

# 1 Origins, Influences and Challenges of Contemporary Case Management

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## Chapter objectives

- » Introduce case management as an approach to complex social care shaped by social policy and welfare, which is in turn influenced by economic, political and intellectual ideas.
- » Describe international and Australian antecedents of social welfare—and its allies, social care and case management—in philanthropy and subsequent influences of the biological and social sciences and professions.
- » Outline neo-liberal conservative reforms to Australian social welfare and service arrangements that present challenges for case management systems and practice standards.

## Introduction

Case management as an approach to social care within the welfare system has endured for over a century, with much iteration. Since this book's first edition in 2009, the pace of the Australian Government controversial welfare transformation project—variously described as retrenchment (Mendes, 2008), rationalisation (Fenna, 2004) or renovation (Spies-Butcher, 2014)—has accelerated. The direction of change has international parallels, and, like its counterparts in other countries, has broadly impacted social provisions of income security, health care, education, childcare and social services to vulnerable population groups. Redressing vulnerability of any type is increasingly regarded as the responsibility of individuals rather than society collectively. The preferred social welfare arrangements have shifted from programs and services delivered through a mix of government and government-funded not-for-profit organisations to a mix of government-contracted not-for-profit and for-profit organisations competing for market share of service provision purchased by 'consumers'. This transformation has changed the ethos, site, organisation and practices of social care and its fellow traveller, case management.

This chapter provides a backdrop to the rest of this book, in which the authors reference these reforms in discussing their respective specialisations that collectively address support

to Australia's diverse population groups experiencing frail ageing, child welfare risks, disability, homelessness, mental ill-health affecting themselves or a parent, immigration and refugee resettlement, rehabilitation, youthful anti-social behaviour and unemployment.

This chapter begins with an orientation to the book's focus: case management as a form of social care that addresses complexity, both in people's life circumstances and in social supports. Following are ideologies that underpin the ascendancy and reform of social welfare systems intended to protect vulnerable citizens, and an account of developments in social care and case management. The ending of the chapter is an account of Australia's neo-liberal conservative transformation of social care and critics' concerns about the ability of contemporary service arrangements to address the complex needs and support of people who are assisted by complex case management. These themes recur in contributed chapters and in the opening to each Part of this book.

## SOCIAL CARE AND CASE MANAGEMENT

Our unifying theme is concern for people who are vulnerable due to adversity arising from one or more physical, developmental or social factors. These include those who confront significant limitations in their capacity for independent personal care, and their participation in 'taken for granted' areas of social life, education, employment and recreation. Some confront lifelong dependency, reliance on the care of others and social exclusion. For others, the adversity arises from a disabling or distressing episode from which they will likely recover. Most of us require assistance at some point in our lives and draw on our personal, social and professional resources to address the condition or circumstance and its negative impacts on our daily living and life goals. We draw on the resources and strategies that can help overcome these impacts—an approach to managing our own wellbeing that provides both the rationale and exemplar for our orientation.

Our focus is on case management systems and practices of health and social welfare service providing organisations that assist people's achievement of optimal wellbeing and social participation by facilitating their access to social care. It is a form of care that includes an adroit mix of compassion, support, resources and services directed toward the attainment of personal autonomy, choice and control, and social inclusion. Chapter 2 explores the diversity of meanings attached to the term 'case management', as well as its applications, models and practices; and other chapters address its application in various circumstances where people can be emotionally and practically overwhelmed. That is, those people—and perhaps also significant others in their family and community—who lack the particular experience and information to fully appreciate the nature of their circumstances and its likely impacts, and the ability to identify and access the needed resources.

