Relational Social Work

# Good social work practices with disabled adults and elders who live at home: More than the delivery of services

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## *Abstract*

*This paper presents a study about social work practices with disabled adults and elders who live at home. The basic idea behind the research project is that, alongside the indispensable functions linked to the provision of standard delivery, there are further interesting areas of action with which social workers contribute to maintaining or improve the quality of life of dependent people. The research was carried out in a district of Northern Italy. Semi-structured interviews were conducted with the five district social workers assigned to assist people with disability: each one was asked to describe some cases which s/he thought are examples of good practice. 32 case stories were collected, transcribed and processed through a thematic analysis. In a second step, 10 cases were chosen and 10 group interviews were conducted for each one of them, with the participation of the main people involved (for example: the service user, his/her caregiver, other family's members, health and social care professionals). So, various points of view about each case were also collected and analyzed. Results show that «good case» does not mean «simple case». In this context, social workers have to construct a tailored intervention plan, integrating family needs and resources, service provisions, formal and informal support from the local community. The most effective paths are those in which social workers can listen to the point of view of users and carers, acting with respect and sensitivity.*

## *Keywords*

*Gerontological Social Work – Disabled and Elderly People – Case Management – Ethic of Care*

Erickson
**Relational Social Work**
Vol. 2 , n. 2, October 2018
(pp. 12-27)
doi: 10.14605/RSW221802

## Introduction

According to Eurostat data[1], Italy has the largest elderly population in Europe. (In 2016, the percentage of the Italian population over the age of sixty-five was 22%, while the average percentage of the European population that was within the same range of age was between 17% and 20%.). Furthermore, Italy has the second-highest aged dependency ratio (the dependency ratio of persons aged sixty-five and over) in Europe. Moreover, the country's aged dependency ratio is higher than the average aged dependency ratio among European countries: 34.3 compared to 29.3, respectively.

Therefore, in the Italian debate, the issue of long-term care is crucial, and it can be defined as «a variety of provisions, in social and health terms, provided continually to people who need constant care due to physical or mental disability. These provisions can be delivered within residential services or at elders' home or in the community and they include both informal care by relatives or friends, and professional care by individual care workers or by care organizations» (Institute of Medecine, cit in Gori, 2006, p. 14). There are three main sources of long-term care (Gori, 2006): the first source consists of informal networks, such as (in order of size) family members, acquaintances, volunteers, and neighbours. In informal network, long-term care is a predominantly feminine burden: wives, daughters and daughters-in-law are often committed to taking care of both elders and the self-sufficient, children and grandchildren (Cesareo, 2009). The second source is care purchased autonomously by families within the private market, which, we must point out, is characterized by the constant expansion of poorly qualified and often underpaid care work carried out by migrant women who work as paid home carers. The third source consists of interventions provided or funded, totally or partially, by a public authority and which include various types of services (residential services, day care services, community care services, etc.) and financial services. (In Italy, the most important financial service is the incapacity allowance). Obviously, if we look at real situations, it is clear that public, private and informal care are constantly intertwined and that social service professionals have to address an extremely complex and varied reality. It is, therefore, evident that social work focused on dependent people (that is to say, gerontological social work) is an area of great interest in the Italian context, both at the policy level and at the so-called «field» level, at which professional social workers are mainly involved. In Italy, few studies deal with the peculiarities of social work in this area (Saporiti, 2003; Pregno, 2016). Through this research we intend, therefore, to contribute to the increasing interest in gerontological social work.

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[1] http://ec.europa.eu/eurostat/statistics-explained/index.php?title=Population_structure_and_ageing/it

## *The social worker in the Italian welfare system: between professional discretion and delivery procedures*

According to one of the latest available studies (Facchini, 2010), about a quarter of Italian social workers take care of elders, and 6% of them address elders with disability: therefore, about a third of social workers address partially or totally dependent users. Social workers are a crucial point in the multi-faceted Italian welfare system (Burgalassi, 2012), since they are at the crossroads between the demand by citizens for interventions and the supply provided by welfare organizations of social care provisions. The presence of professional social work at the essential levels of care is regulated by Law 328/2000 precisely because social work professionals are called on to decode different situations and to provide individuals or families access, in the most flexible and personalized way possible, to the multiple provisions available through the welfare system. To do this, social workers must have and maintain a high level of professional discretion, even while performing their work within laws and official guidelines (Raineri, 2014).

