstoke and Aldershot, because of the proximity of Berkshire and Surrey Local Authorities. However, it is possible to consider more closely the relationship between qualification and type of work within the 4 specialist teams. The Child Care Teams had the highest number of qualified staff - 6 each, whilst the Disability Team contained 4, and the Elderly Team had 2 qualified workers. The total number of staff engaged in work with either Child Care or Adult client groups is markedly different within this Area Centre - 17 workers in Child Care and 11 in Adults. This supports the views of Parsloe and Stevenson (1978) quoted in Chapter Two (Pg.25) that Child Care is seen as the priority,and that Child Care cases are more likely to be allocated. They are also are considered to be more difficult, and, therefore, they are allocated to qualified staff. Goldberg (1978) found that child care problems constituted the major part of social worker's caseloads, even though these problems were numerically smaller than those of the elderly and handicapped. This is only marginally borne out by the study of the Specialist teams, where the combined caseloads for child care amounted to 287 cases, and those for the Adults came to 318. This difference, however, seems to be more the result of a local management decision to deploy resources in this way rather than a drift towards prioritising child care work, as described in Chapter Two. For, example, John Cypher(1980) writes about specialisation "by stealth and by design" (Pg.77).

2. Grades.

A. The 8 Area Teams.

The grades of the fieldwork staff in these teams can be categorised as follows:

Level 3	22 or 38 per cent.
Level 2	14 or 24 per cent.
Level 1	7 or 12 per cent.
Social Service Officers/ Social Work Assistants	12 or 26 per cent.

B. The 4 Specialist Teams.

The 31 fieldwork staff in these teams can be categorised as follows:

Level 3	9 or 29 per cent.
Level 2	4 or 13 per cent.
Level 1	7 or 23 per cent.
Social Service Officers/ Social Work Assistants	11 or 35 per cent.

It is clear that there are some differences here. The Generic teams have a higher percentage of experienced, Level 3 staff, and a lower percentage of unqualified workers. An important difference is that the specialist teams have fewer Level 2 workers, which means fewer staff rising Level 3. There is also a greater proportion of Level 1 workers. All in all, there seems to be a less experienced staff group within this Specialist group.

There is no evidence in the Literature survey to suggest that there is any relationship between specialist teams and a trend towards less experienced staff groups. A significant factor may well be the maturity of the various teams studied. With the generic teams, these had been in existence in that format for quite some years. The specialist teams, however, had only recently been reorganised in that way, and the office had experienced a great deal of change. This can obviously lead to a turnover of staff and the need to recruit newer social workers. It is clear that any future research on social work teams needs to include data on the history

of the teams in question and on the implications of change. This would be particularly true of the recent reorganisation in Hampshire Social Services Department (April, 1990), and the move to establishing specialist teams in preparation for the National Health Service and Community Care Act, 1991. However, the relationship between qualification, grade and caseload bias is discussed later in the chapter when informal specialisation is considered in more detail.

3.Previous Experience.

Howe (1980) makes the point that social workers with experience in departments before the Seebohm reorganisation are more likely to continue in the area of specialisation in which they started out. There were only four social workers in this study with stated pre-Seebohm experience, all from the Generic team group. Three had experience in the former Childrens' Department, and none were specialising in any way with children and families at the time the questionnaire was completed. One of them specialised in Mental Health, another in community care for the Mentally-Handicapped, and the third was a generic worker in an Intake team. The fourth, previously in the Welfare Department, was an Area Fostering Officer. This was obviously much too small a group on which to comment in the light of Howe's research, but it does not support Howe's conclusions.

There is an issue about the timing of the research, here. In 1980, when Howe carried out his research, there were possibly more pre-Seebohm members of staff in Social Services Departments. There must have been fewer by 1986 when this particular study was undertaken. In addition, Howe's research was on a much larger scale - three Local Authorities and eighteen Area teams, involving 285 questionnaires.

This research goes into more detail than Howe in that it looks specifically at "previous experience" more recent to the worker engaging in the particular caseload bias shown on the questionnaire. As regards the Generic group, it is possible to make the following comments:

a. 10 out of 45 qualified workers in this group showed a clear link between previous experience and the sub-groups on their caseload. It is interesting that only one of these was concerned with the elderly, the rest being

involved in child care.

b. 3 out of the 12 unqualified staff showed previous experience relating to their current activities. In terms of proportions, this means that 23 per cent of the qualified staff had caseloads related to previous experience, whereas this was 25 per cent for unqualified staff, albeit with a smaller group.

As regards the Specialist teams, the following general comments seem to be true:

a. 5 out of the 20 qualified workers had previous experience similar to their current workload (25 per cent).

b. Six out of the 10 unqualified staff showed clear links between their previous experience and the current work (60 per cent).

c. Eight out of 17 child care staff within the 2 child care teams had similar experience to their current caseloads (47 per cent).

d. Three out of the 13 Adult team workers had similar previous experience (23 per cent).

It is clear, then, that about a quarter of the qualified staff in both sets of teams had similar previous experience. There was a much higher percentage of unqualified staff within the Specialist teams with like experience. There are two issues about this, seemingly. Firstly, staff may have opted for these teams because of previous experience and knowledge. Secondly, these staff would form a group out of which would emerge qualified social workers at a later stage. This raises a further more general issue with regard to both sets of teams. It became apparent from the research that a large number of staff had experience in a caring role or occupation before achieving a post in an Area Centre or before joining a Social Services Department.

These types of experience included Nursing, Residential Care (of children, adults or the mentally-handicapped), Voluntary work, Youth Work, Teaching, Day Care, Church work, Probation, Personnel, and pre-Seebohm Departments. It also included staff who had experience in other areas of Social Services before their present

post. In the light of this information, it is possible to make the following comments:

a.In the Generic teams, 32 out of 45 qualified staff had experience in one of these groups (71 per cent).

b.Within the same teams, 8 out of 13 unqualified staff had a background in a caring role (62 per cent).

c. Within the Specialist teams, 16 out of 20 qualified staff had experience in a caring role (80 per cent).

d. All of the 10 unqualified staff in the Specialist teams had experience from one of the groups mentioned (100 per cent).

As regards "Previous Experience" generally, Bamford (1982) is discussed in the Literature survey (Pg.15) as follows. Bamford suggests that most social workers have some bias in their caseloads irrespective of how their teams are organised.He suggests that this bias may be caused by personal preference of the worker or by his or her previous experience, or by the propensity of particular kinds of problems within a locality, eg. unemployment.

Certainly, from this research, it appears that "Previous Experience" seems to be a factor with some social workers, but not as an exclusive reason for Informal Specialisation. Parsloe and Stevenson (1978) said that they found some evidence that previous work had some effect on caseload bias, and there could be some relationship between this and pre-Seebohm experience.They give the example of an unqualified worker who had trained as a psychiatric nurse, specialising in mental health within a social work team.

There are, of course, similar examples in this particular research, but this issue seems only to make up part of the picture as to the factors surrounding Informal Specialisation. Caseload bias and its relationship with qualifications, grades and the views of team-managers needs to be looked at next.

4.Caseload Bias.

A. The Generic Teams.

The total caseload figure for all 89 members of staff involved in the study was 1687. This figure included 1067 cases in the Generic teams, and 605 in the Specialist teams. Within the Generic teams, the total number of responses for both primary and secondary biases was 190. For the sake of clarity, it may be useful to repeat one of the tables from Chapter 4.

Responses - Primary and Secondary Biases.

Client Category	Primary	Secondary.
1.Elderly	46	11
2.Mental Handicap	8	5
3.Physical Handicap	4	7
4.Mental Health	6	6
5.Blind/Partial Sight	3	2
6.Children and Families	34	36
7.Generic	16	3
Totals	117	70

Considering these results in the light of comments made in the Literature survey in Chapter Two, there are some interesting parallels. Firstly, the total for the elderly is 57 or 30 per cent of the overall response. The total for children and families is 70 or 37 per cent of the responses.

This accords with the findings of Howe (1980) that child care and elderly cases make up the greatest proportions on caseloads.

If the generic responses are subtracted from this total on the grounds that only a proportion of their work is with either the elderly or children and families, the percentages are as follows:

Elderly	33 per cent.
Child Care	41 per cent.

The situation with regard to the mentally-handicapped and the mentally-ill in terms of the total number of responses is as follows:

Mental Handicap	8 per cent.
Mental Health	7 per cent.

Howe (1980) found that 5 per cent of the caseloads of social workers in his study were biased towards the mentally-ill and the mentally handicapped. It is interesting that Howe's research also showed that 43 per cent was biased towards children and families, which is very close to the figures quoted above. Howe's percentage for Generic work was higher than in this study - 30 per cent with a generic caseload, ie. no marked bias.In terms of the responses and sub-groups, generic work only accounted for 19 out of the 190 (10 per cent.)

Challis and Ferlie (1988) linked bias with qualification and grade, and found that higher grade staff had the greater degree of bias towards children and families. The parallels with this study will be dealt with later in the chapter. The most interesting aspect of Howe's research and this project may well be the data provided about the extent of the bias towards children and families. The Literature survey in Chapter Two refers to the findings of Parsloe and Stevenson (1978), and there is a discussion on caseload bias towards child care (Chapter Two:Pg.25).

Their research found that where bias existed, it was more likely to be in one of the child care sub-groups. Child care was seen as a priority by social workers. Child care cases were more likely to be allocated, more likely to be accepted by duty officers, and considered to be more difficult so were allocated to qualified and experienced staff. Cypher(1980) refers to Goldberg's studies in Southampton (1978) as demonstrating that child care problems formed a predominant part of social workers' caseloads. He attributes this over-emphasis on child care cases is due to a combination of public concern over child abuse, the risk management posture of senior agency staff and the "expressed preference of many social workers" (Pg.81.) Bamford (1982) also refers to the predominance of child care, and feels this is partly due to the need for "fire-proof managements" following the spate of enquiries into child care tragedies (Pg.101).

Considering the results of the research in this project into the responses about the sub-groups, it does appear that a more balanced picture emerged. It is perhaps more helpful to show this in terms of Adults and Child Care rather than separating out different sub-groups dealing with the elderly, mentally-handicapped, mentally-ill etc.