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For some people, their vulnerability arises from multiple and complex problems that interact to cause disadvantage across multiple personal and social domains. Complexity in their circumstances and support needs is greater for people who are highly dependent due to several physical, developmental or sensory disabilities, and for people confronting multiple sources of disruption and disadvantage. In such complex circumstances, the pursuit of optimal quality of life and life goals requires access to a similarly complex mix of emotional and physical supports, resources and services, the nature and configuration of which might need to change through time. It is this group that most needs the type of encompassing and informed approach offered by good case management—well-designed systems and practices that come into play purposefully at the point where people experiencing adversity, together with their natural personal and social (informal) supports, meet with the formal supports of the health and social service sectors. We know that the two domains—the private domestic sphere and the public service delivery systems—are interconnected (Fine, 2007). This is brought into sharp focus by Andrea Reupert and Darryl Maybery in their Chapter 9 account of research-informed case management support to families where a parent has a mental illness. In Chapter 8, Manohar Pawar’s discussion of mobilising informal supports broadens the scope. Both chapters demonstrate how, by understanding the impact of each sphere on the other, case management can aim to ensure that the experience of interconnectedness contributes to optimal wellbeing.

See Chapters  
8 and 9



At the simplest level, social care has been described as comprising a sequence of exchanges of: (i) *caring about*, in the sense of developing an awareness of the needs of the other; (ii) *taking care of*, by assuming responsibility and planning a response; (iii) *care giving*, or doing the work to meet the care needs; and (iv) *care receiving*, in which the recipient responds. At the end of this process, changes in the situation are noted and new needs identified, which might in turn prompt the recommencement of step (i) (Tronto, cited in Fine, 2007, p. 35). What is distinctive about the case management approach to social care promoted here is the recognition of complexity and the importance of the agency of those in need of care, their family and other supporters. Here ‘care’ is understood to deliberately start from the perspectives, interests, wishes, capacities, fears and desires of the person requiring care, and their immediate ‘others’. It is a relational approach to practice that values people over systems. The social care role of case managers involves added layers of complexity arising from the circumstances they address and the service system within which they practise. These complexities warrant care within a problem-solving model exemplified in Chapter 5, with co-author Christine Randall, in a discussion of case management functions and practices.

See Chapter 5



The following case study, contributed by a case manager, illustrates the multiple and complex nature of many people’s vulnerabilities, and the risks of discrimination and exploitation that can be consequences of dependence and exclusion.

## # Scenario 1.1

### *Phuong's journey to independence and inclusion*

Alice, a social worker in a large metropolitan hospital, was concerned that when Phuong Liu's recovery from severe dehydration and malnutrition enabled her discharge, she might return to live alone in the very circumstances that had led to her hospitalisation. Phuong had no visitors during her eight-day stay, so Alice obtained her consent to contact a social service organisation in her home suburb. On his initial visit to Phuong's home address, Robert, the case manager, was led by the landlord to a dilapidated shed at the rear of the walk-up apartment block he owned. The landlord explained that because Phuong is Vietnamese, with limited English language skills, he assumed control of her income benefits and, after deducting rent, each fortnight provided her a supply of grocery items to last until her next payment. Robert asked Phuong if she would accept alternative temporary accommodation upon discharge from hospital, and allow him to introduce her to Tien Nguyen, a community worker from Vietnam. The resultant three-way collaboration helped Robert gain a fuller understanding of Phuong's circumstances, discuss her wellbeing and encourage her to plan improvements to her lifestyle. The rewards came 18 months later when Phuong described her move into a social housing apartment as 'like a honeymoon', and was assisted by friends made through Tien's introductions to local people with shared language, culture and interests.

#### ***Practice tips***

- Understanding Phuong's adverse circumstances requires consideration of complex factors affecting her daily life, in domains of income, shelter, food and social engagement, and her goals for settling in the community.
- Alice, the hospital social worker, works with a clinical health team with a duty of care to discharge Phuong to a safe environment.
- Robert, the case manager, explores Phuong's future goals and facilitates their achievement using a complex mix of formal services that extend opportunities for informal community support.

From this brief orientation to case management as an approach to social care, this chapter now moves to a discussion of emergent post-industrial state welfare systems and founding ideologies, with particular reference to Australia.