The professional actions of social workers are closely connected to and conditioned by a variety of operational contexts and are characterized by constant change and a strong lack of homogeneity of policies and in the organization of services in the various local communities; the organization of services in local communities also tends to enhance local peculiarities in very limited areas (Cimagalli, 2017). The commitment of the social worker is predominantly (though not exclusively) at the level of *fieldwork* to address life problems by carrying out processes established by individuals, groups and communities while being in a position that, however, is always configured as interlocutory between the demands of the citizen and the institutions. All professionals are called on to find a delicate balance between their professional and institutional duties. In the everyday life of many professionals, this often leads to ethical and deontological dilemmas (Banks & Nøhr, 2012).

## *Social work with elders: an area of unappealing employment*

Widening the gaze to international literature, perhaps the most obvious element that emerges from different studies (Manthorpe et al., 2007; Ferguson, 2015) is a widespread underestimation of gerontological social work: social work students do not consider older people to be an «appealing» operational target, and they tend to focus their training on other areas, mainly work with children and families. For example, according to the results of research conducted in the USA (Chonody & Wang, 2014), only 56 students out of approximately 1,000 interviewed indicate work with elders as their favourite area of employment, while some professionals interviewed about the positive and negative aspects of working with elders (Webb et al., 2016) describe it as «depressing» (Ibidem, page 412). According to numerous authors (including Bertin, 2009, Marshall, 2013, Hastings & Rogowski, 2015), it is possible to directly connect these attitudes to *ageism* (Butler, 1969). Stereotypes of elders and prejudices against them are patent and appear to be generalized, even among the public. In today's Western society, which values efficiency, individualism and the ability to «keep up» with change, ageing and disease are considered to have a negative value, to be hidden or postponed as much as possible. Older people are stereotypically depicted as fragile, sick, dirty, and stubborn (Chonody & Wang, 2014), and support and care functions, especially those related to physical care, are considered suitable for unskilled and poorly paid staff. (Lymbery et al., 2007; Olaison, 2010).

## *Roles and functions that are difficult to define*

The area of dependence, compared to other areas of social service, is characterized by a higher health component, dictated by the need to cope with the many diseases affecting elderly and disabled people. The integration of the social and health fields embraces several aspects that are linked, for example, to the division of competences among the various professionals; to the functions of project coordination and, more generally, to hierarchical responsibilities; to the division of expenditure between public authorities; and to the concept of «care» (Folgheraiter, 2006).

Generally, the professional intervention of the social worker is perceived as implementing bureaucratic procedures for provisions delivery. The paperwork occupies 15% of the working time of social workers (Facchini, 2010), and this percentage is probably higher for social workers who deal only with elderly users. On the one hand, if having some paperwork to sort out helps professionals to «distance themselves» from the emotionally and more engaging delicate aspects, such as the constant confrontation with illness and death (Lymbery et al., 2007); on the other hand, excessive proceduralization may allow social workers to avoid addressing the complexity of the user's situation (Ray et al., 2014), in which the needs of the dependent person and his life problems are intertwined inextricably with those of family members and carers and cannot be reduced to «technical problems» (Folgheraiter, 2011). Proceduralization leads to an excessive simplification of work that involves dependent people and, thus, confirms the idea that fewer professional skills are needed compared to other types of work. This corresponds to the belief that working with disabled or elderly people offers little satisfaction to social workers (Bonifas et al., 2012; Simons & An, 2015). Remaining within a framework in which the particular function of the social worker is considered to be facilitating access by users to welfare services, in a welfare-mixed system, a social worker can also assume the role of *case manager* (Payne, 1998; Bortoli, 2006), whose task is to help the dependent person (or his family) choose the most suitable provider within a tailored care plan. However, both when he is limited to delivering the performance of the public authority on which the care plan depends and when he assumes the role of «external» case manager, the social worker is in a position of strong ambiguity. The task is, in fact, to reconcile the needs of people and families with the increasingly stringent demands of controlling expense from a perspective that aims at maximum efficiency. Some authors (Ray et al., 2014) show how social workers have felt, in recent years, that there is a «passing of functions»: instead of taking care of people and their needs, social workers have become «resource providers»; for this reason, what prevails is a bureaucratic approach over a social work approach, which enhances dialogue and interpersonal relationships (Beresford et al., 2007).

