

The Critical Practitioner in Social Work and Health Care

Critical social work practice

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The Critical Practitioner in Social Work and Health Care

Edited by
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Contents

Editors	vii
Contributors	viii
Acknowledgements	xiii
List of Abbreviations	xiv
Introduction	1
1 Introducing critical practice <i>Ann Glaister</i>	8
2 Social work, professionalism and the regulatory framework <i>Mike Burt and Aidan Worsley</i>	27
3 Practice with service-users, carers and their communities <i>Hilary Brown and Sheila Barrett</i>	43
4 Working with complexity: managing workload and surviving in a changing environment <i>Keith Edwards, Chris Hallett and Phil Sawbridge</i>	60
5 Counting the costs <i>Colin Guest and Philip Scarff</i>	78
6 Reflections on past social work practice: the central role of relationship <i>Barbara Pryn</i>	97
7 Values and ethics in practice <i>Maureen Eby and Ann Gallagher</i>	114
8 Practitioner research <i>Celia Keeping</i>	132
9 The challenge of working in teams <i>Linda Finlay and Claire Ballinger</i>	149
10 Organisations and organisational change <i>Janet Seden</i>	169

11	Accountability <i>Maureen Eby and Alun Morgan</i>	186
12	Understanding the policy process <i>Celia Davies</i>	203
13	Continuing professional development: a critical approach <i>Barry Cooper</i>	222
14	Social work in new policy contexts: threats and opportunities <i>James Blewett</i>	238
	Index	254

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Chapter 1

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Chapter 12

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Chapter 1

Introducing critical practice

Ann Glaister

The day-to-day experience of health and social care work is often one of fire-fighting; managing time constraints; dealing with conflicting demands; setting difficult priorities; managing tricky relationships; finding short cuts; dealing with stress and frustration (both internal and external); and struggling to hang on to simply doing the job. It is about operating within organisational and social constraints as an individual, feeling accountable and responsible, yet often powerless and lacking in any real autonomy (Fish and Coles, 1998).

The challenge is to find an approach which acknowledges the inadequacies as well as the difficulties of much current practice; recognises the major policy changes that have been taking place; welcomes moves towards greater inter-agency co-operation and the increasingly proactive role of service-users; but still values the positive motivation to provide support for others, which takes many practitioners into health and social care work in the first place. This chapter will develop a concept of 'critical practice' as a way of trying to engage with such challenges, particularly at a level appropriate to the experienced practitioner.

What is 'critical practice'?

The critical practitioner

The term 'critical' is used here to refer to open-minded, reflective approaches that take account of different perspectives, experiences and assumptions. It is not about being critical in the common parlance of being negative and destructive. Taking a constructive critical stance is not, of course, the prerogative of professionals. Here, however, it is discussed in the professional context with the implication that it encapsulates what experienced professionals and practitioners try, and indeed are called upon, to offer.

What is required increasingly is a capacity to handle uncertainty and change, as well as being able to operate in accordance with professional skills and knowledge. Practitioners must, in a sense, face both ways, drawing on a sound knowledge and evidence base on the one hand, but at the same time being continually aware of the discretionary and contextual

basis of their practice. Most practitioners will recognise this sense of dilemma. Barnett (1997: 143–4) puts it like this:

Professionals have the duty to profess. But professing in a post-modern age calls for the capacity to be open to multiple discourses and to engage, albeit critically, with them.

A critical approach implies no particular moral direction in itself. If, however, we agree that there is a fundamental assumption of social justice underpinning the provision of care for others, it follows that successful caring processes must be both empowering and anti-oppressive. And practitioners' purpose will be to achieve solutions that are at some level felt to be just by all parties. Kitwood, in his book *Concern for Others*, talks of 'the converging threads of integrity and integration' as desirable for one's own moral development and, therefore, necessarily for others,

since there is a crucial sense in which all human beings are made of the same stuff, suffer the same kind of anguish, experience similar joys. It is to wish and hope for that same integrity for all persons, within their own particular cultural frame. In short, to seek an inner truth and integration for oneself is of necessity to desire integrity on the part not only of a few close others, but of a much larger circle of friends, colleagues and acquaintances. But if these, then why not all?

(Kitwood, 1990: 211)

Three case studies are described over the next few pages. Each reflects the complexity of critical practice. They are not so much accounts of the expertise involved in knowing what to do; rather they tell the story of the expertise involved in being able to tolerate the 'not knowing' as practitioners negotiate their way around different opinions, beliefs and practices. They reflect Kitwood's 'converging threads of integrity and integration'. Being able to acknowledge uncertainty and recognise conflicting lines of argument and different perspectives, while staying true to one's own understandings, lies at the heart of much professional work.

Case Study Jaqui – a physiotherapist

A young mother of three children has circulatory problems caused by diabetes, leading to progressive breakdown of tissue in one foot and leg. Amputation is inevitable and the surgeon sees his role as minimising the damage by removing as little as is clinically essential at each stage. An initial operation to remove the toes is followed six months later by a removal of half the foot and then the whole of the foot. Jaqui, the physiotherapist, sees from her vantage point the devastation this approach wreaks on the family and the mother's health generally. Each time the disease process reasserts itself to the point of tissue breakdown, with associated stress to other body systems. The procedure involves time in hospital, there is the stress of the operation itself, time off work for the young woman's

husband, further separation for the children, followed by the period of recovery before any functional rehabilitation can begin.