## FORMATIVE DEVELOPMENTS, SOCIAL POLICY AND WELFARE

### Post-industrial social policy

In pre-industrial feudal society, as in many contemporary village communities of economically developing nations, the family is the site of economic security and social care for all members, from birth to periods of dependence in childhood, infirmity and frail age. In contrast, care in contemporary post-industrial nations is not the sole domain of the private domestic sphere. Care is also provided in the public sphere, as market commodities or welfare provisions of the 'social safety net' (Fine, 2007). Global population migration today sees many people (such as Phuong in Scenario 1.1) swap a society where care is typically provided in the private sphere of family and community, for one where care is provided in the public sphere. In Chapter 21 Robin Bowles and co-authors, who practise in the provision of support to refugee survivors of trauma and torture, show that the mismatch between actual care and immigrants' expectations of how care will be forthcoming is compounded by their migration experiences. Indeed, for any Australian in need of health and welfare support, the complex institutional arrangements can be overwhelming.

See Chapter 21



The availability of social care and its structures and approaches are shaped by government social policy and welfare provisions, where *social policy* is 'government action providing benefits to individuals to improve their social and economic competencies, standard of living or access to essential services' and the *welfare state* mechanism for delivering benefits is 'a broad or less comprehensive framework of government policies and programs designed to ensure individuals an acceptable level of economic welfare and access to necessary services as a right of citizenship' (Fenna, 2004, p. 223). In Australia and elsewhere, welfare is a site of economic and political contest. Typically, economic debates focus on the wisdom of redistributive interference in the economy and the amount governments should spend, and political debates focus on whether, what, how and by whom welfare and social care should be provided. The functions of welfare are variously argued as: protecting people against risks (e.g. infirmity, unemployment); reducing poverty (i.e. providing a minimum income floor that prevents social exclusion); balancing life-cycle needs (i.e. drawing on resources from our productivity in times of hardship); and reducing inequality (i.e. vertical redistribution from more to less wealthy) (Fenna, 2004, p. 325).

At the heart of social policy debates in Western capitalist democracies are ideological differences about the desirable relationship between the state, citizens and capital that originated with eighteenth-century industrialisation and the state's 'laissez-faire' role of abstention from intervention in the market economy (Fenna, 2004). Influenced by political economist Adam Smith, the accepted wisdom was that a natural consequence

of individuals operating out of self-interest in a market economy was the advancement of both their own wealth and society's. This *classical liberal individualist* ideology was contested by *reform liberals* (progressives) who, in response to unacceptable levels of rural and urban poverty arising from industrialisation, advocated industrial regulation and social policy as instruments to protect the working class. Progressive views again influenced an increased state role in protecting citizens' welfare after the Great Depression of the early twentieth century (Fenna, 2004). Economist John Maynard Keynes argued that capitalism could not function as a self-regulating economic system and that government intervention was required to maintain living standards for all citizens, including those unable to work due to poor health or old age (1936, cited in Jamrozik, 2005). These ideas echo through subsequent debates between social democratic protagonists of the welfare state and its neo-liberal antagonists; the former promoting its establishment and enhancement, and the latter its limitation. In essence, social democrats favour collective responsibility for social wellbeing, and conservative liberals favour individual responsibility through the free market and families, not the state, to address risk (Jamrozik, 2005). Mark Davis (2014) argues that the term *neo-liberal conservatism* most accurately describes the ideology of contemporary Australian public policy—a pairing of neo-liberal ideas about the economy with conservative political ideas about society.

The international social policy literature provides a chronology of broadly similar developments in Western post-industrial capitalist democratic nations in the role of the state in promoting social wellbeing, though with differences in 'regimes of welfare' (Esping-Anderson, 1999). Continental European nations adopted occupation-linked life-cycle balancing and inequality-correcting social insurance approaches. English-speaking countries, including the United Kingdom, the USA and Australia, focused on protection against risk and poverty reduction through residual provisions that restrict assistance for people not supported by the job market.

The next section turns to the emergence of social care as a form of social welfare, its antecedents in charity, and broadly similar subsequent developments in the United Kingdom, the USA and Australia.