Client Category	Primary bias	Secondary bias
Adults	67	31
Child Care	34	36
Generic	16	3
Totals	117	70

These results show that Adult client groups made up 52 per cent of the total figure, whilst child care accounts for 37 per cent, and the generic responses 11 per cent.

B. The 4 Specialist Teams.

It is more difficult to measure the attention given to the various client groups in the specialist teams because of the low number of sub-specialisms identified in the questionnaire, ie. 30 for both primary and secondary specialisms. As explained in Chapter 5, the tendency was for social workers to be described as generic within their client specialism, whether this was in the Child Care teams, or the Elderly team. The exception was the Disability team, in which individual workers took responsibility for particular client groups, eg. the mentally-ill, the physically handicapped, and the mentally handicapped. However, it is nonetheless interesting to compare the percentage input of effort into the various client groups. It may be useful to repeat the following table from Chapter 5 showing the number of cases involved in the study and the numbers of staff engaged in each.

Child Care	287 cases	17 staff - (11 full-time, 6 part-time.)
Adults	318 cases	11 staff - (8 full-time, 3 part-time).

Although there are 31 members of staff in all, three of these do not carry caseloads, eg.Intermediate Treatment Officer, a Duty Officer, the Co-ordinator/Care

Attendant scheme. If these are added to the staffing complement, the figures are 18 and 13 for child care and adults respectively. The percentage of caseload weighting and staff effort can therefore be represented as follows:

Child Care	47 per cent of workload	58 per cent of workforce.
Adult	53 per cent of workload	42 per cent of workforce.

However, as with the Generic group of teams, the division of the work into Child Care and Adult may be misleading, since it could be argued that each of the categories making up 'Adults' should have equal emphasis to Child Care. It may be more illuminating to break this down into Adult sub-groups, as follows:

Elderly	30 per cent of workload	16 per cent of workforce.
Mentally ill, Mentally handicapped, Disabled	23 per cent of workload	26 per cent of workforce.

These percentages are interesting compared with some of the comments in the Literature survey in Chapter Two. Firstly, the two largest percentages in all are concerned with the elderly and with children. Howe (1980) writes:

> "Work with children and their families and work associated with the elderly and physically handicapped forms the greatest part of fieldwork practice".

It is also interesting that Howe found that out of the 12,825 cases included in his study, 12 per cent of these were concerned with the mentally-ill and the mentally-handicapped. Within the Generic teams, the figure for the responses on mental handicap and mental health as sub-groups was 15 per cent.

In both the Specialist and the Generic teams, the figures are in accord with the findings of Howe(1980) that the mentally-ill and the mentally-handicapped occupy a lowly status compared with other client groups.

As regards physical handicap, Howe links this with elderly as a total client group. Of all the cases he included, these two groups accounted for 38 per cent, compared with 41 per cent in the Specialist teams. The responses for physical

handicap accounted for 11 out of 190 within the Generic teams.

In summary, this part of the research data has been concerned with the concentration on client groups according to the responses on sub-categories on the questionnaire, eg. elderly, mental handicap, child care, physical disability. As regards the Specialist teams, there were fewer responses on sub-groups because of the specialist nature of the work, eg. Child Care teams, Elderly team, Disability team, so information on total caseloads and the numbers of workers involved in the client groups was used as well.

5. Informal Specialisation - The Generic Teams.

A. Generic work.

It is probably more appropriate to deal with generic work first, and then move on to look at Informal specialisation per se. Six out of the 7 Level 1 workers in the study were described as 'generic.' The team-leaders said that their caseloads were kept generic in order to give them as much experience as possible after their professional training. This is consistent with Howe's research (1980), who found that there was a greater degree of generic work with social workers with less than two years post-qualifying experience.

Challis and Ferlie (1988) found that the degree of caseload bias in their study was highest among social work assistants and lowest amongst new entrants - Level 1 workers (Chapter Two:Pg.28). Parsloe and Stevenson (1978) found similar views expressed during their research, in that a generic caseload was essential to the newly qualified worker in order to gain experience. As quoted in Chapter Two, Pg.26, this was expressed as follows:

> "You should not specialise until you've gained full experience generically.Everything intertwines - therefore you can't be an expert in one field without a sound generic base" (Pg.173.)

As regards generic qualified staff at other grades, there were 6 at Level 3 and 6 at Level 2. There were, therefore, a total of 18 social workers across the three levels whose caseloads were described as 'generic.'

This represents 40 per cent of the qualified staff across the 8 generic teams. There were 2 workers described as generic within the unqualified group of 12 workers. If these are added, the percentage of generic workers across the complete staff group (of 58) within the generic teams is 34 per cent.

It is interesting to compare this with the research of both Howe (1980) and Challis and Ferlie (1988). The latter found that 80 per cent of the staff in their survey had biased caseloads, and only 20 per cent, therefore, could be described as generic. The scale of this research was much larger than the present study, however, involving 278 teams and 2, 982 fieldworkers. The authors refer to Pritchard (1983) who found that 69 per cent of basic grade staff and 71 per cent of team-leaders favoured specialisation by client group.

Howe (1980) researched into 3 local authorities and 18 Area Teams. As explained in the Literature survey, he found that 70 per cent of the social workers in the study had a bias on their caseload - 30 per cent, therefore, being described as generic, or, as described by this author, with no marked bias at all. There is also accord with Howe in this particular study, since he found that Intake/Short term workers were also more likely to have generic caseloads. In this study, 8 out of the 18 social workers described as "generic" came from the 2 Intake teams in the study.

The percentage of generic workers in this study, ie. 34 per cent, is in accord with the findings of Howe(1980), Pritchard (1983), and Challis and Ferlie (1988).

However, the next category to be considered within the Generic group of teams could alter the picture to some degree.

B. Child Care/Adult Mix.

It was explained in the Chapter on Methodology, that Challis and Ferlie (1988) defined bias as "75 per cent of cases coming from one or two of the 5 main client groups, (child care, elderly, mental illness, mental handicap, and physical handicap.) The Child Care/Adult Mix category was included in this study as a type of "half-way house" between generic workers and informal specialists, since they did not fit totally into either group. This category was defined as a caseload where child care featured equally alongside one or two Adult sub-groups. There were no

Level 1 workers in this category. There were 6 social workers in the Level 2 group and 6 in the Level 3 group with this type of caseload. **This represents 27 per cent of all the qualified staff.** There were 2 members of staff in the unqualified group with a Child Care/Adult Mix caseload.The overall figure, therefore, of social work staff with this bias is 24 per cent.

If Challis and Ferlie's formula is adopted, it would mean that any social worker showing specialisation at a primary and secondary level in not more than 2 of the main sub-categories in the questionnaire should move across into the "generic" group, particularly if these 2 sub-groups were shown as a joint primary bias. This applies to 4 out of the Level 2 social workers, 3 out of the Level 3 social workers, and to one of the unqualified staff. **This would add a further 8 social workers to the generic group and the total number would represent 48 per cent of the fieldworkers within the 8 Generic teams who could be described as "generic" workers, clearly a much higher percentage than found by Howe, Challis and Ferlie, and Pritchard.**

C. Informal Specialisation - Child Care.

It was to be assumed that the majority of the informal specialists would be in the field of child care. This was certainly the assumption in Hampshire Social Services at the time the study was begun in 1986, particularly for Level 3 social workers.

One major difference between this research and the study by Stevenson (1980) is the range of sub-groups mentioned. Stevenson refers to a limited number, e.g. "adolescents" and "one-parent families" (Pg.46). The Literature survey also refers to an earlier study by Parsloe and Stevenson (1978). Here, there is mention of a larger number of sub-groups, eg. adolescents, one-parent families, children at risk, children in care, and adoption and fostering. This particular study expands on this and adds "sexual abuse" as a category, as well as "Under Fives" and "Voluntary supervision", although it excludes "one-parent families".

As explained in the Chapter on Methodology, a further category - "Child Care - All types", had to be added. One of the sub-groups, "Children Leaving Care", attracted no responses at all, whilst "Sexual Abuse" and "Child Placement" showed nothing as a primary bias but 2 and 3 responses respectively as a secondary bias. The largest responses were for "Voluntary Supervision" (14 total for primary and

secondary biases); "Statutory work - Children on Care and Supervision Orders" (14 total), and "Child Care - All Types" (13 total).

As regards the number of social workers whose responses showed that they were informal specialists in Child Care, that is, with no other client type shown, the following table may be helpful:

Level/Grade	Number of staff	Percentage
Level 3	7	35 % of Level 3
Level 2	1	7 % of Level 2
Level 1	1	14 % of Level 1

These figures show that 9 out of the total qualified group of 40 social workers were specialising entirely in child care, that is, 22 per cent.

This is in accord with the findings of Challis and Ferlie, (1988), whose research showed that higher grade staff had a greater degree of bias towards children and families. There is also some support for the findings of Parsloe and Stevenson (1978), who found that child care cases were considered to be more difficult and were therefore allocated to qualified and experienced social workers.

However, the Literature survey does tend to throw up the impression that the degree of specialisation in child care should be greater than this. Bamford (1982) says that the client group attracting most specialist roles is "children and families", (Chapter 2, Pg.16), and suggests this is due to the importance of statutory work and to the impact of enquiries into child care tragedies.John Cypher (1980) refers to Goldberg's studies in Southampton (1978) as demonstrating that child care problems formed a predominant part of social workers' caseloads. He questions whether this bias towards children and families achieves anything for social workers, unless it is related to training and a consequent enhancing of skills. He feels that there has been a move to specialisation by "stealth" which has consisted in an over-emphasis in informal specialisation in child care.

Cypher also refers to the Parsloe and Stevenson study (1978) and says that they found that many "social workers' caseloads, for a variety of reasons, contained a bias towards or a concentration on child care problems" (Pg 81.) It is clear that this

is not the same as saying that most social workers were completely informal specialists in child care.

As regards the more detailed research of Challis and Ferlie, (1988), there were no actual percentages given for staff specialising in child care work. The authors found that 80 per cent of social workers had biases in their caseloads, and 71 per cent had biases solely towards one of the main client groups, eg. children and families, elderly and physically-handicapped, and mental health and mental handicap. The authors also say that higher grade staff had a greater degree of bias towards children and families.