## Aims of the study

The basic idea behind the research project is that, alongside the indispensable functions linked to the provision of standard delivery, there are further interesting areas of action to which social workers contribute, or could contribute, to maintain or improve the quality of life of dependent people. The aim of the research is to find and describe these spaces and to explore the topic of cognitive control over the total help needed by the non-self-sufficient person (called care management) to identify how the scope of action of professionals is intertwined with the requests of families and with institutional mandates.

The following questions guided the research:

- What is the work of social workers who help dependent people and their caregivers, and what are the guidelines on such work?
- Which aspects of this work appear to be more relevant to improving the quality of life of families, and should these aspects be enhanced? Are there any aspects that should be redefined? Are there any areas of action not yet covered that could be addressed?

## Method

The research is qualitative, and it was carried out between March 2016 and April 2018 in the district of Rozzano (MI), which consists of four municipalities (Rozzano, Locate di Triulzi, Basiglio, and Opera) and has 72,000 inhabitants.

The research was conducted in two phases. In the first phase (March 2016 – December 2016), we proceeded with a preliminary analysis of the context; this analysis was carried out through a study of administrative documentaries, such as the «Piano di Zona» (Local Social Services Programme), and the demographic framework of the district. Subsequently, a focus group was held, which was attended by five social workers who address dependent people in the four district municipalities. The purpose of the focus group was to obtain a description of the main activities and the most significant aspects of social service in the area of dependence and to highlight points of similarity and differences among different locations. Semi-structured interviews were then carried out (Bichi, 2005) with the five social workers, who were asked to describe some of the cases they were dealing with or had been working on for the last three years for which they had been reached. The social workers were also asked to describe the cases in which (from their point of view) a positive outcome was being achieved or, in any case, a significant improvement in the situation had occurred. The five interviews were held during nine meetings, each of which took between 30 minutes and 1 hour and 45 minutes. On the whole, 32 «successful» cases were described, 20 relating to the situations of elderly people and 12 of adults with a severe disability. Each interview was transcribed, and a thematic analysis of the content was carried out (Sala, 2010). The synthesis of the research results was discussed in an additional focus group with the five social workers.

In the second phase (January 2017 – April 2018), a reconstruction of the care processes was carried out to try to grasp the opinion of all the subjects that had made a significant contribution to the care process itself, both within the family and friendship network and within the services (formal and voluntary). It was considered useful to use a particular type of group interview, a sort of «case conference» for research purposes, in which all the people — professionals and non-professionals — were invited to participate by the user and / or the carer considered to have been significant in the care process. Specifically, users (or, in cases where a user's involvement was not possible, carers) were asked to identify «who had helped them the most» to reach a condition that, according to the social worker, they considered sufficiently good (Neander & Skott, 2006). The situations to be examined were selected in December 2016 during a meeting with the five social workers of the district. In the sample consisting of all the cases «gone well», 8 case conferences have been built, two for each of the four municipalities of the district, 5 relating to the situations of elders and 3 of adults with disabilities. The case conferences included the participation of a minimum of two people and a maximum of four (excluding the researcher) and had a duration varying between 20 minutes and one hour. The case conferences were audio recorded, transcribed in full and subjected to thematic analysis.

## Findings

Regarding both the interviews with social workers and the case conferences, it is considered useful to report the most significant issues emerging from the research to try to highlight the peculiar aspects.