## **Welfare state emergence, expansion and reform**

Late eighteenth-century charitable activities of churches and philanthropists were the precursors to social welfare and care in the United Kingdom, the USA and Australia. Industrialisation promoted large-scale migration to cities—sites of economic production—and free and enforced settlement in colonised countries with desirable resources. In both environments, the lack of adequate sanitation, housing and

transportation resulted in high rates of disease, death, disadvantage and social disorder. Social care began as localised philanthropy dispensed to the ‘deserving poor’. Australian colonial governments increasingly assumed responsibility for the operation of such institutions as hospitals, orphanages, lunatic asylums and prisons (Dickey, 1987), the latter disproportionately capturing Aboriginal and Torres Strait Islander people who suffered from the stress of cultural oppression (Rosen, 2006).

In 1901 the Australian Federation delivered a blueprint for Australia’s welfare state, with national strategies to protect economic growth and productivity. Combined industrial regulation and social policy measures constituted a progressive approach to social protection described as the ‘Australian Settlement’ (Beilharz, cited in Spies-Butcher, 2014). Included were wage protection, a ‘living wage’ sufficient for a working man to support his family, and a ‘social safety net’ under the *Invalid and Old-Age Pension Act 1908*, a distinctive combination described as a ‘wage earners’ welfare state’ (Castles, cited in Fenna, 2004). Distribution of the economically progressive pension was based in conservative principles of *residualism*—only to those deemed *deserving* of assistance; *meagre*—to avoid the moral hazard of undermining motivation; and *stigmatising*—promoting social disapproval of the recipient. Australia’s *mixed economy of care* commenced when family care was supplemented with two government measures: pensions to individuals, and grants to supplement charity funds for the provision of food and accommodation relief to the destitute. Both were distributed according to the ‘less eligibility rule’, public assistance being less attractive than the lowest-paying available work (Fenna, 2004).

In mid-twentieth-century post-Second World War capitalist economies, the state’s role in citizens’ welfare assumed the mantle of public responsibility—an expression of commonly held values about justice and equity, arrived at through democratic processes and controlled by government and the civil service. Progressive and social democratic ideals promoted the welfare state as the foundation of a superior form of society. Political scientist T.H. Marshall proposed new rights of social citizenship and social provisions as their logical outcome, of equal importance to the civil rights of equality before the law, and political rights to free expression (Marshall, cited in Jamrozik, 2005). Social rights became the basis of social policy, and the welfare state became the mechanism through which governments endeavoured to accord citizens equal status, a guaranteed share in society’s wealth and a living aligned with prevailing standards (Fenna, 2004). In 1942, British economist and reformer William Beveridge proposed a social policy program to abolish the ‘Five Giant Evils of Want, Ignorance, Squalor, Disease and Idleness’ that included universal health insurance and income maintenance (Jamrozik, 2005). For welfare state protagonists, this marked the beginning of the post-Second World War ‘golden era’, a descriptor later displaced by ‘retreat and retrenchment’, and, in Australia, ‘a post-welfare society’ (Jamrozik, 2005).

See Chapter 20



See Chapter 6



See Chapter 10



Social policies imported to Australia from the United Kingdom in the eighteenth and nineteenth centuries failed to address unique population groups. Australia's First Peoples were not regarded as citizens; the colonisers having pursued successive hostile extermination and assimilationist policies, with continuing negative social impacts for Australian society. These negative impacts are addressed by Emily Munro-Harrison and her co-authors in Chapter 20, with data evidencing the continued removal of children from parental care, and an Aboriginal community-led response to resultant youth anti-social behaviour. Although successive waves of immigrants provided skills for economic expansion, the 1901 White Australia Policy limited immigration and established institutionalised racism that adversely affected immigrant and First Peoples. This policy ended with the introduction of the Commonwealth *Racial Discrimination Act 1975* under the 1972–75 leadership of Prime Minister Gough Whitlam (National Archives of Australia, 2015). This is the context for Susan Mlcek and Barbara Hill's Chapter 6 contribution on the attitudes essential in order to attain culturally competent practice.