Jaqui knows that the eventual picture will resolve itself as a below-the-knee amputation, at which point things are likely to stabilise. To move to that point at the outset would mean one traumatic event instead of multiple interacting traumas; it would lead to better health for the mother, rather than for her to be trapped in a cycle of illness and partial recuperation for years, and a satisfactory rehabilitation process with functional prosthesis.

With care and tact, Jaqui attempts to discuss it with the doctor, but to no avail. She considers ways in which she might raise it during a ward round with the doctor in front of the family, or even behind his back, but concludes that the potential damage from such an intervention might be worse for the family than the current position. She recognises that the likelihood of her arguments being accepted would be minimal. Without the doctor's backing, the family is unlikely to accept the idea of a major amputation.

Jaqui's decision not to intervene further flew in the face of what she felt to be the best outcome for the family, and was probably harder for her than to argue her case further. Her personal and professional analysis of the situation had to include awareness of the family's likely reactions and feelings as well as the context of the more powerful role of the doctor and the importance of the family's trust in him. The difficulties partly arose, she knew, from the unequal status and consequently limited communications between doctors and therapists.

Case Study Adjoa – a community nurse

An experienced nurse working as part of a team attached to a large primary care practice, Adjoa finds the increasing use of agency nurses on temporary contracts very worrying. She has no management or supervisory role and yet is aware of her greater expertise in relation to their often unknown (at least to her) level of experience. As a black, female nurse, she is also conscious of the sensitivity of such tensions about roles and responsibilities when a white, male nurse is appointed on contract.

For a period the male nurse takes over some of Adjoa's excess workload. On subsequently revisiting one of her elderly patients (an 80-year-old Asian man) she finds that a lesion that had been healing well has begun to break down again because the wrong kind of cream has been used. She finds herself very angry and yet unable to remedy the situation. She confronts the contract nurse who is offhand about the matter, making her acutely conscious of her lack of any formal seniority. She feels her gender and racial and ethnic identity, and those of the client, make matters worse, but does not feel sure whether this is her problem or her colleague's. (Is he being racist and sexist or does she just anticipate that he will be?) Even angrier now, she takes up the matter with her senior, but is effectively made to feel that she is overreacting.

Unlike Jaqui, Adjoa acted on her initial feelings about the situation but ended up feeling that she had 'blown it' by getting so angry. A friend helped her to talk it through some

weeks later and suggested that maybe she had every right to feel angry. What seemed to have happened, though, was that her anger had made it very difficult for her to really analyse the situation or reflect on her own reactions. When she could do this, the picture began to change. She could see the problems for the contract nurse, thrown in at the deep end without obvious lines of peer support being established; she could see the financial limitations forcing short-termism in appointments; she could see her own uncertainties, despite her experience, limiting her capacity to offer non-judgemental support to colleagues.

At this point she began to formulate a new strategy and approached her line manager to discuss how the team might support itself more effectively in the longer term.

Case Study Martin – a residential care home manager

As manager of a care home for young people, Martin found himself faced with a difficult dilemma. Sophie, a 15-year-old, was persistently self-harming and heavily involved in substance abuse. For some time it had been clear that the home could not provide a safe environment for her and after a process of negotiation and consultation a specialist foster placement was found for her, which, combined with intensive support work, offered a good chance for her to make some progress towards recovery. But Sophie refused to go. She understood all the reasons and the arguments, but simply dug her heels in and refused to agree.

Existing legislation and Martin's training stressed the importance of the young person's right to choose. Yet here he was confronted with a situation where he knew the young person's welfare was seriously at risk. His decision, not taken alone or lightly, was to insist that she must go. He knew he was taking away a part of her autonomy, in the hope that she would gain more subsequently. He also felt strongly that insistence must be presented with explanation and acknowledgement of the conflict, conveying in essence 'I know this is not what you want, but these are the reasons why I believe it is what must happen.'

Martin's difficulty was that whatever action he took or did not take would be wrong in one sense or another. The best he could do was to be clear about the context of his decision and the value base he was drawing upon, and on that basis to make the best decision he could. His concern to maintain respect for Sophie's different view was an important part of the story for him. He did not pretend that her view did not matter or that his view was right and hers was wrong. He did not feel comfortable about it, but decided his primary concern must be to protect her welfare in this situation.

Practitioners, as these examples illustrate, cannot occupy some detached space from which vantage point they make clear-cut, evidence-based decisions about their clients. They are in there too, struggling to make sense of things, to communicate, and buffeted in the same way by winds of change, by personal and cultural influences, as are service-users and others. Practitioners face conflicting principles and a context that is complex and requires reflection, rather than the straightforward application of knowledge and skill.

These examples argue, then, for a professionalism involving not just the critical appraisal of knowledge and action – not just a critical handling of theory and practice – but also the importance of acknowledging personal involvement and discretion.