David Howe (1980) goes into more detail in his study.The caseloads of social workers were analyzed in terms of 3 main client groups, similar to Challis and Ferlie described above.He found that 43 per cent of social workers had a bias towards children and families, and this rose to 63 per cent in metropolitan areas. In addition, he found that 50 per cent of the 12, 825 cases considered were in child care.

Although this research project is on a smaller scale, it is interesting that there is a much lower figure for informal specialists in Hampshire, with a correspondingly higher percentage of generic workers. However, this has to be balanced against child care effort as a whole, and more information emerges on this when other groups of staff are considered later in this chapter.

D. Informal Specialisation - Adults/Elderly.

There was one social worker at Level 3 specialising in work with Adults and elderly clients - a worker in an Intake team in one of the City areas. There were no members of staff in the groups of Level 1 or Level 2 workers who were entirely with either adult or elderly people. However, the picture is very different for the unqualified staff, with 7 out of 13 specialising completely in these client groups, that is, 53 per cent of the total. Only 2 of these specialised entirely in work with the elderly, the others showing sub-groups in physical handicap, mental handicap, and the blind or partially-sighted.Work with the elderly featured as a primary bias for 3 of the remaining unqualified staff, and as a primary bias amongst child care sub-groups for a fourth. In fact, all unqualified staff featured work with the elderly as a primary bias, but there were different weightings according to how this work

was shared with other client groups.

As regards Mental Handicap, this was shown as a primary bias for 4 out the 13 unqualified workers, that is, 30 per cent. Mental handicap did not feature at all as a secondary bias. Mental Health Support (as opposed to Mental Health Statutory, which, of course, does require a qualified and "approved" social worker under the 1983 Mental Health Act) did not show up at all as a primary bias, and only on two occasions as a secondary bias. There were 44 response on sub-groups in all from the unqualified group, and these mental health responses account for 15 per cent.

If the responses for mental health and mental handicap are added together, they account for 13 per cent of the responses for the unqualified group.This is similar to the overall response rate for these client groups amongst the generic teams - 15 per cent.

This seems to back up the findings of Howe(1980), whose research showed that 5 per cent of his group of social workers specialised in mental health and mental handicap, and that these client groups accounted for 12 per cent of the total caseload of 12, 825.

As regards informal specialisation and elderly/adult client groups, the Literature survey makes numerous references to unqualified staff.Bamford (1982) refers to Parsloe and Stevenson's research (1978) and their conclusion that specialisation was influenced by the type of staff employed, for example, a large number of social work assistants dealing with the elderly inhibited this as a specialism for the qualified staff. Cypher (1980) refers to the British Association of Social Workers' study (1978) and the finding that elderly people are allocated to social work assistants or volunteers. He goes on to say,

> "It is evident that some social workers do not see a professional role for themselves in working with elderly people" (Pg.81).

Parsloe and Stevenson (1978) in their research into 8 Local Authorities between 1975 and 1977 make the following comment:

> "....our study shows that, although it is seldom spelt out at higher levels, the elderly are accorded a low priority for social work provision (as distinct

from social service provision)....." (Pg.169).

It could be argued that the work undertaken by the social work assistants and social service officers mentioned above does constitute "social service provision" rather than social work help.

Challis and Ferlie (1988) found that Social Work Assistants had a pronounced bias in favour of work with the elderly. It is interesting that they found that the degree of bias was highest amongst Social Work Assistants (and lowest amongst new entrants to social work, ie. Level 1 workers.Howe (1980) does not give a percentage of staff specialising in work with the elderly or adult client groups per se. However, he does give a percentage of the total caseload of 12, 825 which were concerned with elderly and physically handicapped clients - 4873 or 38 per cent. He also found that when asked about preferred areas of work, 17 per cent of fieldworkers said they preferred to work with the elderly. It is an interesting comparison that in this study, the responses on work with the elderly accounted for 37 per cent in the Generic teams and 30 per cent in the 4 Specialist teams.

The findings in this research, therefore, seem to be in accord with the general comments in the Literature, e.g., Bamford (1982), Cypher, (1980), Parsloe and Stevenson (1978), Howe (1980) and Challis (1988), that Social Work Assistants and Unqualified staff have caseloads biased towards elderly and adult client groups.

More general conclusions about informal specialisation will be drawn in summary form at the end of the chapter.

6. Issues and Attitudes Surrounding Informal Specialisation.

There are a number of comments in the Literature about some of the reasons for bias on caseloads. This particular study involved asking the team-managers of the various teams for reasons for this, and space was designated on the questionnaire for this purpose. For the sake of clarity, it may be worth repeating the sub-headings from the questionnaire, and the number of responses for each is also shown. Both the Generic and Specialist teams will be shown:

Sub-Heading	Generic Teams	Specialist Teams.
Defined by Role	15	14
Not Encouraged	3	0
Encouraged for Professional Development	2	3
Encouraged subject to priorities	19	17
Commitment to Genericism	12	0
Specialist by Default	0	0
Conflict between S.W. and Team-Leader	4	0
Intake/Short term Specialisms	0	0
Other	4	0

Of the 59 responses within the Generic teams, it can be seen that the third category, "Encouraged subject to priorities in the team" was the most numerous. This sub-heading is probably the most significant since it implies "choice" on the part of social workers and also agreement with the team-leader on the extent of the specialisation. Out of the 19 staff in this category, 5 were Social Service Officers dealing with adults. As regards the 14 qualified workers, 10 were at Level 3, 6 of whom specialised entirely in child care, and 2 to an extent with elderly, whilst 2 were generic. The 3 Level 2 workers in this group included a member of staff with a part generic and part child care caseload, and another who specialised in work with adolescents and with families. A third specialised in elderly work and mental health.

The comments from the team-leaders all indicated a high proportion of agreement on the content of these caseloads, showing a combination of the wishes and skills of the worker and the needs of the team. Examples of these comments are as follows:

- "what she is good at, needs of the team".
- "what she wants to do, is capable of, needs of the team".
- "a happy coincidence, team needs and social worker's preference".
- "needs of the team, her wishes and skills".
- "He enjoys this kind of work, it is what the team needs,
- also for his own professional development".
- "genuinely interested - suits team and her".

The responses in this category for the Specialist teams was also the most numerous - 20 out of 34 in all. Although it could be expected that these workers opted for work in a particular specialist team because of their interest in a client group, there was still expressed views about this in relation to sub-specialisms. For example, a Level 1 worker where preventive work with children and families was described as "a reflection of his own interest". There was also a Level 3 worker in the Disability team who specialised in the Profoundly Physically Handicapped "by choice and interest and the needs of the team".

There were more responses, though, which were less explicit and just indicated "needs of the team" or "needs of the Area. "This applied to 8 out of the 17 child care workers, the whole of the elderly care team. The Disability Team included one further worker who showed a different kind of comment, apart from the member of staff quoted above - a Level 1 who specialised in dealing with the blind and Younger Physically Handicapped because they were his "own areas of interest and because of the needs of the team".

The Literature survey in Chapter 2 makes a number of references to "choice" and informal bias. Bamford (1982) suggests that the bias on caseloads may be caused by personal preference of the worker. He also suggests that although the basis of a team's work may need to be generic, workers should have the opportunity to specialise. Sainsbury (1980) feels that although the overall emphasis in a team should be generic.."all workers would be encouraged to develop personal areas of expertise relative to specific tasks and skills within the total range of work responsibilities allotted to the team" (Pg.66). O.Stevenson (1981) lists 5 factors which determine informal specialisation, (Literature survey, Chapter 2, Pg.23) and the fifth of these is as follows:

> "The freedom for individual staff members to develop special interests, which may not be formally described as specialisms but have implications for the allocation of work" (Pg.63).

Stevenson also goes on to say that social workers should be encouraged to acquire "greater knowledge and skill in areas of work which fire their imagination" (Pg.102). There are also references to this in the Parsloe and Stevenson study of 1978. The authors state that bias usually occurred within a generally mixed caseload, "but most social workers seemed to welcome this within genericism"

(Pg.172).

Howe (1980) suggests that child care work is allocated to those qualified workers who, because of their status, have the most power to influence their caseloads. **In this study, it did not seem to be a question of social workers choosing all child care work, or being powerful enough to determine the content of their caseloads, but more an agreement as to the development of skills with particular client groups, as long as this was consistent with the needs of the team.**

The response, "Encouraged subject to priorities within the team," accounted for 32 per cent of the total of 59 responses with regard to the Generic teams. The second largest number of responses was in the category, "Defined by Role", - 15 out of 59. This applied both to formally designated specialist workers, eg. Area Fostering Officers, and to staff in Intake Teams.It was also applied to much of the work of Social Service Officers and Social Work Assistants, whose role was seen to be concerned with a certain level of service to adult and elderly client groups. **This type of response, "Defined by Role, " accounted for 20 per cent of the total number.** Thirdly, "Not Encouraged - commitment to Genericism" attracted 12 responses. This applied to staff at all levels - three at Level 1, three at Level 2, and six at Level 3. Four of the latter were in the same Intake team. **It is interesting that the expressed commitment to genericism should appear to be a lower figure in terms of the percentage of the total (20 per cent) than the overall figure for generic work mentioned earlier in the chapter, i.e. 34 per cent.**

The remaining categories on the questionnaire attracted a much smaller number of responses. There were 4 instances of disagreement between social worker and team-leader - 7 per cent of the total. There were no explicit instances of "Specialists by Default", although it could be argued that the policy of allocating the elderly and other adult client groups to Social Service Officers and Social Work Assistants is tantamount to this.

"Not Encouraged - Area Policy" as a response attracted 3 responses, but these could equally have come into the "Defined by Role" category, since they applied to people who needed to build up generic experience, both at Levels 1 and 2.

7. The 4 Specialist Teams - Issues and Attitudes Surrounding Informal Specialisation.

The situation is similar for the Specialist Teams, with responses to "Encouraged within the priorities of the team" as most numerous (15), with "Defined by Role" next with 13 responses. These represented 39 per cent and 34 per cent respectively of the total number of 38 responses. To take the second first, this is a higher figure than the Generic teams (at 20 per cent). In many ways, this is what one would expect in Specialist teams, with much tighter definitions of boundaries of work. As regards the first, it has already been mentioned that the comments on this response (Chapter 5, Pg.126) evolved into "Needs of the Team", with less emphasis on choice of work.It could be argued that the element of "choice" came at an earlier stage when the workers chose to be in that particular specialist team.