## *Cases with a positive outcome: complex situations*

For the interviewed social workers, «case with a positive outcome» did not mean «simple case». All described cases that presented physical pathologies (Parkinson's disease, diabetes, oncological diseases, severe disability), and many elderly people were suffering from dementia, 11 people out of 32 presented mental health problems, and others were suffering from alcohol addiction.

Furthermore, for half of the cases presented, social workers spoke of lonely people with no family members to refer to. In some cases, children were present, but they also had personal or family difficulties, often related to poor parental care received in the past and a negative relationship with the elderly person. Therefore, such children were not helpful as carers and were themselves an additional source of problems for the user.

A common feature of all the situations was the impossibility of having a private paid carer because neither the user nor his family members had the necessary management skills to hire one and to organize care tasks.

> This situation concerns a disabled adult with a mental disability, but the intervention took place starting from the warning that instead concerned his elderly mother (Social worker, interview 5).

The complexity of the situations is confirmed and, if possible, amplified by the descriptions made during the case conferences, where the extreme vulnerability of the assisted persons clearly emerges. These are often multiproblematic situations, in which difficulties due to dependence are accompanied by problems at home, poverty issues, and the inability to manage everyday life. In some situations, users have been the victims of deception, fraud, or even physical and psychological violence by other family members or by people who should have taken care of them.

> It just seemed that the carer beat my aunt up and she was aggressive for that (nephew, case conference A).

This is reflected in the weight that care entails for carers. Assisting a dependent person is difficult, both physically and emotionally: difficult choices must be made, and often there are feelings of guilt, despair, and impotence. The situation is more complicated when the carer is also elderly and has health problems or commitments to other family members, such as grandchildren, parents, and siblings. Economic, organizational and other difficulties related to the difficulty in getting involved in the bureaucracy have been described.

> The nights spent at the First Aid. I went in with the sun and went out with the snow, 40 cm of snow, and I said to myself: now what? ...That life! Please, do not talk about that... (nephew, case conference A).

## *The way to help*

Observing the descriptions of the cases with a positive outcome carried out by social workers, we note that in most situations, we start from the request by the user and / or his family for a specific care service to come to a help process built together with the professionals. This request is integrated into the professional assessment of the social worker; this assessment takes into account the importance of respecting the wishes and timing of his interlocutors. In this way, the social worker does not impose his own vision of the situation, even in cases where he does not agree with the others but welcomes the points of view of the persons concerned so that they feel involved in improving the situation.

> Our task was not only that of trying to respond to the needs of the older lady, but also to enhance what the daughters did for their mother, then to support them and actually make sure that they could continue to be there...because the fact that someone recognizes and values what they are doing is definitely a positive feedback (Social worker, interview 4).

This issue emerges clearly from the case conferences: the first contact with the social service almost always occurs following a very specific event, in most cases a health problem, which leads the interested parties to request an intervention from the social work service. Usually, people imagine a well-defined performance, which, in their opinion, should resolve or otherwise significantly improve the problem. However, the process assumed by the interested parties is not always the ultimate one. However, in cases with a positive outcome, it is clear that, starting from the first request, a relationship had begun; the relationship had gone beyond the granting or denial of the hypothesized performance but had led to a shared definition of the support project.

> The social worker, who took charge of my situation very effectively, did not find the job for me, but started to see what could be done, then the questions to have my disability pension, all this series of things, in short. And so there a relationship with R. [municipal employee] began... (Disabled, Case conference B).

An extremely significant aspect, which vividly emerges in almost all the descriptions, is the difficulty on the part of those directly involved to recognize that they need help or, in any case, accept support from the outside. People feel humiliated by having to ask for help or feel guilty and view their condition as a «burden» on family members. This has led, in many situations, to reject support proposals or even to deny the presence of hardship, even when the difficulty of the case was evident.

> He did not accept to be medicated at home. We hired a nurse, but while the nurse treated him, he punched her on the head, and then [the nurse] phoned me... (Sister, case conference D).

The acceptance of help is almost always the result of a gradual process, in which the family members and the professionals (the social worker but also other professionals) take some small steps (for example through the provision of a home meal, an intervention for personal hygiene, nursing service, etc.) to share strategies and reflections that, on the one hand, help the dependent person to become aware of help and, on the other hand, help the family member to accept a process in which it is not always possible to «control» everything and in which it is sometimes necessary to make difficult choices.