These three examples illustrate the importance of what Barnett (1997) describes as ‘the three domains of critical practice’. Adapting his terminology previously (Brechin et al., 2000), we framed these as the domains of critical analysis, critical action and critical reflexivity. The domain of critical analysis can be seen as the critical evaluation of knowledge, evidence, policies and practice, with an in-built recognition of multiple perspectives and an orientation of ongoing enquiry. Critical action requires a sound skill base, but also calls for a recognition of power inequalities and structured disadvantage and seeks to work across difference towards empowerment. The third domain, critical reflexivity, presumes an aware, reflective and engaged self; the term ‘reflexivity’ implies that practitioners recognise their engagement with service-users and others in a process of negotiating understandings and interventions and are aware of the assumptions and values they bring to this process.

This chapter will argue that professional education and development need to draw out a capacity not only for critical analysis and critical action but also for critical reflexivity, combining to create an awareness of the circular and interactive processes by which the ‘self’ develops as a critical practitioner. An adapted version of Barnett’s three domains of critical practice is shown in Figure 1.1.

In each of the case study examples, the practitioner was operating across these three domains. Each was drawing upon their professional knowledge and understanding to analyse the situation; each had been using a repertoire of skilful actions (including inaction); and each held a reflexive view about their own position and feelings. It is artificial, of course, to describe these as separate processes; the reality will be rather more integrated – ‘joined-up practice’, perhaps.

There seem to be some crucial aspects of the process those practitioners were engaged in which span or underpin the three domains. It may help to identify these in terms of two guiding principles: the principle of ‘respecting others as equals’ and the principle of an open and ‘not-knowing’ approach.

The principle of ‘respecting others as equals’

Given the relatively powerful position of professionals in society, and the fact that health and social care practitioners are working explicitly with people in vulnerable positions, it is not surprising that built-in oppression is increasingly recognised. A substantial body of work in the form of research, papers, books, policy documents and practice experience addresses explicitly the problems of the imbalance of power and how attempts may be made to redress it. Not only that, but the concept of establishing a value base, which affords equal rights and respect to all, is at the core of all the vocational qualifications and occupational standards relevant to work in this field.

In the field of child care, the legislative and policy frameworks have shifted significantly towards upholding children’s rights to be heard, but also towards the rights of children to be protected from harm (Scottish Executive, 2003; HMSO, 2004a). Against this backdrop, Martin understood the power he had and the responsibility he had to intervene in a life. Already a ‘looked-after’ young person, Sophie was now to be moved again against her

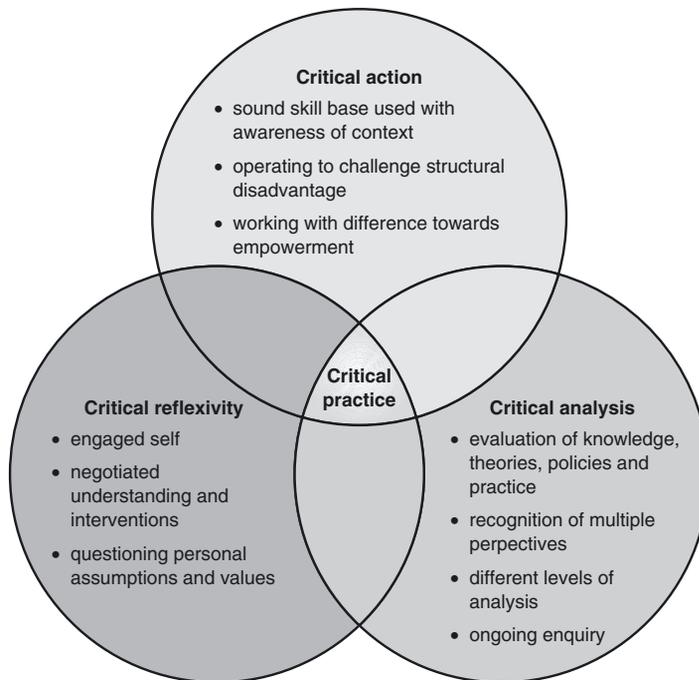


Figure 1.1 Three domains of critical practice

Source: Barnett, 1977: 105

wishes, and yet as far as could be foreseen ‘in her best interests’. What he did to acknowledge this conflict was to respect her views and feelings, not in this case by accepting them, but by talking about them and allowing them to be different from his own. Respecting Sophie’s rights did not lead Martin to abdicate his own rights and responsibilities.

Had Sophie been one year older, at 16 she would now be technically eligible to apply for direct payments to support herself, putting her in a much stronger position to make her own decisions. Legislation in England and Wales, Northern Ireland and Scotland has broadened the scope of direct payments to include eligibility for 16- and 17-year-olds (Department of Health, 2001; Northern Ireland Executive, 2002; Scottish Executive, 2003). There are exclusions, however, and in fact Sophie’s known substance abuse, the risks she would run and the fact that she was in residential care as a looked-after young person would all be likely to exclude direct payments as a possibility. The continual evolution of such policies nevertheless highlights the shift in relationships in favour of greater equality and autonomy for service-users, and illustrates the degree of challenge to Martin and others like him and the delicate, ethical balancing act involved in managing such situations.