The third most numerous response was to the category, "Encouraged for Professional Development", (4) and this represented 10.5 per cent of the total. There were only 2 responses to this from the Generic teams, accounting for 3 per cent of that total (59). The remaining response rate was very small, although one of these is worth a mention. "Encouraged because no other worker could do the work" applied to a Social Service Officer who took on all the cases involving adolescent boys in the team.In this sense, he was a "Specialist by Default", since it sounded as if there was no-one else prepared to do this type of work.

In both groups of teams, the 2 most numerous categories were "Encouraged subject to priorities" and "Defined by Role." The Generic teams showed a greater percentage of staff in a position of "choice" with an emphasis on agreement with the team-leader. In the Specialist teams, the position is reversed, with the emphasis on "Role" as the determining factor.

8. Intake and Short-Term Specialisms.

As explained in Chapter 4, this section was designed mainly for the workers in the 2 Intake teams. The response rate to the specific types of intervention was limited, with a preference for more general comments. For 5 out of the 9 members of staff in one of the teams, the comment was "generally good at all of these", or "good duty officer - dependable, reliable". As regards the number of responses, "one-off" assessments was mentioned 3 times, as was "resource-finding". Others, such as

"Welfare Rights", "homelessness", "family crises", "telephone work", and "at risk" work, were all mentioned once only. It can only be assumed from this that the Intake workers did not see themselves as specialising in particular aspects of crisis intervention, but adopted a "generic" approach. This further supports the findings of Howe (1980) that Intake and Short-term workers are more likely to be generic."

9. Specialisation by Method.

The Generic teams produced 120 responses within these categories. The most numerous was in "Casework" - 48 responses or 40 per cent of the total. Secondly, there were 20 in the "Support and Practical" group, 17 per cent. "Groupwork" and "Family Therapy" both attracted 15 responses, or 12.5 per cent. "Task-Centred Work" accounted for a further 13 responses, or 11 per cent.

The Specialist Teams produced 37 responses in all. Again, the most numerous was "Casework" - 26, or 70 per cent of the total. "Groupwork" responses amounted to 5, or 14 per cent. "Family Therapy" and "Support and Practical" attracted 2 responses each, or 5 per cent respectively. "Task-Centred Work" drew one response, and there were none for "Community Work" or "Modelling."

It is interesting that there was a much higher percentage in the Specialist teams for "Casework", with correspondingly lower numbers for other methods. "Groupwork" applied to formally designated specialist workers in both sets of teams, e.g. Area Fostering Officers, Intermediate Treatment Officers. This is to be expected, since the use of groups is implicit in their roles.

"Support and Practical" seemed to be a matter of interpretation in the Generic teams - this category applied to groups of staff at all levels in 4 out of the 8 teams, ranging from 3 workers in a team of 8 to 6 out of 7 workers in another team. In the Specialist teams, it only applied to the Family Service Workers, whose role in the Disability team is traditionally seen as one of practical support.
There were 5 responses to "Community Work" in the Generic teams, and none in the Specialists. "Family Therapy" accounted for 12.5 per cent of the responses in the Generic teams, and 5 per cent in the Specialists. It was, however, difficult to pin down with the Generic workers how much "Family Therapy" was an interest and how much it was actually being practised. There is clearly a marked difference

with the Specialists, and it may be important that "Family Therapy" here appeared once in each of the child care teams.In the Generic teams, it appeared 3 times amongst informal child care specialists, and applied to a further 10 workers with either mixed or generic caseloads.This method, therefore, was certainly not the sole property of child care staff.

It emerged that there was a greater number of responses per social worker in the Generic teams than in their Specialist counter-parts, almost on a ratio of 2:1. **This research may well show that Generic teams are more able to foster a wider range of methods of intervention than in Specialist teams, where the focus of interest seems to be more concentrated. This may be imperative in order to cope with the demands of the workload, and it is possible that staff are prevented from exploring other methods of intervention.** "Casework" is still seen as the major method of intervention, and there is a particularly high emphasis on this in the Specialist teams.

10. Identified Workers.

There were 33 responses to this category in the Generic teams, although these actually applied to 22 social work staff, 11 of whom carried more than one area of special responsibility. The combinations usually consisted in Approved Social Worker/Guardian ad Litem, or Guardian ad Litem/Court Officer, and, in one case, it involved all three. Identified workers accounted for 38 per cent of the total of fieldwork staff in the Generic teams.

The Specialist teams produced 6 Identified workers, and there were no instances of social workers taking on more than one area of special responsibility. These staff accounted for 19 per cent of the total of 31 fieldwork staff. There was also a narrower range of special responsibility in the Specialist teams. There were Approved Social Workers, Guardians ad Litem, and one Practice Teacher, but no mention of Court Officers, workers dealing with Aids/Adaptations for the Physically-Handicapped, or with the Visually-Handicapped, as was the case with the Generic teams.

There was a lower percentage of Approved Social Workers in the Specialist teams - 9 per cent (3 out of 31 workers), as opposed to 22 per cent in the Generic teams (13 out of 58 workers). However, as was shown in Chapter 4, there were 8

workers in the Generic teams who were shown as "Approved Social Workers" but who had no mental health biases on their caseloads. The Specialist teams seemed more able to "target" the staff time in this area of work. There was one Approved Social Worker in a child care team, and a further member of staff in training - both seen as a back-up to the Duty system, with no expectation of taking on mental health cases. As regards Guardians ad Litem, there were 2 in the Specialist teams and accounted for 6 per cent of the workforce.In the Generic teams, there were 15 "Guardians", and these made up 26 per cent of the fieldwork staff.

This research shows that the Specialist teams had a lower percentage of Identified workers. This may be due partly to the lower number of specialist staff in each team from which to recruit these workers, but also there may well be issues about a greater ability to target staff time within such teams.

11. Caseload Numbers.

There has already been some discussion on caseload numbers at the beginning of this chapter. However, it is interesting to note that out of the Level 3 workers in the Generic teams, the highest caseloads are held by those specialising in child care - an average of 30 or more cases. Those involved in either "generic" or adult work, i.e. elderly, mental health, tend to have caseloads of around 20 - 24, with one exception, a worker specialising in the elderly, who had 30 cases. Level 2 workers showed no specific pattern to their caseloads, which range from 6 to 34 across the 14 members of staff. Intake workers had the lowest caseloads. It has already been shown that Level 1 workers tend to be generic, and their caseloads reflect a period of building up of experience. Numbers on their caseloads are low, ranging from 5 to 20, but with one notable exception from an Area of generally high case-loads - a worker with 25 - 30 cases, where there was an average of 40 cases to each team-member.

The situation was quite different for the Specialist teams. The highest caseload figures were in the Elderly team - 3 out of 5 workers holding more than 40 cases each. The Child Care teams obviously had more staff to allocate to, and caseloads ranged between 12 and 44. Some of the formal specialist workers, eg. Under - 5's, Intermediate Treatment Officer, held no cases or very few (40, as did one of the Social Work Assistants (2). The Child Care Team North had higher caseloads than their colleagues in the "South", with the highest in the latter being 27, and in the

former, 35 and 44. There was no explicit reason for this. It was apparent that the "North" team had no case-carrying Level 3 workers - both of these in the team had the role of Area Fostering Officer. The rest of the team, as far as case-carrying staff were concerned, consisted of Level 2's, Level 1's, and Social Service Officers.

The Disability team had 2 Level 1 workers with high caseloads, with 30 cases each. This was unusual, in that the number for this grade of staff in the child care teams was between 7 and 15 cases. There was no set pattern for the other staff - a Level 3 with 40 cases, and a Level 2 with 25. As with the Elderly team, there were fewer staff to allocate to, (3 case-carrying social workers), compared to the child care teams.

The total caseload figure for all 89 members of staff involved in the study was 1687 - 1067 for the Generic teams, and 605 for the 4 Specialist teams. This is a much smaller number than that considered by Howe (1980), whose study involved 12,825. However, from the information given on the questionnaires, it is possible to make the following comments:

This research shows that caseloads for Level 1 workers were consistent with their need to build up experience. Amongst Level 3 workers in the Generic teams, those specialising in child care work held the highest caseloads, but this was often influenced by the level of experience of other team-members. Caseloads for workers in Intake teams were generally much lower. The Specialist teams had the added dimension of dealing with all cases of a particular client group or groups in one team, and the lower numbers of staff in the Adult teams led to higher caseloads than with their child care colleagues.

PART B.

1. General Conclusions.

The main body of the research data concerning social work staff and their caseloads leads to conclusions in two main areas. Firstly, it provides a picture of the position with regard to "generic" work and informal specialisation. Secondly, it shows the emphasis and attention given to the main client groups, ie. child care,

the elderly, the physically-handicapped, mental health and mental handicap. The research also draws some comparisons between the Generic and Specialist teams.

As regards informal specialisation and the Generic teams, the information on the questionnaire on primary and secondary biases indicates that the hypothesis has not been proved. The data shows that there is a commitment to "generic" work amongst many social workers, and 34 per cent of the fieldwork staff showed this as a main area of interest. A second group, which was termed "child care/adult" mix, accounted for 24 per cent of these staff. It has already been established that there is a narrow dividing line between this group and their truly "generic" colleagues.The overall picture for the two groups combined suggests a much higher proportion of generic work in Hampshire at the time the questionnaire was completed (48 per cent)than in other research ie. Howe (1980), Challis and Ferlie (1988).

The assumption underlying the hypothesis was that most qualified social workers, particularly those at Level 3, were informal specialists in child care. The results from the Generic teams shows that only 22 per cent of the qualified staff specialised solely in child care, and this is lower than in other research ie. Howe (1980) who states a figure of 43 per cent. The smaller number in this particular research is also low compared with the general impression given by previous studies - the "predominance" of child care mentioned by Bamford (1982) does not seem to be in evidence. There is support, however, for the views that child care work is usually considered to be difficult, and therefore usually allocated to qualified workers.