The Whitlam Government introduced social policy reforms and social democratic ideals to 'establish a welfare apparatus which was devoid of class discrimination and could not be stigmatised as providing charitable concessions to the "deserving poor"' (Whitlam, cited in Fenna, 2004, p. 342). The budget included a 'social wage' (Saunders, 1994) of expenditure on universal provisions in education, health, income security, welfare services, housing and community amenities. The ambitious Australian Assistance Plan created partnerships with regional councils and voluntary organisations to govern the delivery of social services regionally, which for a short period provided community-funded alternatives to the institutional care of vulnerable people. The policies were favourable to the community development ethos and practices which, as Alison Wannan convincingly demonstrates in Chapter 10, are an essential partner to effective contemporary case management systems and practices. The Governor-General's controversial dismissal of the Whitlam Government and the subsequent tenure of the conservative Fraser Liberal Government began a retreat from universal measures under the social wage.

The Hawke–Keating Labor Government, like its immediate Labor predecessor, the Whitlam Government, embarked on an ambitious but cautious agenda that sealed its longevity in office, spanning 1983–96. Changed economic conditions saw a close alignment of welfare reforms and economic priorities. Reminiscent of the Australian Settlement described above, labour market and social policy reforms were aligned through an Accord—a compact with labour that exchanged deregulation of the labour market and wage restraint for increased social wage expenditure (Fenna, 2004). Universal private health insurance was reintroduced, and occupational superannuation was introduced as a market-conforming alternative to the age pension. Family allowances, childcare and parental leave provisions

were targeted, residualist and delivered minimum provisions; they were regarded by critics as an abandonment of social democratic ideals. Labour market deregulation, wage suppression and uncertain employment led to increased inequality, a departure from the Keynesian assumption of full employment, and concern about the economic sustainability of welfare (Jamrozik, 2005).

Seemingly neutral descriptors of ‘refurbishment’ (Castles, cited in Fenna, 2004) and ‘renovation’ (Spies-Butcher, 2014) of welfare reform, rather than ‘retrenchment’ or ‘retreat’, are grounded in the invisibility of recent subsidy and taxation-linked payments that have increased the number of people accessing social provisions and the total value of the social wage. Fenna (2004) and Spies-Butcher (2014) observe that internationally and in Australia there are few instances of a government withdrawing from a social provision. Australian reforms have extended provisions to working people and residualised provisions to vulnerable citizens. The traditional ideologies of the two major political parties have converged—the neo-liberal conservative framework ascendant in the last four decades is no longer an exclusive Liberal domain, and the Labor social democratic ideals are less in evidence; this is exemplified by Mendes (2008), who cites the Liberal ‘Work for the Dole’ and the Labor ‘Working Nation’ policies.

Neo-liberal conservative reform strategies affecting social provisions are summarised in Box 1.1.

### Box 1.1

#### Australia’s neo-liberal conservative reform strategies

- › the extension of subsidies and concessions, crucially described as ‘middle-class welfare’; for example, generous untargeted tax concessions on superannuation
- › the selective indexation of income security payments; for example, age pension, not unemployment benefits
- › the tightening of income security eligibility rules; for example, those relating to disabled and young unemployed people
- › compliance for benefit recipients; for example, the transfer of single parents to unemployment benefits; job search and training requirements for all unemployment benefit recipients
- › New Public Management (NPM) strategies reducing investment in government policy and services, and contracting out policy advice and service provision to corporate, for-profit and not-for profit organisations; for example, replacement of Commonwealth Employment Service with private Job Network providers

- › aligned with NPM, the marketisation of social services through government-controlled 'quasi-markets', where not-for-profit and for-profit organisations compete, and service users purchase; for example, shift from program funding to 'fee for service'
- › the individualisation of provisions and location of responsibility and risk with individuals and families; for example, tightening eligibility rules and establishing individualised budgets

Fenna (2004); Spies-Butcher (2014)

Social policy and provisions are no longer based on an assumption of collective responsibility for economic, personal and social risk, and the welfare mix is located in a two-tier system of income-based and residual provisions. So how has the partnership of social care and case management developed?

## DEVELOPMENTS IN SOCIAL CARE AND CASE MANAGEMENT

From a focus on Australian governments' establishment of the mixed welfare economy, in which government, not-for-profit and for-profit organisations contribute to a complex web of services, this section turns to other influences on social care—philanthropy, professions, sciences and bureaucratic organisational forms.