Respecting others as equals applies not only to working with service-users but also to working with colleagues, including supporting and being supported by them. Indeed, in the case of children’s services, Martin is also required to work across agency boundaries co-operatively as the policies and principles driving the integration of children’s services are implemented (see Scottish Executive, 2001; HMSO, 2004b; or for a review of this experience on the ground in Scotland, Glaister and Glaister, 2005). Power differentials

between professions, hierarchies within professions, and different theoretical, structural and practice frameworks all contribute to major difficulties in communication between one practitioner and another. The cases of both Jaqui, in her relationship with the more powerful doctor, and Adjoa, in her ambiguous relationship with her colleague as well as the problems with her line manager, illustrate these difficulties. Interestingly, both of them looked for solutions that involved moving towards greater opportunities for learning and support through establishing more respectful and equal relationships.

This principle is well developed and has a good pedigree. It is not, however, easy to translate into practice. It does not mean denying or disparaging professional knowledge and expertise. Rather, it is about seeking to share skills and understandings and offer potential interventions or explanation. Such offers will not always be accepted, however, and critical practice will be about struggling to build and sustain respectful and equal relationships within which meanings and ways forward can be negotiated.

The principle of an open and ‘not-knowing’ approach

The second guiding principle for critical practice is openness. Accepting a degree of uncertainty about any intervention has to be part of the job. There will be conflicting needs and widely varying views about priorities and the desirability of different outcomes. Who is to say, for example, whether a half-leg amputation and remaining healthier and more active is more desirable than struggling on with less devastating surgery for a longer period? Who is to say whether insisting on a move to a foster placement will be for the best – and whose best? And if things go wrong, who is to say where the blame lies?

To take up a position of openness is to accept that professional practice is an evolving process within a social and political context. This is not to deny the importance of established thinking and evidence – far from it. Professional practice is rooted in theories, and keeping up with the latest research evidence will continue to be important. It is more like the adage, ‘The more you know, the more you know what you don’t know.’ Openness and ‘not-knowing’ require engagement with the process of evolving knowledge.

Practice then, can be seen as part and parcel of a continual process of theorising and evidence building. Theories develop as attempts to make sense of how things seem (Howe, 1987; Thompson, 1995). They do not tell some absolute truth, but theorising is part of a human process of trying to make our experiences more intelligible (Argyris and Schon, 1974). Practitioners are, *par excellence*, theorists, as Schon (1983) in particular has argued. Thompson suggests it is a mistake for practitioners to see themselves as concerned only with practice, while others attend to the theory. He argues that:

we need to recognise the fallacy of theoryless practice so that we are not guilty of failing to review our ideas and lacking the flexibility to adapt or abandon them in the light of changing circumstances.

(Thompson, 1995: 29)

Theories are always ‘only theories’, in the sense that certainty is always elusive, partial and seen from a particular perspective. Being ‘only a theory’, however, is also an essential feature of open-mindedness, in that theories are provisional and there to be tried

and tested and debated in order to evolve. To accept 'not-knowing' is in the best tradition of philosophers and scientists down the ages. What is strange is how far professionals have been pushed (or have pushed themselves) into a defensive position of seeming to be the opposite – all-seeing and all-knowing. Acknowledging 'not-knowing' indicates, in contrast, a clear stimulus for further exploration and knowledge development and provides a climate for the development of defensible rather than defensive practice.

What is suggested here is that critical practice should be seen as an integral part of an ongoing shared and discursive process of theorising and knowledge development.

A theoretical context

Critical practice occurs in a theoretical context, although the influences may not always be very apparent to practitioners. The ideas behind the accounts and analyses of critical practice offered here can be seen as stemming from several interrelated theoretical traditions.

For some, particularly those who have studied sociology at some point, the most obvious link will be to critical theory – historically to the work of the Frankfurt School and more recently to variants of the work of a writer such as Habermas (1972). For others, critical practice will gel with an understanding they have developed of social constructionism in psychology or sociology, with its insistence that the social context in which we live is not extraneous reality, but is constructed by us as part of a process of creating that context. The language that we use is seen as part of a process of creating shared meanings and experiences. What this argues essentially is that humans are 'meaning-generating systems'. Such thinking has a long history, but has more recently been extensively debated – for example by Bateson (1972), Harre (1986), Shotter and Gergen (1989), Gergen (1991), McNamee and Gergen (1992), and Shotter (1993).

There are broader links too with feminist theory (see, for example, Maynard and Purvis, 1994) or with history from below (as in Porter, 1985) or with the implications of the social model of disability (for example Oliver, 1990 or Shakespeare and Watson, 1997), particularly in the sense that these challenge established ways of formulating and researching issues and insist that, from the standpoint of oppressed groups, there are new questions to be addressed and new ways of collecting data.

While it may be helpful and may enrich an understanding of critical practice to be able to make links such as these (see, for example, Layder, 1997; Porter, 1998), it is by no means necessary to do so. A critical practitioner needs to recognise that their work involves them in activities and relationships which are not adequately explained by theories and evidence drawn from the material world. The concept of critical practice is based on assumptions that:

- Social and organisational structures are not given and immutable.
- Individuals have agency in that they imbue situations with meaning and that these meanings have consequences.
- Interpersonal relationships and structures reflect and create power imbalances which can be uncovered and challenged.
- Alternative circumstances, strategies and outcomes can be envisioned and sometimes brought about.

This is to acknowledge that practitioners in health and social care need to work with a broader theoretical framework in their daily practice. Acknowledging different discourses cannot fail to bring the questioning stance which is at the heart of critical practice.