There was only one instance in the research into the "Generic" teams of qualified staff as informal specialists with the elderly. The position for unqualified workers was quite different, however, with 53 per cent specialising completely in elderly and adult client groups. Even this percentage seems low, given the emphasis in previous research to the idea that cases involving the elderly and physically handicapped are always allocated to unqualified workers. There were many instances of unqualified staff taking on child care work. In the "Generic" teams, there were no informal specialists with the mentally-ill or the physically-handicapped, and the only specialisation with the mentally- handicapped was in the role of Adult Placement Social Worker.

It was possible to gain a very different impression with the 4 Specialist teams. Child Care did seem to make up a considerable part of the overall workload - 47 per cent as opposed to 53 per cent in adult work. There was also a greater infusion of staff time into child care, 17 workers as opposed to 11 in adult client groups. There is also a dilemma here in juxtaposing "Child Care" and "Adults" as if they are somehow equal in the attention they need, and this ignores the fact that "Adults" comprise a number of groups, ie. the elderly, the mentally handicapped, the physically-handicapped, the mentally-ill, and the visually-handicapped. This dilemma is equally true of the Generic teams, but tends to be hidden more because of the emphasis on "generic" and "child care/adult mix" caseloads. The overall percentage of child care work (as given by the sub-groups) was 37 per cent in the "Generic" teams.

It was, of course, different in the Specialist teams in terms of informal specialisation, since all the workers were "specialists" within their teams. It was interesting, however, that the responses on sub-groups was so low, and they saw themselves as "generic within their area of specialisation". This meant that they seemed more comfortable dealing with all types of work, rather than becoming highly specific as with their "generic" colleagues. This applied particularly to the workers in the two Child Care teams and in the Elderly team.

The results also give a picture of the relative input into the various main client groups,and there is no doubt that the elderly and child care attract a great deal of the interest and staff time available. The position for the mentally-handicapped and mentally-ill is similar to the findings in other research, in that they do seem to be accorded a lower priority - 15 per cent in the Generic teams, and 14 per cent in the 4 Specialist teams. Physical Handicap also attracted less attention - 6 per cent of the responses in the Generic teams, and 11 per cent in the Specialists. It seems that the principle benefit of the Specialist teams may be the coordinated effort into work with the elderly, since the investment in mental handicap and mental illness is not very different to the Generic teams.

These lower percentages for physical handicap, mental health and mental handicap are in accord with previous research. Howe (1980) refers to "hierarchies" and "dirty work" (Pg. 144). He suggests that child care work is at the top, with elderly next, and the disabled much further down. He also refers to the views of Pinker (1971), who suggests that value accorded to individuals is based upon their future

economic potential, and this reflects on the resources allocated to them, eg. the difference in status in medicine between paediatrics and obstetrics on one hand, and geriatrics and mental handicap on the other. It is difficult to assess whether these forces are still in motion when considering a Social Services Department in the late 1980's and early 1990's. Factors which influence this, including a brief outline of developments since the research took place, will be considered in Part B of the conclusions in the discussion on current operational arrangements in Hampshire, particularly in the light of new legislation.

Other information from the questionnaire served more as a back- up to the main findings, and was as much interest in showing some of the differences and similarities between the Generic and Specialist teams. There was a higher percentage of qualified staff in the "Generic" teams - 78 per cent as opposed to 65 per cent. However, it must be remembered that the "Generic" teams (apart from 2) were in separate Area Centres, and it would be necessary to do some research on all the teams in a small number of Areas to see if there was a difference in qualifications compared to Specialist teams. As regards "Previous Experience", there was a similar percentage in both the Generic and Specialist teams (25 %) of qualified staff with clear links between previous work and their current role - 22 and 25 per cent respectively. There was no clear pattern for the remainder of the staff in both teams. It was interesting that the majority of workers had experience in a "caring" profession" or job before taking on their current position. There was no support for the assertion that workers with pre-Seebohm experience tended to remain in that particular specialisation, as found in other research, eg. Parsloe and Stevenson, (1978), and Howe, (1980).

The reasons for informal specialisation threw up some interesting material. In the Generic teams, the most quoted issue concerned "choice" and agreement between worker and team-manager, as long as these choices fitted with team priorities. It was apparent that this caused few problems, and there was no indication that staff chose child care or had this client group thrust upon them. The next most numerous response was concerned with caseloads being defined by the particular role of the worker, as in the case of formal specialist staff, eg. Area Fostering Officers, Intermediate Treatment Officers. The situation was reversed in the Specialist teams, with the emphasis on caseloads being determined by definition of role. There was actually a slightly higher figure given for the response denoting "choice", but these responses evolved into a general comment about role

boundaries. It is to be expected, perhaps, in Specialist teams that the work is governed by the task of the particular team, and the question of "choice" came earlier for these staff when they either opted for or were recruited into these teams.

Specialisation by method raised some differences between the two types of teams, with the Generic team staff showing a much higher figure. These included established methods, eg. Family Therapy, as well as a variety of different projects involving groupwork and community work. This was singularly lacking in the Specialist teams. This was also shown by the higher percentage of responses to "Casework" in the Specialist teams as compared with their Generic colleagues - 70 per cent and 40 per cent respectively. It may well be that one of the results of specialisation in teams is that all the work in a client category is concentrated in a smaller group of people instead of being shared around an entire office. This could well lead to a focus on just getting the priorities covered, and there is little room for innovative work. This is also pertinent to the discussion on the restructuring in Hampshire Social Services (April, 1990), which is discussed later in this chapter.

The findings on Identified Workers in the Generic teams showed rather a "hit or miss" situation, with staff sometimes carrying a number of roles, and the client groups to which these related did not show up at all on their caseloads. There was both a smaller number and smaller range of "identified" staff in the Specialist teams, but there was more of a sense of targeting staff time, and a sense of planning in what the staff would be involved in. Again, similar to the discussion on "Methods", there were fewer staff in each discipline to choose from in the Specialist teams, so there presumably had to be more thought as to who could take on these roles. There was no information on whether there was any more pressure of work on the Identified workers in the Specialist teams than their Generic colleagues, nor whether there was an expectation that they should be fielding a greater number of staff in these specialisms, eg. Guardians ad Litem, Approved Social Workers.

Lastly, the information on caseloads showed that, in the Generic teams, Level 1 and Intake team workers held the lowest caseloads, and this is consistent with the previous research (Howe, 1980). The highest caseloads generally in these teams were held by workers specialising in child care, particularly amongst Level 3 staff,

but this was often influenced by the level and experience of other workers in the team. Level 2 and "generic" workers seemed to have the most manageable caseloads. There was some interesting information on the impact of Specialist teams on caseload numbers. The 2 Child Care teams had generally smaller caseloads, and there were more workers to whom a team-leader could allocate cases. One of these teams had higher caseloads, and it was apparent that there were fewer "case carrying" staff (as opposed to formal specialists) in this team to take on work. The caseloads in the Elderly team were much higher - there were 5 members of staff in this team who had to deal, presumably, with all the "elderly" work in the Area. The Disability Team also showed high numbers on caseloads, and, again, there were few "case carrying" workers (3) who could take on work.

It is clear, however, that numbers of cases do not necessarily make up the full picture of pressure on staff. It could be argued that 5 difficult child care cases are equal to a far larger number of other client groups in terms of time, effort, and anxiety. This really leads back to the hypothesis and the relative importance of client groups and informal specialisation. It seems clear from the research into the Generic teams that, despite a considerable amount of bias on caseloads, "generic" work per se was seen as a viable approach to the task in hand. It was apparent that work with children and the elderly do indeed make up the greatest proportions on caseloads, with a much more reduced input into the problems of the mentally-handicapped, the mentally-ill and the physically-handicapped. Although the overall percentage of child care work, certainly in the 8 Generic teams, was not as huge as the assumptions at the time would have indicated, there is still a major issue as to whether "Child Care" should equate with "Adults", given that the latter is made up of a number of quite separate client groups.

2. Hampshire Social Services - The New Structure, April, 1990.

The information on the Generic teams leads one to believe that there is no great problem with "Informal Specialisation", and there are many positive comments in the Literature about workers needing to develop their own special skills. There is surely a case for leaving Area Centres just as they are, and the evidence is that they would continue to function more or less successfully as they have been doing? There were a number of problems with this in the period leading up to the restructuring of the Department. Firstly, there was an over-centralised management structure, with a large Headquarters staff, and a reduced level of responsibility for

the geographic areas for which Area Centres were responsible. A further problem was that the management structure in Headquarters was client-group based, "Adults" and "Children and Families", each with its own Assistant Director, but not responsible for the management of that work in Area Centres, which answered to a different (Senior) Assistant Director. The result was confusion over who was responsible for practice issues and problems in Area Centres. A third issue was the difficulty in Areas and the Residential and Day-Care sector working more successfully together. Not only were these two managed quite separately, but there were a number of different management arrangements within each sector. For example, in the Child Care sector, the Assistant Director had management responsibility for Residential Children's Homes, Family Centres for the Under 5's, Intermediate Treatment Centres (later, Juvenile Justice Units), Fostering and Adoption etc. The units or staff involved in these areas of work all had different lines of accountability and management to the Assistant Director, but often had little to do with each other. These factors not only led to management problems for the sectors themselves, but to increased difficulty in their working alongside the social work staff in the Areas. Fourthly, the Department had to assess how the current structure was designed to meet the new demands which would be imposed by the Children Act, 1989, due to be implemented in October, 1991, and the National Health Service and Community Care Act,1990, with its phased implementation in the period 1991-1993.

The restructuring of the Department took place officially on April, 1st. 1990, although it was recognised that this would be an evolving process and would not be completed immediately. The new management structure was geared to alleviate the problems outlined above. Firstly, the management of all day and residential resources was devolved to a new Area management structure. Higher status Area Managers were appointed, with concomitant greater responsibility. Assistant Directors (4) were appointed on a District basis, but each with responsibility for a major client group, eg. Children and families, the Elderly, Physical Handicap, and Mental Health and Mental Handicap, although it was clear that this would be for the purposes of standards and policy development, with the Areas having undisputed management responsibility for the units and staff in their "localities."