> [At the beginning] I did not follow [the indications of the professionals]. Instead, later, the social wworker told me things, I did them and I saw that my life was gradually getting better (Disabled, Case conference H).

> The most important moment for me was to understand that I could be helped (Disabled, Case conference D).

## *A tailored care plan beyond performances*

Within this context, the social worker often performs a function that can be defined as «social-care intermediation,» which includes identifying the various necessary services and helping people to decide what to do and to sort things out. The social worker promotes and connects interventions in favour of the family unit (those provided by both the social service and other services, for example medical visits, retirements, the necessary paperwork to obtain specific services, etc.) and connects different people and services. However, from the description that emerges from the interviews, the social worker does not limit himself to following procedures according to a bureaucratic approach. Each «well done» intervention, in fact, starts from a careful reflection on the specific situation; is designed in an individualized way; and is, as much as possible, shared with the user and his family.

In a variety of descriptions, it emerges how the availability of the social worker allowed a positive outcome. This flexibility went sometimes beyond tasks and even beyond working hours. This is because, according to the interviewees, it was necessary not to be blocked by bureaucracy, which could have conditioned the interventions to the point that the social workers might not have responded adequately and promptly to the needs of the people.

> I had to take her to the First Aid for a medical exam and I was there all the time, that is practically twenty-four hours...because she was really sick, that was some time ago. (Social worker, interview 3)

This type of approach is also evident in the descriptions that emerged from the case conferences: for users and family members, help does not correspond only to the provision of services, even if they are considered fundamental. Above all in the initial moment, the prevalent experience of people is that of confusion: the choices to be made are not clear, the relatives feel that they are facing an «enormous, unmanageable» situation alone, and some call themselves «desperate». The intervention of the social worker is configured as to provide support in decoding the situation and in identifying all the possible paths from which the real project will originate. The social worker is referred to as someone who helps to line things up, to set priorities, to understand what processes can be useful, to make their way «in the jungle», to use the words of an interviewee. Even in the following phases, the social worker is a constant support presence: above all, for dependent people who live alone, support in the management of the «bureaucratic» aspects and in relationships with other services, mainly the health services, is crucial.

> The positive thing was that the social worker helped us to understand what was the right path to take, and the negative one was not having been helped first and so wandering in the dark (Nephew, case conference A)

Users and family members describe the social worker as «the face of the service»: the professional figure that allows access to provisions, the one who conveys «practical help». However, alongside what could be defined as «material help» or performance, the importance of finding a different support also emerges: feeling welcomed, accompanied, and supported in the choices and fatigue involved in one's condition.

> N: From the social worker of M. [another territory] I had nothing, absolutely nothing.
> R: But are you talking about services?
> N: Yes, services and then even...from the heart (Niece, Case conference C).

## *The help relationship: trust and cooperation*

The most recurrent term in the description of cases with a positive outcome is «trust». A climate of trust is what, according to social workers, allows people to reveal their difficulties, to feel welcomed and, therefore, to collaborate actively. Trust also allows professionals to gain a deeper insight into the situation and to make long-term assumptions shared with the user and his family. The interviews revealed that the process of building trust is complex, and it is necessary for social workers to be credible and transparent and to put themselves in a position of listening. The initiative to build a relationship of trust starts from the social worker, who feels responsible for the quality of the relationship established with people.

> A bond of trust, surely this is the positive outcome. Confidence in the social work service, despite the interruption of it (Social worker, interview 3).

Trust is not a foregone conclusion: often, social work professionals are faced with the dilemma of respecting the will of the user (who, in many cases, rejects the intervention) and fulfilling their duty to protect a fragile person. The social workers described a work of mediation between different positions taken by the different family members or even by different professionals. Mediation is a long and difficult process, which involves the need to carefully evaluate the risk and protection factors and to consider different aspects, not least the economic one. The social workers believe, however, that this dialogic attitude is essential and, above all, coherent with the professional principle of respect for self-determination.