Critical practice in action

So how does any of this relate back to the three case studies? It was argued earlier that practitioners are engaged in theorising, but does it make any sense to suggest that they might think in such abstract terms as these? The exercise involves thinking about their arguments and dilemmas in relation to a theoretical framework which takes on board not just a sense of an individual in society but also a sense of how meanings and understandings may be socially constructed.

Jaqui was very clearly aware of the wider context in which both the family and the professional service operated. The issue was not just about physical rehabilitation after an amputation. It was about a young woman in the context of a family life and the particular roles and expectations she would expect and be expected to meet. Jaqui's own role as physiotherapist set her in a particular and subordinate relationship to the doctor in the context of wider professional and regulatory systems. What took her beyond this into the realms of critical practice was her recognition that different meanings could co-exist and have validity; that more powerful voices might hold sway, but that this did not mean they were right, or necessarily wrong, and most importantly that not knowing what was best to do in the circumstances was perfectly appropriate, although decisions had to be made and ways might be found for opening up some further dialogue around these meanings in the future.

Adjoa was similarly aware of the constraints of the system on how she and others worked. She also saw the potential of the more powerful white majority to discredit her voice as a black professional and identified her lack of formal status as making it difficult to support or know how to criticise her colleague. As she grappled with the issues, she began to take on a different perspective, realising that her view of things was not the only one or necessarily the most helpful and constructive one. She was able to blend together a view which respected her own agency as well as others, and to understand the power of existing structures to constrain or facilitate, in a way that provided her with a course of action for the future.

Martin knew the systems in which he and the young person were located; they could not be more clearly spelled out in policy documents in the child care field. He also understood the importance of the meaning that might be attached to his decision. Inevitably for the young person, it meant her wishes were overruled, at least on the face of it. He hoped that his explanations and respect for her views would create a more positive meaning for her; one that said she had been heard and understood, but that a decision genuinely thought to be more in her best interests had been taken. To have gone along with her wishes would not necessarily have been more respectful.

Where does this take us in terms of defining 'critical practice'? Drawing together all these elements, which address process, guiding principles and theoretical perspective, leads us to the following summary.

Critical practice entails:

- operating across the three domains of analysis, action and reflexivity;
- working within a value base that respects others as equals;
- adopting an open and ‘not-knowing’ approach to practice;
- understanding individuals (including oneself) in relation to a socio-political and ideological context within which meanings are socially constructed.

Having framed a concept of critical practice in this way, we now turn to consider what this means in terms of fundamental, everyday processes – what you actually do to engage in critical practice.

Becoming a critical practitioner

Forging relationships

What most practitioners are concerned with on a day-to-day basis is being a good enough practitioner, seeking to help and striving at least to do no harm, within increasingly tight budgetary constraints. The case studies offered some examples of what might be described as critical practice in action, where outcomes are not perfect, nor even satisfactory much of the time, but where, nevertheless, good enough decisions must be made on the best information and judgments available. In a sense, the professional has ownership of his or her working role and space and, within that, both experiences and creates professional practice (Kolb, 1995; Tsang, 1998). This second section will unpack those ideas just a little further, exploring what it means to ‘respect someone as equal’, for example, or to maintain an ‘open mind’.

At the heart of health and social care practice, then, there is the first pillar of critical practice: forging relationships with people, whether as clients or colleagues. This requires sophisticated interpersonal skills. Being a good communicator and able to forge good relationships is a starting point, but it has to extend to include, for example, the capacity to establish a dialogue in difficult circumstances: to negotiate, mediate, set boundaries, challenge and influence. Constructive relationships may have to be developed with diverse and challenging clients, relatives, colleagues, managers, trainees, other professions, planners, politicians and often the media and the public. This requires, as we have argued, not only a good understanding of how others may operate but also a sensitive and well-tuned awareness of oneself.

This aspect of direct care work has been described in terms of emotional labour (Smith, 1992) and is beginning to be more widely recognised within training and support. As a professional develops, further emotionally demanding tasks arise. There is the process of balancing priorities in meeting the competing needs of many clients (including potential clients who are not accessing the service); the balancing of time and resource constraints; balancing statutory, interventionist and preventative work and the balancing of time for face-to-face work against time for administration, liaising, supervisory or personal development responsibilities, and a growing sense of responsibility for, or at least awareness of, the direction of the organisation and the professional roles within it on a wider scale. This

wider political professional perspective may still remain connected with individual client work. As depth and breadth of understanding and skill grow, so the awareness and critical perspective on work and relationships with individuals has to evolve (Mann, 1998; Allen, 1997).

Within this broader critical framework, interpersonal skills remain central (Thompson, 1996). The professional will be handling communications with a wide range of people. This will involve multiple roles and among these we might identify the following relationships:

- professional–client relationships
- professional–team relationships
- inter-organisational relationships
- purchaser–provider relationships
- supervisor–learner relationships
- manager–staff relationships
- relationships with policy-makers or politicians
- relationships with the media or the public

Not all will be in agreement with each other and the capacity to create and maintain open dialogue while holding on to core principles and negotiating priorities demands sophisticated skills. Forging relationships is not just about being friendly, but about creating connections and channels through which real communications can occur, bringing opportunities to learn about other views and perspectives, and discovering ways of talking constructively about differences of opinion.