In order to assist the Area Manager, a new middle management post was created in the Areas - a Service Manager. The Service Manager would have responsibility for both fieldwork and day and residential care staff in their Areas, and there would

thus be an "integrated" approach. The size of the Area and the type of resource would determine the number and designation of Service managers in each Area, eg. some just would have 2 Service Managers,one for "Adults" and one "Children and Families", others would have an extra manager for Health workers if there was a hospital team in the Area.Others again would have a manager for "Disability", if there were significant resources for physically disabled and the mentally-handicapped. The interesting result from the point of view of this research was that there was then an expectation that Areas reorganised their team structure to both reflect these changes and to be able to work more closely and in an integrated way with their colleagues in Day care settings, residential homes, and specialist units, eg. Family Centres, Family Resource Centres (for preventive work with children and families and for fostering and adoption work.) The new structure, then, consists of Areas with child care teams, elderly teams, disability teams, and mental health teams, the exact specialisation depending on the needs of each Area.

There is a return, then, to some of the issues raised in this research. There is the division between "Child Care" and "Adults", and the Specialist teams are very similar to the ones included in this study in 1986. **Already, there is a new assumption - the Child Care Service Managers and the Child Care teams are under greater pressure than their Adult counter-parts.** Research needs to be done to see whether some of the issues raised with regard to the Specialist teams in this study are being recreated, in that the result of specialisation is a smaller number of staff to carry the workload. There are, however, other factors, such as the need for the new structure to settle down, and the need to recruit staff into vacancies. There are the same recruitment problems in Hampshire as in many Local Authorities, and many Child Care teams have vacancies, which increases pressure on staff.

However, the benefits of the devolved structure emerged quickly, with a greater degree of support and "sense of belonging" felt by the residential and day-care units, the capacity to solve problems quickly and locally, a clearer management framework, and greater potential for planning in each of the client groups. The teams and Service Managers are also supported by a smaller but more effective group of Headquarters Advisers in each of the client categories. And what about "Generic" work in all this? Firstly, there will be issues about newly trained staff coming off qualifying course into Specialist teams. There will be a need to ensure a broad experience, and the possibility of a change into other teams may have to be written into a worker's development or career plan. More importantly, "Generic"

work has changed focus to encompass a different range of concepts, e.g. principles of a "consumer" oriented service, the need for "Quality", and support to "Carers" - all of these are spelt out clearly in "Caring for People - Community Care in the Next Decade and Beyond (1989). Generic principles are also enshrined in the overall management of each Area, which has to encompass all client groups, particularly in terms of planning.

The situation with regard to the division between "Children" and "Adults" will need to be monitored. It has already been discussed that they are not necessarily equal bed-fellows. The distinctions begin to show with regard to Service Managers in the participation in special interest groups for joint planning with local Health authorities. Service Managers for Adults find themselves having to take a lead role in a number of different groups, eg. the mentally-handicapped, the mentally-ill, the elderly, and the disabled. This is more manageable for Service Managers for Children.

The objectives for any new structure must first and foremost centre around a better service to "consumers". The indications are that the new specialist team structure is easier for the public to understand, especially those voluntary organisations involved with specific client groups. There seems no doubt that the integrated management of resources makes more sense for the staff involved, who feel a greater sense of identity with their Areas, with the removal of many of the boundaries which have separated "fieldwork" from "day and residential care" for quite some years. However, the issues about pressure on teams relate as much to the newer roles envisaged for Social Services within the NHS and Community Care Act, 1990, and the Children Act,1989.

3. The NHS and Community Care Act, 1990 and The Children Act, 1989.

There is an important paragraph near the beginning of the paper, "Caring for People - Community Care in the Next Decade and Beyond" (1989), which links the plans with the new legislation for children, as follows:

> "1.3 The Government is pursuing separately in the Children's Bill, at present before Parliament, a major reform of children's services in England and Wales to be implemented in 1991. The two programmes are consistent and complementary and, taken together, set a fresh agenda and new challenges

for social services authorities for the next decade. There is no intention of creating a division between child care and community care services: the full range of social services authority functions should continue to form a coherent whole" (Pg.3).

It seems as though anyone who thought that at last a Social Services Department had at last bitten the bullet and had specialised along client group boundaries now has to face a new framework of "generic" principles.

Concepts such as "Quality", "Support to Carers", "the promotion of the development of domiciliary, day and respite care", could all fit into whatever client group a social worker is involved in. Others, however, such as the new arrangements for "Assessment", and "Case" or "Care Management", the local authority as "enabler" as much as a "provider" all seem to require considerable thought in how they apply to both the adult client groups and to children and families. It is interesting that the section in The White Paper dealing with a "needs led" service and "packages of care" says the following:

> "Decisions will need to take account of the local availability and pattern of services as well as any sources of support available in the community - whether from family, friends, neighbours or local voluntary organisations - and should seek where necessary to provide assistance and respite for the carer" (Pg. 21).

This reads remarkably like the wording underpinning Section 1 of the Child Care Act, 1980, and the requirement to look to family, friends and relatives when considering a child's need for "care",
a principle which is developed still further in Section 17 of the Children Act, 1989. On the basis that new legislation often "catches up" with excellent practice and existing trends as well as setting higher standards, it may be worth looking at some of the developments in Hampshire Social Services in the period leading up to the emergence of the new legal context for social work. Particular developments in child care may help to throw some light on how these principles could be applied in practice within the adult sector.

It has already been mentioned that one of the objectives of the Departmental Restructuring in April, 1990, was to ensure that the fieldwork and the day and

residential care sectors worked more closely and cooperatively together. This was just as true of the Child Care Sector as any other. In the period before restructuring, there were also concerns about the high numbers of children being either received or committed to care. There was clearly a need not only for staff to work together, but also to consult at the point of decision-making. Another issue at that time was the perceived status or power of fieldworkers, and problems with this were evident when they enlisted the support of their residential or day-care colleagues in helping children and families. There was often a lack of clarity in the task and confusion over expectations.

In order to remedy the problems outlined above, it was decided that no child would be received into or committed to care unless the situation had first been brought before a "Children's Resource Group". These groups would be made up of a representative from each of the child care units in any Area, e.g. Adoption and Fostering Unit, Family Centre for Under 5's, Family Resource Centre, Juvenile Justice Unit, Residential Children's Home. The Area representative would be at team-leader level, and the "Chairs" of the groups would be drawn from both Senior Headquarters and Area staff. The groups had the following features:

a. It was expected that the child, family or young person in question would attend and would be helped to join in with the discussion of their particular problem.

b. The staff representing units or Areas must be of sufficient seniority to commit resources at the time of the discussion.

c. Although a decision for reception into care etc. may well be an outcome, the focus would be on offering alternative "packages of care."

d. It was expected that the social worker or caseholder dealing with the child, family, or young person would also attend, and arrange for any other interested party to attend, eg.relative, teacher, etc.

Although this was really a "gate-keeping" exercise, it was more positive in its emphasis on preventive work and providing resources. The results were quite remarkable. Firstly, there was a considerable reduction in the numbers of children coming into care. Secondly, parents and children responded extremely well to the

opportunity to be present at the meeting, to join in the discussion, and comment on the usefulness of the help being offered. The fact that they were present from the beginning at the meetings seemed to have an "empowering" influence. A further development was that social workers found that they had access to a wider range of support services than previously. There was a great deal of "cross-boundary" working, and some innovative approaches were initiated across all units in the Child Care Sector. It was not unusual, for example, for staff in Residential Children's Homes to engage in visiting children within their own homes in order to keep them with their families. Foster-parents and Child-minders came forward to offer over-night or week-end respite care in order to alleviate stress in families. Parents and children had direct access to support from such specialist units as Family Resource Centres, who usually had to rely on "referrals" from social workers, and whose resources were often underutilised.

These Resource Groups met initially either twice or three times per week depending on the Area. Situations could be brought back for monitoring or for extra resources. Each package was time-limited with clear review dates. Because of the number of people involved, it was necessary to be precise about who was coordinating the various initiatives, and who was responsible for supervision.

This approach could be described as the beginnings of an Assessment and Case-management process. More work is needed on costing the different types of help offered. This was not difficult for respite care, sessional worker or volunteer involvement, and costs associated with activities - all paid for out of Section 1 budgets. It was not unusual for parents to offer to pay some of the costs themselves, particularly for respite care. There were considerable implications for Area Centre budgets, since respite care had to paid for locally out of the Section 1 budget, rather than centrally-funded Section 2 care, eg. payments to foster parents. Social Work time was not costed, but Residential staff time available had to be calculated in terms of how many vacancies their particular children's home was carrying.

As Resource Groups developed, they involved a wider selection of multi-agency staff, eg. teachers, health visitors, and the process is still evolving. The crucial factors seem to be the emphasis on "consumers" and the degree of commitment to the "package of care" working from all involved. The Social worker became more of a "case- coordinator" or "case-manager", and it was not always easy to

keep track of the help offered. There was some resistance to these groups initially, since the social worker and Area Centre, in some instances, felt that their power was being eroded. The opinions and judgements of Residential workers and Day-care staff, however, were found to have just as much relevance as their fieldwork colleagues. Some members of staff found it very uncomfortable to have parents and children present, especially when strong feelings or emotions were expressed. A further important factor was that "packages of care" were designed around the needs of the client, rather than trying to fit the client in to a limited range of existing resources.

Taking these initiatives into consideration, therefore, it is possible to argue that it is not the client group which is at issue but the approach to meeting needs and problem-solving. Some of the changes which the Children Act and the White Paper will bring about seem to hinge on Area Centre and social workers adopting a different approach. The emphasis will be on agreeing the nature of help offered with clients or consumers at the time key decisions are made, and on encouraging others to share in the responsibility of putting together, maintaining and reviewing the package of care. Whether this involves friends, relatives, staff from voluntary or statutory organisations, this is just as much "enabling" as putting out entire services under contract.

The Children's Resource Groups are just one example of an evolving process in which planning has anticipated new legislation. Since this research was begun, there have been equally important developments with other client groups. Services to the mentally handicapped have become much more sophisticated, with initiatives in individual care planning having been taken by staff in the Day Care sector. Attendance at "Day Services," formerly "Adult Training Centres" is radically different to the situation five years ago, when the emphasis was on "training" and the provision of industrial-type work experience. The focus now is on social skills and normalisation.