### From philanthropy to professions in social care

Late nineteenth-century colonial nation building and developments in scientific understanding of people both contributed to contemporary expertise in addressing personal and social problems (Dill, 2001). In the USA philanthropic and charitable migrant settlement houses—including Jane Addams' Hull House in Chicago, Henry Street Settlement in New York, University Settlement in Philadelphia and Charity Organization Societies (COS), established in several cities (Weil & Karls, 1985; Dill, 2001)—formed the well-spring from which case management as an approach to social care grew, as well as its associated professions of social work and (to a lesser extent) nursing. Services offered to immigrants included 'visiting nursing, public housing, music schools and art houses for the poor, community-based adult education services, courses for naturalization, and parks and playgrounds' (Hawkins, Veeder & Pearce, 1998, p. 27). Some organisations assumed an advocacy role that advanced egalitarianism and social citizenship through the pursuit of legal protection from exploitation and access to health and social services. The importance of

immigration for economic growth ensured government support through the establishment of social programs and funding. Chapter 7, by Mark Hughes and Jill Wilson, shows the place of advocacy in inclusive community case management and its contemporary nuanced meanings, knowledge base and applications.

See Chapter 7



Other enduring features of case management include gate-keeping of services using eligibility criteria, systematic collection and recording of service user information, and service coordination across disciplines and organisations. Early philanthropic organisations also made explicit the two enduring goals of *effectiveness* or *efficiency*—a continued source of tension in targeting case management program resources (Weil & Karls, 1985). Settlement Houses emphasised service quality and effectiveness with a strongly articulated service user focus. The COS movement, including its Australian counterparts, emphasised service efficiency and service system functioning; its ‘friendly visitors’ providing poor relief to those deemed deserving. Recipient records were maintained by COS to avoid waste, fraud and duplication in resource distribution within and between agencies (Weil & Karls, 1985; Garton, 1990).

Essential to precursors of contemporary case management was knowledge about the wider system of care and active coordination. Mary Richmond developed the first formal precedent, a mix of individualised informal supports and formal services (Dill, 2001). A holistic approach viewed the individual within their social context, recognising that the attainment of sustainable recovery and autonomy necessitates utilising natural resources and supports. Richmond’s focus on second-order relationships between practitioners across organisations and disciplines, aimed to ensure the effectiveness of first-order relationships of practitioners with care recipients.

It is not enough for charities to refrain from saying disagreeable things about each other; it is not enough for them to make commercial contracts, dividing the burdens of investigation and relief ... Real cooperation implies the hearty working together of those who are striving with convictions held in common toward ... the restoration of the recipient ... to a position of independence (Richmond, quoted in Weil & Karls, 1985, p. 6).

At the service system level, importance was placed on knowledge of the objectives, methods and services of other agencies and formal agreements on areas requiring cooperation. At the practice level, case conferences afforded collaborative problem-solving by multidisciplinary and multi-agency specialists (Weil & Karls, 1985), their contemporary importance in complex case management, highlighted here in Chapters 9, 17 and 18 on children’s experiences of parental mental ill-health and risk of harm. The community locus of service provision, the expanding number of services and service-providing organisations,

See Chapters 9,  
17 and 18



and appreciation of the complex causes of disadvantage informed the approach to care of a well-planned and coordinated mix of resources, supports and services.

These endeavours influenced the development of social work and nursing, and their case management approaches. Hawkins et al. (1998) observe similarities between the two professions in their early practice contexts, their care ethos and their championing of social causes, including the women's suffrage movement, though with differences in the development of professional education.

Richmond influenced the early social work curriculum (Dill, 2001)—the first six-week course implemented in 1898 by COS in the USA, leading to over 15 university-sited schools of social work by 1910. In Australia, momentum derived from women's activism and the medical profession's demand for hospital almoners, with Sydney University offering the first degree in 1940 and the national Australian Association of Social Work forming in 1946 (Alston & McKinnon, 2005).