Fundamentally this is about establishing equity and mutual respect. The Rogerian emphasis on warmth, positive regard, genuineness, empathy and equality holds sway here and is hard to better as a foundation (Rogers, 1951). Recognising and respecting the other person's viewpoint and feeling positive and accepting towards them does not mean losing touch with your own beliefs and feelings. Dialogue and partnership essentially involve bringing yourself and your own ideas, principles and knowledge base to the relationship and communication. To do that without disempowering the other, to remain genuinely open to learning from them, to offer ideas without defensiveness or pressure, and to hear and receive in return – those are the sophisticated skills of constructive engagement with others.

Given the multiple differing roles, perspectives and power relations, this will seldom be straightforward. A capacity for mediation and negotiation is required when relationships threaten to break down or cannot easily be established in the first place.

Negotiation is the only way to achieve the best outcome for individuals or organisations who need things from each other ... You need to get people talking, keep people talking and work towards a better understanding of different parties' needs and wishes.

(Fletcher, 1998: 21)

The concept of working together in partnerships and across role boundaries towards goals which may have to be negotiated evokes a very different image from that of the individual autonomous professional fixing something that has gone wrong. The expectation

that professionals should be able to work in such a way has increased significantly (Hornby, 1993; Loxley, 1997) and the relational aspect, or forging of relationships, within such work can be seen as central.

Seeking to empower others

The concept of empowerment is the second pillar of critical practice. Concepts such as oppression, discrimination, empowerment and equal opportunities have become part of the language in health and social care work (Dominelli, 1988; Braye and Preston-Shoot, 1995; Thompson, 1998). They have reflected a recognition that less powerful or minority groups tend to become oppressed and disadvantaged and that health and social care services and professionals are so much a part of the status quo that they inevitably and unconsciously play a part in this structured oppression. In recognising this, critical practitioners begin to understand oppressive forces and work to reconstruct power imbalances. What has been learned from disabled, feminist and black perspectives has valuable messages for all critical practice (Pinkney, 1999).

The concept of empowerment is often called into question, particularly when it is lightly bandied about without any real justification. Empowerment, as a term, also risks seeming to carry the implication that power is in the gift of the practitioner to bestow. It can also be in danger of focusing too much on individuals and overlooking structural disadvantages. Or it may ignore cultural differences in the perception of how power should be appropriately vested and deployed. Gomm (1993) rightly challenges naive and circular justifications of professional power in practice, but nevertheless allows, rather grudgingly, that the term 'empowerment' designates many excellent practices and it is hard to see, indeed, how striving towards clearer understandings of and better practice towards empowerment can be a bad thing.

Direct payments enabling recipients to choose and pay directly for whatever kind of support they feel they need, are now established as an alternative way of delivering services, and can be seen as a natural development of any strategy to empower. Following revised legislation and guidance (Department of Health, 2001; Northern Ireland Executive, 2002; Scottish Executive, 2003; National Assembly for Wales, 2000), it is now mandatory for local authorities to offer a direct payment option and individuals are enabled to draw directly on such payments to purchase support tailored to meet their needs as they see them, untrammelled by the opinions of professionals or the nature or accessibility of care service provision. The option is also now extended to include 16- and 17-year-olds, over-65-year-olds and carers, including young carers. It is also clear that advocates, whether parents or guardians, can act as supportive intermediaries for the receipt and deployment of direct payments. Buying in the support of personal assistants is a frequent use that is made of the payments and Spandler (2004: 187) offers a useful review, considering this trend critically within a wider context. She suggests:

There are a number of factors that need to be addressed to ensure that direct payments continue to be a progressive strategy. These include reconciling conflicting ideologies such as those advocating individual choice and/or collective provision; the need for political action to secure adequate resources; and the development of alternative strategies such as cooperatives to address the collective needs of direct payment recipients and workers.

A push towards market forces and a shift away from the development of more broadly tailored responses to collective need has led to a plethora of voices welcoming the introduction of direct payments as significant and long overdue (for example, Morris, 1997; Campbell, 1997; Glendinning et al., 2000; Stainton, 2002). Concerns are raised not so much by individual recipients as by others, who note a longer-term concern about the drive towards cost-cutting; the difficulties of developing and evaluating new services; and the problems of ensuring that the needs of those who are most vulnerable and least able to articulate their requirements are well protected and can be met.

There has been a necessary shift in professional perception and understanding towards a broader and more politically framed arena. Such debates have now become central to professional codes of practice and to professional training, and have also featured strongly in relation to minority ethnic groups (Dominelli, 1988 and 1997; Culley, 1996 and 1999; Doyle, 1997; Pinkney, 1999). This seems to reflect a growing awareness among professionals that working alongside service-users in tackling oppression is an inherent aspect of critical practice (Dominelli, 1997).