As regards services for the Elderly, developments have been driven by a current lower take-up of vacancies, which is affecting the private sector as much as the Local Authority homes. The emphasis now is on trying to develop "Elderly Persons Resource Centres", which can offer Day and Respite care, and an Information Centre, possibly run by a voluntary organisation such as Age Concern. "Part 3" homes are also increasingly moving into "Group Living", in which care is offered

within a smaller group, who develop a sense of ownership for a particular part of a building, and are then encouraged to have a greater say on how they want their day organised. This is much more difficult in a large group.

Services to the mentally-ill have been given a much-needed boost by money made available under the Mental Health Specific Grant of the NHS and Community Care Act. The White Paper says the following:

> "In the face of other calls on resources, local authorities generally have not been able to give as much priority to providing services to those with a mental illness as other vulnerable groups.....only about 3 per cent of social services authorities' expenditure is currently spent on services specifically for those with a mental illness" (Pg. 57).

The specific grant has made possible in Hampshire a substantial increase in resources, eg. in one Area this has included the appointment of a Day Service Officer (with a budget) to promote day care activities and clubs, a "Mind" coordinator, and a joint project with another Area to establish a Day Centre.

Both the Children Act, 1989 and the NHS and Community Care Act, 1990, have set standards which promote a number of principles. These include a commitment to listening to and involving consumers and to providing choice, "working alongside", a commitment to "quality", efficient assessment and case-management, the importance of considering the needs of ethnic groups, "minimal intervention" in family life, and the need for the local authority to act more as an "enabler" rather than as a "provider". It could be argued that these are now the "generic" principles by which Social Services Departments will operate.

This research has looked at "informal specialisation" and caseload bias in the context of Area teams as they were in 1986. This was a time when the climate was much more influenced on the separateness of the management of Area and Residential and Day Care resources, and when Area Centres were very much left to their own devices. In this sense, issues about informal specialisation and generic work could be left to either Area or team-managers to deal with, and, largely, this did not seem to cause too many problems. Specialist teams were also considered in the research, and some comparisons drawn. The difference then was that it was very much an Area or management view as to how they organised, with little

reference to the voice of either consumers or the community. Both the climate and the legislation are changing, and this has led to changes in both the way Area social workers operate and in the way services are organised. The current move into specialist teams may well be appropriate for the reasons stated, eg. ease of working with residential and day-care resources, more opportunities for the public and other agencies to understand the organisation, opportunities to publish team objectives and plans etc. There are also issues about giving client groups a particular focus, eg. mental health teams, rather than this group getting lost in a welter of other more pressing problems within a generic team. It remains to be seen as to how this will develop, particularly in the light of changes brought about by "purchasing" and "providing", the details of which are yet to be clarified. "Assessment" and "Care Management" will also impact on a Specialist structure. Further research will be needed to assess how this has affected the tension between "Adult" and "Child Care" client groups.

It is interesting that the "generic" social worker as described by team-managers during the course of this research has disappeared seemingly without a great deal of mourning. There has also been little comment about the loss of "patch teams". In the study of the Generic teams earlier in the research, six out of the eight teams were "patch" based, but this orientation seemed to have little impact on caseload bias. Further research will also be needed to test out how much social workers develop "sub-specialisms", or whether they will follow the model of the 4 Specialist teams in this study and remain "generic" within their "specialism". Issues about different methods of intervention and the need for community projects and initiatives will certainly need to be monitored, since these are implicit in both the Children Act and the NHS and Community Care Act. It would be a retrograde step if specialisation means pressure on social workers to perpetuate traditional roles, with an emphasis on "casework". It is also pertinent that the conceptual view of "genericists" and "specialists" has to change, and at present there is a lack of a suitable enough language to describe the evolving and developing role of Social Service staff. These two words in this study have been used to describe workers in terms of client groups, but the literature shows that definitions arising out of different levels of skills and different types of intervention have also been widely discussed. Perhaps the focus has been too much on trying to describe what social workers are doing and not enough on the needs that either communities or consumers are presenting, and how they would prefer services to be organised.

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APPENDIX - A

Qualifications and Grades

1. ALTON

Alton Team

Level III - C.Q.S.W.

Level III - C.Q.S.W.

Level III - C.Q.S.W./Degree (part-time)

Level II - C.Q.S.W./Degree

Level II - C.Q.S.W./Degree

Level I - C.Q.S.W./Degree

Total: 6

2. ALTON

Petersfield Team

Level III - C.Q.S.W./Degree

Level III - C.Q.S.W.

Level III - C.Q.S.W.

Level I - C.Q.S.W./Degree

Level I - C.Q.S.W./Degree

S.S.O. - No qualifications

Total: 6

3. HAVANT

Southern Team

Level III - C.Q.S.W./Degree

Level III - C.Q.S.W. (part-time)

Level II - C.Q.S.W.

S.S.O. - No formal qualifications

S.S.O. - No formal qualifications

S.W.A. - No formal qualifications

Adult placement Social worker - C.Q.S.W./Degree

Total: 7

4. FAREHAM

Portchester team

Level III - C.Q.S.W.

Level III - No formal qualifications

Level II - C.Q.S.W.

Level I - C.Q.S.W.

Level II - C.Q.S.W. (Area Fostering Officer)

I.T. Officer (Level II Equivalent) - Teaching qualification

Total: 6

5. PORTSMOUTH - AREA II

Intake Team

Level III - Degree/C.Q.S.W.

Level III - C.Q.S.W./Degree (part-time)

Level II - C.Q.S.W./Degree

Level II - C.Q.S.W./Degree

Level I - C.Q.S.W.

Level I - C.Q.S.W

S.S.O. - No formal qualifications

S.S.O. - No formal qualification

Total: 8

6. ANDOVER - TEST VALLEY

Romsey Team

Level III - C.Q.S.W./Degree

Level III - C.Q.S.W./Degree

Level III - C.Q.S.W./Degree

Level II - C.Q.S.W.

Level II - p/t - C.Q.S.W.
p/t - Adult Placement Social Worker

S.S.O. - No formal qualifications

S.S.O. - No formal qualifications

Level I - C.Q.S.W.

Total: 8

7. PORTSMOUTH - AREA III

Portsea Team

Level III - C.Q.S.W

Level III - C.Q.S.W.

Level III - C.Q.S.W. (fostering Office Part-time Social Worker part-time)

Level II - C.Q.S.W./Degree

Level II - C.Q.S.W./Degree

Level II - C.Q.S.W./Degree

S.W.A. - In service Social Care Course

Total: 7

8. EASTLEIGH AREA CENTRE

Intake Team

Level III - C.Q.S.W.

Level III - C.Q.S.W./Diploma in Social Admin.

Level II - C.Q.S.W./Degree (M.A.)

Level II - C.Q.S.W./Degree

Level III - C.Q.S.W./Degree (MSC)

S.S.O. - No formal qualifications

S.S.O. - Certificate in Soc. Services (part-time)

S.S.O. - No formal qualifications (part-time)

Adult Placement - C.Q.S.W. Home Office Social worker - Letter of Recognition (part-time)

Level III - Home Office Letter Degree

Total: 10

APPENDIX - B.1

Level I Social Workers

Previous Experience	Primary Bias	Secondary Bias
No previous experience.	Generic	-
Residential - Children and Families.	Generic	-
Teacher/Voluntary Organiser.	Children and Families (no sexual abuse).	Adoption.
Youth work. YTS.	Generic	-
Psychiatric nursing.	Generic	-
Social Services Department experience.	Generic	Child Care, particularly Child Abuse, Adoption.
Residential work - children.	Generic	-

Appendix B.2

	Primary Bias	Secondary bias
Psychiatric nursing.	Elderly support Elderly at risk.	Children and families. (Vol. supervision)
Teaching - residential Voluntary Playgroup Association.	Children and families - preventive C.O.s and S.O.s.	Mental handicap.
Voluntary work.	Elderly at risk. support - elderly. Mental health and support.	Children and families.
Personnel.	Generic caseload. M and T support. I.T group.	Sexual abuse children and families.
II Residential children. Part-time generic. Part-time A.P.S.W.	Children and families - all types. (within her split).	-
Theology. Engineering Social Services Department.	Psychogeriatric mental health.	Generic. imposed child care. (reluctant Genericist).
Residential elderly.	Generic.	Generic. Mental handicap. Physically handicapped. (Wants to do generic).

APPENDIX - B.2

Level II Social Workers

Previous Experience	Primary Bias	Secondary Bias
Probation	Generic	-
No previous experience.	Generic child care all types.	Elderly.
Clerical.	Children and Families. Voluntary supervision. Elderly support. Adoption.	Under 5's C.O.s and S.O.s. Physically handicapped Generic (encouraged).
Residential children.	Children and Families - child care all types, particularly preventive adolescents.	Day support for mother and children.
Specialist A.F.O. Social Services Department Youth community.	Foster-parent assessment.	N.A.I. Sexual Abuse. Adoption.
? not known.	Mental handicap. Child care. Adoption. Adolescents.	Elderly.
Social Services Department	Elderly. Children and Familes. (excellent social work across the board).	-

APPENDIX - B.3

	Primary Bias	Secondary Bias
½ NFO ½ III Children's Department. Social Services Department.	Foster-parent assessment.	C.O.s and S.O.s.
Child Care Officer.	Mental health support. Statutory. Generic - group.	Multidisciplinary group in handicap and physically handicap) special needs.
Part-time. None shown.	Child care mix M and T group.	Ditto.
Social Services Department.	Child Care. Mental health. M and T group.	Mental health support group.
Auxiliary nursing.	Generic.	Adoption.
V.S.O. I.T. Community worker. Social Services Department.	Generic.	Cover's group - Elderly and physically handicapped. Adoption.
Hospital social worker. Social Services Department	Generic.	Mental health. Child Care general.
Management Social Services Department.	Generic.	-

APPENDIX - B.3

	Primary Bias	Secondary Bias
Part-time. Social Services Department	Elderly. Family functioning. Children and Families - voluntary supervision.	C.O.s and S.O.s. Blind. Physically handicapped. "commited to genericism".
Residential. Housing elderly.	Elderly support at risk.	Generic work.
I.T.O. Teacher.	-	Adolescents. C.O.s and S.O.s.
Part-time A.F.O. Residential Child Care. Derby House. Welfare Department.	Foster-parent assessment.	-
Part-time. Social Services Department. Hospial Social Worker.	Elderly completely.	-
Church Community work.	Generic	Court reports. Adoption. G.A.L. /Elderly.
Voluntary work.	Children and Families - C.O.s and S.O.s. Adoption - G.A.L.	Vol supervision. N.A.I.
None shown.	Vol supervision - Children and Families. C.O.s and S.O.s.	G.A.L.