> Well, today I can say that Paolo, with all his complex situation, is framed by his community, where such a situation could continually make us work in a risk dimension (Social worker, interview 5).

Specifically, from the case conferences, it was clear that the ability to work «in the network» of family and services was the strength of many situations that went well: we use the term «network» to mean the capacity of everyone (families, social workers, volunteers, and other professionals) to gather their resources to achieve a shared goal. Each one contributes, but in the awareness of constituting «a piece» of a larger and bigger picture.

> It's something in which I believe so much. If you build a network, you can deal better with things, make them work (Social worker, Case conference B).

In this collaborative perspective, a fundamental theme emerges, which is that of co-responsibility: in the cases that went well, all the people involved feel equally responsible for the process. The personal and professional commitment, as already highlighted, assumes a strong ethical connotation and the outcome concerns everyone in the same way. In this case, the image of the social worker is fitting: social workers whose cases went well claimed to have worked «in symbiosis» with the family members to face a particularly complex situation.

> *Sister*: In these years she was especially helpful [the social worker].
> *Social Worker*: No, you did a lot.
> *Sister*: Both of us may have worked in symbiosis.
> (Sister and social worker, Case conference D).

## Conclusions

### *Working with multiproblematic situations*

The descriptions collected show that the situations of dependent people who are taken care of by social workers are very complex: these situations are often multiproblematic and require, with increasing frequency, interventions to protect the fragile person. In the collective imagination, social work with children and families is usually described as difficult and linked to protective actions, while work with elders or people with disabilities is usually considered simpler or otherwise connected predominantly to the provision of standardized services, which do not require the social worker to exercise much professional discretion. In contrast, the stories that have been gathered testify to the social workers' ability to carry out evaluations in delicate contexts, in which there are conflicting interests, and it is often necessary to choose which one of the many needs present to address first. It is also necessary to find a balance between the ethical duty to respect people's self-determination and the duty—one should be human before being professional—to act to protect weak people, sometimes even from themselves. In this context, it is not possible to refer to formulas ready for use: The processes are necessarily uncertain and need to be negotiated each time, and the social workers can rely exclusively on their own assessments and on the comparison with the other actors involved.

It should be borne in mind that people do not always want to be involved and do not always engage without difficulty. It has been highlighted how difficult it is, especially for those directly involved, to accept one's own condition of non-self-sufficiency and the consequent help process. There are individual oppositional positions, which have been overcome through dialogue and the construction of interventions in small steps, showing in fact the usefulness of the help. At a broader perspective, these difficulties can be traced back to the aforementioned tendency to *ageism* (Butler, 1969); consequently, aging and disease are considered a negative value, to be postponed as much as possible and to be hidden, even from oneself. Within this context, the professional interventions of social workers, aimed at promoting self-determination and the ability to express an opinion on behalf of older people with disabilities, help significantly to promote inclusion. Even at a micro level, it can be said that whenever the paths of improvement are not imposed from above but are shared, we promote the empowerment of citizens and their ability to be full-fledged interlocutors in the paths of help, which are more effective.

The principles of the *ethic of care* (Tronto, 1993; Lloyd, 2005; Sevenhuijsen, 2013) help us to address the issue of fragility as an element inherent in human beings and to see the coexistence, in everyday life, of experiences in offering help and experiences in which you are helped. Help is, therefore, seen as exchange, mutual support, and reciprocity. The processes described highlight the importance of paying attention to the «intangible» aspects of help: the welcoming attitude, transparency in information, a clear and direct interpersonal relationship, attention to experiences and feelings; these are examples of what people recognize as having often «made the difference».

## *A tailored provision of services*

In almost all the interviews, the importance for families of obtaining provisions and services—what have been called «practical help», such as financial help, home care, and placement in a residential service —was emphasized.