Analyses have historically tended to polarise people according to particular attributes, whether gender, ethnicity or role (including the role of service-user). This can be seen as a form of 'essentialism' (see, for example, Clarke and Cochrane, 1998) in which social behaviour is ascribed to some particular 'essence' of the individual, such as 'blackness' or 'femaleness' or 'disablement' or 'neediness'. It is easy then to fall into the trap of assuming that all people who are socially constructed as 'black', 'old', 'disabled' or 'homosexual', for example, share similar experiences and aspirations (SSI, 1998; Pinkney, 1998; Culley, 1999). New developments, such as direct payments, increasingly challenge such limited ways of thinking and talking. For example, the firm line on anti-oppressive social work practice has been reformulated in terms of inclusivity and citizenship (Clarke and Cochrane, 1998; Saraga, 1998; Pinkney, 1999; Thompson, 1999). The polarising of characteristics by gender, particularly in relation to asserting women's capacity for caring, has been reframed, for example by Davies (1995 and 1998), who argues that these stereotypes represent 'cultural codes of gender' rather than gender attributes. The dependency relationships imposed on disabled people have been challenged by thinking emerging from the social model of disability (for example, Oliver, 1990) and, as we have seen, more recently by challenges to the delivery of 'care' through the increasing implementation of 'direct payments' (Morris, 1991 and 1997; Swain and French, 1998; Spandler, 2004).

All this impinges very directly on practice. For example, Pinkney suggests, in discussing 'same-race' adoption policies, that current reformulations see the child 'as an individual', with an identity which is multi-layered and complex, rather than one-dimensional. 'Race' is an important feature in this assessment, but so are other factors such as class, gender, health, friends, school, neighbourhood, the child's and the family's wishes, and so on (Pinkney, 1998).

Lewis (1996), in research with social workers, describes how race and gender relations emerge from 'situated voices' – in other words, from the way people talk about other people and each other, thus creating complex and shifting personal meanings about gendered and racial identities, but meanings which arise also from particular historical and social situations. We are all, in Lewis's sense, 'situated voices' playing a part in creating our own and others' understandings and experiences – using our own voices, but voices which carry a heritage, are embedded in a current context and anticipate a future. Such voices will have racial and ethnic elements, gender, sexual orientation, socio-cultural

experiences, religious or ideological beliefs, family positions and experiences, and social role through work or other contexts.

For white Anglo-Saxons, ironically, owning and valuing ethnic and cultural identity and its influences can be problematic, in the first place because they are rendered almost invisible by being the norm in the UK context. The ethnocentric assumption is that it is others who are different, who have racial and ethnic identities, which are then seen as requiring special pleading. Owning a white cultural identity brings the discomfort of an implicit label of oppressor. Yet valuing and understanding one's own identity is fundamental to offering empowering help to others (Dutt and Ferns, 1998).

Seeking to empower individuals and to challenge oppression and discrimination may involve more than just recognising and challenging on the basis of rather simplistic models of identity and social relations. Increasingly, it becomes part of a wider project of critical practice aiming to facilitate more permeable boundaries, acknowledge more flexible roles and identities and develop more dialogic ways of working with others. It is about supporting the inclusion of service-users or recipients as equal – or indeed lead – participants within negotiations and decision making and in the control of service planning and delivery.

Making a difference

The third suggested pillar of critical practice is 'making a difference'. Practitioners assess, judge and intervene with the aim of making something better than before, whether by helping a wound to heal (physically or emotionally) or helping to improve somebody's circumstances or situation in some way. There is in this sense both a moral and a pragmatic or evidence-based dimension. In order to make, and continue to make, 'good enough' interventions, practitioners have to keep up to date with the latest practice and research evidence, weigh up that evidence in relation to their own working practice and situation, and act and evaluate outcomes accordingly.

Scientific method offers an approach to evolving knowledge and practice in this way by testing out beliefs to prove or, alternatively, to attempt to disprove them. The notion of evidence-based practice stems from this tradition (Muir Gray, 1997) and now forms the basis for policy planning and implementation, for professional practice and audit and for professional training and professional development.

The call for evidence-based practice reflects a rational and, what some would describe as, a Western frame of reference. That does not make it right – or wrong – but it does give it a particular cultural 'style'. Fernando (1991), in discussing mental health services, suggests that 'style' will affect the underlying assumptions and the nature of interventions:

The goal of all Eastern religions and psychology is enlightenment, subjective experience and meditation. In general, the quest for understanding in Western thought is for facts, in the East, for feelings. The Westerner seeks knowledge, the Easterner seeks to know.

(Fernando, 1991: 93)

Dutt and Ferns (1998), in their training pack on 'black people and mental health', draw upon Fernando's analysis to develop three dimensions of cultural style (see Figure 1.2).