APPENDIX - B.3

	Primary Bias	Secondary Bias
Naval Officer.	Children and Adolescents Sexual Abuse.	Child Abuse.
Residential Child Care, (C of E - under 5's).	Children - Child Abuse Under 5's.	Child Placement.
(Part-time) Teaching.	Elderly.	Child Care general.
Social Services Department.	Elderly. Prefers Children and Families.	Adoption. (Prefers elderly - needs of team dictate Child Care.
Clerical.	Child Care - whole range, not under 5's.	Physically handicapped, younger adults, residential schools.
Residential. Voluntary organisers.	Children and families. Elderly.	Mental handicap. (Prefers mental handicap - other work needs of team).
Residential Child Care.	Under 5's C.O.s and S.O.s Children and Families voluntary supervision.	Mental health support, child placement.

NDIX - B.4

.al Services Officer.	No experience.	Elderly. Visually handicapped.	-
	Voluntary organisers.	Statutory C.O.s and S.O.s. Under 5's. N.A.I. Elderly.	Family functioning.
.al Services Officer.	Police.	Elderly support. Blind. Physically handicapped.	Elderly at risk. (specialist by default - retiring).
ial Work Assistant.	Draughtsman. Marconi.	Elderly support. Elderly at risk. Mental handicap. Vol. supervision. Under 5's.	C.O.s and S.O.s. Vol. supervision. Mental health support.
ial Services officer.	S.N.O. Social Services Dept.	Elderly.	-
ial Services officer,	Social Services Dept, numerous years.	Elderly.	Families - Vol. supervision. Gentle and supportive.
ial Work Assistant.	Residential elderly. Vol. organisers.	Elderly support. and at	Physically handicapped. Blind.

NDIX - B.4

al Services Officer.	Teaching residential Child Care. Mental handicap nursing.	Elderly support. Elderly at risk.	Child Care - teenager sexual counselling.
al Services Officer.	Social Services Dept.	Elderly support at risk.	-
al Services officer.	Nursing - NIA. Geriatric nursing.	Blind. Elderly at risk. Elderly support,	Mental handicap. Physically handicap.
al Services Officer. -time.	Residential Child Care	Elderly/ psychogeriatric. Mental handicap. Child Care	-
ial services officer.	Clerical/ Adminstration. SWA/O.T.	Elderly at risk support. Mental handicap. Physically handicapped.	-

APPENDIX - C

Level III Social Workers

1. Informal Specialists - Child Care

Area	Primary Bias	Secondary Bias
Alton	Children and Adolescents (C.O.s and S.O.s statutory work).	Sexual Abuse. Child Abuse.
Alton	Child Care - all types. Child Abuse under 5's.	Child Placement.
Alton	Child Care - all types except under 5's.	Younger physically handicapped.
Havant	Children and Families - Vol. supervision under 5's statutory - C.O.s and S.O.s.	Mental health (support) Child Placement.
Romsey (part-time)	Child Care - all types -	Mother and Toddler Support Group.
Portsmouth Area 3	Children and Families (vol. supervision). Statutory C.O.s and S.O.s. Adoption - G.A.L.	Vol. supervision Child Abuse.

APPENDIX - C

Level III Social Workers

2. Generic Social Workers.

Area	Primary Bias	Secondary Bias
Portsmouth Area II	Generic.	Court work, including G.A.L., elderly, marital counselling.
Eastleigh	Generic.	Adoption.
Eastleigh	Generic.	Carer's Group - elderly and phyically handicapped. Adoption.
Eastleigh	Generic, basically, but Child care bias.	Mental Health. Child Care.
Eastleigh	Generic.	-
Havant	Elderly. family work/functioning. Vol. supervision.	Statutory C.O.s and S.O.s. Blind. Physically handicapped.

APPENDIX - C

Level III Social Workers

3. Child Care/Adult Client Groups - Mix.

Area	Primary Bias	Secondary Bias
Alton (part-time)	Elderly.	Child Care - all types.
Alton	Child Care - all types. Elderly.	Mental handicap
Fareham	Elderly support. Elderly at risk.	Generic, including all types of Child Care.
Romsey	Child Care - all types. Mental Health.	Mental Health Support Group. Mother and Toddler Support Group.
Alton	Elderly. Child Care - all types.	- Adoption.
Fareham	Elderly support. Elderly at risk.	Generic, including all types of Child Care.
Portsmouth Area III	Children and Families - vol. supervision. Statutory C.O.S and S.O.S.	Adoption/G.A.L.

APPENDIX - C

Level III Social Workers

4. Elderly/Adult - Informal Specialisation.

Area	Primary Bias	Secondary Bias
Portsmouth Area II (Part-time)	Elderly.	-

APPENDIX - D

Level II Social Workers

1. Informal Specialisation - Child Care.

Area	Primary Bias	Secondary Bias
Fareham	Children and families - all types of preventive work.	Day Support - mother and young children.

APPENDIX - D

Level II Social Workers

2. Generic Workers.

Area	Primary Bias	Secondary Bias
Alton	Generic.	-
Havant	Children and Families - Voluntary supervision. Elderly support.	Under 5's. Statutory - C.O.s and S.O.S. Physically handicapped.
Romsey	Generic. (bias towards Children and Families).	Adolescents.
Portsmouth Area III	Elderly support. Elderly at risk. Mental Health support.	Children and Families (vol supervision).
Alton	Generic work, including Child Care of all types.	Elderly.
Eastleigh	Generic.	Mental Handicap. Physically Handicapped.

APPENDIX - D

Level II Social Workers

3. Child Care/Adult Mix.

Area	Primary Bias	Secondary Bias
Portsmouth Area II	Mental Handicap. Child Care - adoption and adolescent work.	Elderly.
Portsmouth Area II (Part-time)	Elderly. Children and Families.	-
Romsey	Generic mostly, Mother and Toddler support. Intermediate Treatment.	Children and Families. Sexual Abuse.
Portsmouth Area III	Elderly support. Elderly at risk.	Children and Families. Vol. supervision.
Portsmouth Area III	Children and Families. Vol. supervision. Statutory C.O.s and S.O.s.	Mental Handicap.
Eastleigh	Psychogeriatirc work. Mental Health.	Generic. Imposed Child Care.

4. Elderly/Adult - Informal Specialisation.

Area	Primary Bias	Secondary Bias
None	None	None

APPENDIX - E

Level I Social Workers

2. Generic Workers.

Area	Primary Bias	Secondary Bias
Alton	Generic.	-
Alton	Generic.	-
Fareham	Generic.	-
Portsmouth Area II	Generic.	Child Care general, particularly Child Abuse and Adoption.
Romsey	Generic.	-
Portsmouth Area II	Generic.	-

APPENDIX - E

Level I Social Workers

1. Child Care - Informal Specialisation.

Area	Primary Bias	Secondary Bias
Alton	Children and families, (all types, excluding sexual abuse).	Adoption.

APPENDIX - F

Social Services Officers

1. Child Care - Informal Specialisation.

Area	Primary Bias	Secondary Bias
None	None	None

2. Generic Workers

Area	Primary Bias	Secondary Bias
Havant	Statutory - C.O.s and S.O.s Child Abuse. Under 5's. Elderly at risk.	Family Functioning. Mental Health Support. Elderly - support.

3. Child Care/Adult Mix.

Area	Primary Bias	Secondary Bias
Portsmouth Area II	Elderly.	Children and families - vol. supervision.
Romsey	Elderly support. Elderly at risk. Mental handicap.	Child care - adolescents. Sexual counselling. Divorce Support Groups.

APPENDIX - F

Social Services Officers

4. Elderly/Adult - Informal Specialisation.

Area	Primary Bias	Secondary Bias
Alton	Elderly. Visually handicapped.	- -
Havant	Elderly support. Blind. Physical Handicap.	Elderly at risk. - -
Portsmouth Area II	Elderly.	-
Romsey	Elderly support. Elderly at risk.	-
Eastleigh (Part-time)	Elderly. Psychogeriatric. Mental Handicap.	-
Eastleigh (Part-time).	Elderly support. Elderly at risk. Mental Handicap. Physical Handicap.	-

APPENDIX - G

Social Work Assistants

1. Child Care - Informal Specialisation.

Area	Primary Bias	Secondary Bias
None	None	None

2. Generic Workers

Area	Primary Bias	Secondary Bias
Havant	Elderly support. Elderly at risk. Mental handicap. Physical handicap. Children and Families (vol. supervision). Under 5's.	Statutory C.O.s and S.O.s. Vol. supervision. Mental Health Support.

3. Child Care/Adult Mix.

Area	Primary Bias	Secondary Bias
None	None	None

4. Elderly/Adult - Informal Specialisation.

Area	Primary Bias	Secondary Bias
Portsmouth Area III	Elderly support. Elderly at risk.	Physical handicap. Blind.

Specialist Workers

Area	Title	Primary Bias	Secondary Bias
Havant	Adult Placement Social worker. (Part-time)	Elderly support. Elderly at risk. Physical Handicap. Mental Health Support.	-
Fareham	Intermediate Treatment Officer.	I.T. Work. Groupwork with offenders..	Small number of C.O.S and S.O.s. Statutory work.
Fareham	Area Fostering Officer.	Foster-parent Assessments.	All Child Care sub-groups, particularly Adoption, Child Abuse and Sexual Abuse.
Fareham	Area Fostering Officer.	Foster-parent Assessments.	-
Portsmouth Area II	Area Fostering Officer.	Foster-parent Assessments.	Statutory - C.O.S and S.O.s.
Romsey	Adult Placement social worker. (Part-time). Level II - Part-time.	Elderly. Mental handicap Mental Health Support.	Generic, but bias towards Children and adolescents.
Eastleigh	Adult Placement social worker.	Mental handicap	Elderly support. Elderly at risk.