The research clearly points out the *gatekeeping* role played by the social worker, who appears to be only partially autonomous in making decisions about provisions delivery. Although the analysis focused on cases with a positive outcome, critical elements emerged; these elements were linked to the lack of availability of certain services, to the formal restrictions that limit access and to the rigidity of certain official procedures. In a time frame characterized by a restriction in the provision of services, it is essential for social workers to consider how to optimize scarce resources while continuing to guarantee people what they are entitled to. In this context, the social worker's professional intervention assumes different connotations: first of all, it allows social workers to obtain personal social services provisions for their users in a tailored way. An intervention deviates from a simple formal (administrative) control of eligibility criteria, as the social worker performs an extremely complex assessment, which takes into account, on the one hand, the resources of the organization but, on the other, the resources and capabilities of the family. Furthermore, we are not faced with an assessment carried out from the outside and in a static way: the social worker manages the project plan and the evolutionary dimension of the situations in which he himself plays an active role. In other words, the preparation of the intervention plan takes place starting from the requests of the people, thereby integrating the requests with the professional evaluation, with available resources (both of the organization and of other subjects of the territory) and with the opinion of the other professionals involved. The design takes on a temporal dimension and changes according to the changes that have occurred.

The social worker, therefore, does not aprioristically take the side of the citizen as an *advocate*; however, the social worker is the mediator of the demands of people, the needs underlying the requests, the resources available and the procedures for obtaining them. This mediator function places social workers in an intermediate position between their organization and citizens (Evans & Harris, 2004). Social workers are part of their organizations, but they do not identify with them uncritically. It could be said that the social worker assumes, in fact, the role of *case manager* (Payne, 1998), in which he helps people choose between different services from different providers, thereby carrying out a function of care intermediation, which takes into account the power, also from an economic point of view, of families and helps them in the construction of a care plan. Following this logic, we could easily hypothesize situations in which the social worker takes care of supporting people and families in the care organization, even if no provision delivery is fostered by his organization. The ability to integrate different resources and to modulate one's intervention according to individual situations and different moments also prevents people from becoming dependent on the care organization. Becoming dependent on the care organization could happen easily, since, in most cases, those receiving help from care organizations are lonely or have families who are unable to pay or manage a paid private carer.

## *Networking and integration between services*

The social worker is a sort of intermediary who can look «inside» his/her organization, as s/he helps families to choose the most suitable services and to organize the care plan by combining the «private» resources present in each situation with help offered by the organization. However, the social worker's «intermediation» goes further: the position of the social worker is that of one who finds himself in the position of mediating not only between citizens and his own organization but also between citizens and other social or health care services and often between citizens and their local communities (Barnes, 1997). Mediating between citizens and organizations (or services) is a complex and tiring task, although this is not always obvious from the outside. However, mediation is fundamental to building truly effective paths, as all the descriptions collected testify.

Sometimes collaboration, both in action and in reflection, originates quite spontaneously; however, more often, collaboration must be solicited and must involve the social worker, who is thus involved in connecting institutional actors with volunteers, friends, neighbours, and referents of associations. Promoting a shared responsibility and networking undoubtedly implies more time and attention, compared to a plan focused exclusively on the responses provided by the organization. On the other hand, it is very clear that in this way, professional responsibilities are more shared (Folgheraiter, 1994), people are better protected, and interventions are more effective.

In this context, collaboration with health professionals is frequently indicated as a weak link, as health professionals are not so willing to enter into planning that also takes into account social aspects. Often, families say that the social worker's support has been fundamental to helping them in their relationship with health professionals. The issue of health and social care integration is very broad, and the present research has focused on the work of the social worker; therefore, it is not possible to make a detailed contribution. However, from what has been gathered, a possible interpretation emerges: clinical logic, according to the interviewed professionals and according to the families, can and must live alongside social logic, and the health treatment of vulnerable people requires the development of interpersonal relations. In a context where, increasingly, working with dependent people entails the need to protect them from health risks or physical, psychological or economic abuse (Bergeron & Gray, 2013), the most effective paths are those in which one can listen to the point of view of the users and caregivers and treat them with respect and sensitivity. *Caring* (that is, caring for people) is as important as providing them with health care and technical social care, since medical treatment and basic personal care are more effective when a genuine help relationship is provided than when it is not.

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