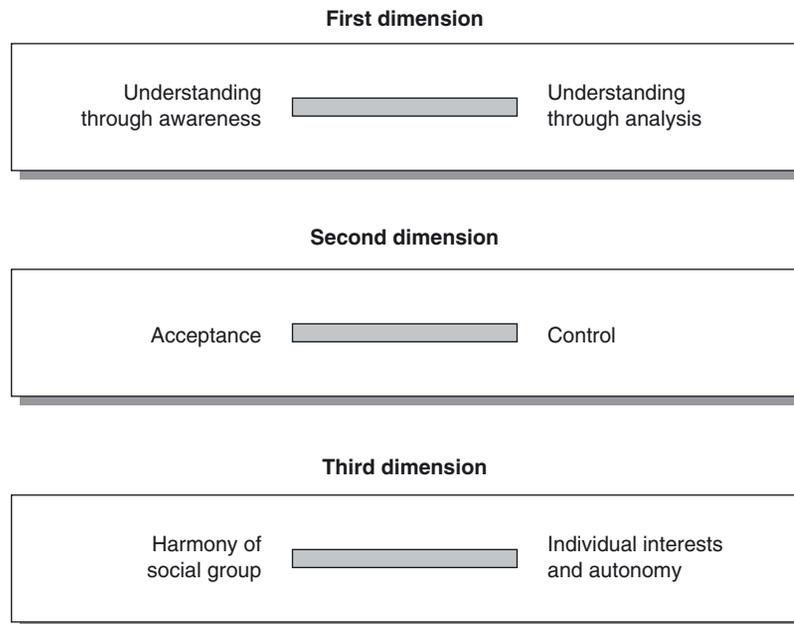


Figure 1.2 Three dimensions of cultural style

Source: Dutt and Ferns, 1998: 29

The first dimension is about achieving understanding: in ‘rational’ terms, through analysis of formal information; and in ‘emotional’ terms, through achieving greater self-awareness. The second dimension of cultural style concerns the response: whether by seeking to control or eradicate the symptoms, or by acceptance combined with a restoration of balance. The third dimension addresses assumptions about outcome – whether a concern with re-establishing the autonomy and interests of the individual or with the harmony of the social group to which the individual belongs.

In seeking to build partnerships and to empower, it is the professional, ultimately, who will be expected to ‘know’ and to be responsible for any decisions, advice or interventions. Yet professionals have their own ethnic and cultural origins and styles and, as with those they are working with, these will vary widely. To some extent such ‘differences’ will be overruled by a professional training, which privileges intellectually based arguments and views, and by the power of the professional to impose those views. And yet, increasingly, this power is called into question by the central importance of creating dialogue, partnership and respect.

As well as such concerns about whether practitioners should rely solely on rational analytic approaches, there are also reasons to doubt that professionals do, or even can, operate in a purely rational way. Theoreticians exploring how people make decisions have struggled to find models which account for how they do so. Typically, these have been cognitive and statistical models, describing the kinds of factors that may be taken into account in thinking rationally about the best decision to reach (Ranyard et al., 1997; Kahneman et al., 1982). Such a formulation would fit comfortably with the implementation of evidence-based practice.

Subsequent work in psychology, however, has suggested that in practice people do not actually operate in this rational way. We tend rather to ‘base our choices on rules and strategies derived from past experience with similar problems’ (Eiser and van der Pligt, 1988). We are also influenced by our attitudes and values and by the feedback loops from earlier decisions. Therefore, they argue, it is essentially a social process rather than a rational, individual one. In other words, belief systems and cultural style may have a powerful impact on practice.

From large-scale policy issues to specific practice decisions and the moment-to-moment decisions that are part of an ongoing process – how to respond to a request, how to initiate or conclude a conversation, the tone of voice, the interpretations placed on what is said or done – all will be influenced not just by formal evidence and analysis but by a host of other less formal understandings and feelings (Schon, 1992 and 1994; Lester, 1995; Schell and Cervero, 1993). Rational, evidence-based practice can be powerfully effective, but it will always depend on what evidence is seen as relevant and what outcomes are seen as meaningful. It is inevitably limited in its range of vision, and the critical practitioner seeking to make a difference and also to value difference must draw on it as a tool and source of information, but not as the whole or only story.

Experience and expertise should not be devalued, nor, as Claxton (1998) argues, the power of human intuition. Neither should we ignore the importance of the value base operating alongside our own unconscious motivations and defences. In professions and organisations which are mediating human need and social justice, there is surprisingly little emphasis on the fundamental human processes involved. Kitwood (1990 and 1998) argues for the importance of moral space and draws upon ‘depth psychology’ to examine caring work. Smith (1992, 1999) talks of ‘emotional labour’. Hornby (1993) discusses the essentials of ‘self-responsibility and social integration’. Barnett (1997) suggests we cannot have genuine critical thinking and critical action without self-engagement.

We need to recognise these broader frames of reference in thinking about evidence-based practice and professional development. If the professionalisation of work in health and social care is ultimately of value, it must be because it enhances rather than dehumanises our capacity to value and understand ourselves and others as moral and sentient beings – and our capacity to treat others, especially vulnerable others, accordingly, in working to support and provide for health and social care.

Conclusion

The concept of critical practice developed here locates the practitioner within the frame as an active participant in a process of creating meanings and understandings and forging relationships and dialogue across difference. Rather than presuming a detached, objective and wholly rational role based on assumptions of passive compliance from others, the critical practitioner is seen as reflexive and engaged. Thus, in seeking to work in an empowering way, awareness of personal and socio-cultural origins and belief systems is seen as an essential basis for creating respectful and equal relationships and for challenging discriminatory barriers.

Critical practitioners must be skilled and knowledgeable and yet remain open to alternative ideas, frameworks and belief systems, recognising and valuing alternative

perspectives. 'Not-knowing' and uncertainty need to be valued as an orientation towards openness and a continuing process of learning, even if, at times, it can be essential to act swiftly and confidently. This sense of critical practice with its dilemmas and conflicts, but also its sense of creative and developmental process, underpins and infuses the work of all health and social care practitioners today.

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