Unique to nursing is the legacy of engagement with civil and international military life by compassionate women who volunteered to care for injured soldiers and families of soldiers who died in war (Hawkins et al., 1998). Nursing education was established after the 1860 publication of Florence Nightingale's *Notes on Nursing*; it was originally sited in hospitals and subsequently also sited in colleges and universities. In Australia, the gradual emergence of accredited courses in Colleges of Advanced Education culminated in a 1984 agreement for the tertiary education sector as the site of registered nurse preparation (Commonwealth of Australia, 2002).

Rehabilitation emerged in the USA as a multidisciplinary specialisation. It originated with the post-First World War federal–state rehabilitation program and was furthered through legislative amendments in 1954 (Roessler & Rubin, 2006). The distinctive nature of rehabilitation case management in contemporary Australia is detailed by Christine Randall and her co-authors in Chapter 16.

See Chapter 16



See Chapter 4



See Chapter 12



The biological and social sciences are a foundation for the professions that provide the knowledge base of how people and society function, of impacts and outcomes of adverse circumstances, and of health and welfare interventions that are more or less effective in redressing negative impacts. Lynelle Osburn's Chapter 4 provides a seamless demonstration of the application of key theories that inform social work practice.

The emergence of case management as a multidisciplinary activity presents systemic and practice challenges in both service provision and education for practice. In Chapter 12, Pat Dorsett elucidates the values, knowledge and skill required for a professional standard of complex case management across disciplines and the availability of pre-entry and continued education for practice in the similarly complex landscape of contemporary vocational and professional education.

## INFLUENCES OF WELFARE STATE REFORM ON SOCIAL CARE CASE MANAGEMENT

While social policy provided the ideological framework for social welfare, approaches of service-providing organisations were informed by scientific knowledge and the professions. Deinstitutionalisation, government responses to demographic ageing, and the conservative liberal transformation of social policy and service provision in the reworked model of the corporatised state all influenced social care and case management approaches.

### From institutional to social care and case management

Consider another case manager's description of a rewarding practice experience.

#### # Scenario 1.2

##### *Joseph's strengths lead to employment*

Victoria, a newly appointed community nurse case manager with New South Wales Health, conducted a home visit to meet Joseph, a young man with severe and multiple disabilities impairing his mobility and speech. Joseph's disabilities were genetic and lifelong, and his life was marked by health complications requiring occasional hospitalisation. His education and work experience were in disability-specific services.

In response to Victoria expressing curiosity about audio-recordings lining his bedroom wall, Joseph, assisted by his parents, told her they were frog calls recorded during regular visits to a national park. Realising Joseph's remarkable hearing acuity, his parents helped him to record, catalogue and store the recordings.

In the course of 12 months of case management assistance focused on Joseph's health and social needs, Victoria noticed a newspaper article about university research that involved compiling a 'frog dictionary'. Pleased to be contacted by the family, the university researcher visited Joseph in his home. Eventually Joseph accepted a position as project research assistant and the family relocated to support him.

#### **Practice tips**

- Community nurse case manager Victoria views Joseph not as a person defined by his disability, but as someone with talents and aspirations—a 'social valorisation' perspective (see below).
- Victoria applies a social-ecological model of health care, complementing family support with access to health care in Joseph's chosen environment. She can facilitate continuity when the family relocates.

Exceptional and serendipitous though it may seem, that Joseph's unique skill and the research opportunity converged to bolster the outcome, this illustrates the community locus of care and the case manager's respect for personal autonomy.

Until the 1970s, the site of care for Australians with high levels of dependence due to physical or cognitive disability, mental illness, frail ageing, or childhood parental neglect or abuse was more likely to be a state-run and/or -funded institution than family and community. The post-Second World War recognition of citizenship rights, and concurrent developments in the biological and social sciences, challenged the acceptance of institutions as the site of care. In the 1970s social rights activists, some in tandem with service user activists, challenged practices of enforced institutional and therapeutic care that constituted rights abuses (e.g. Szasz, 1970; Kittrie, 1974; Crossley & McDonald, 1980). The institutional environment and medical/psychiatric model of care, reliant on diagnostic labels and their treatment, arguably embedded negative behaviours by constraining expectations of a person's social value and potential, and generated internalised and enduring negative self-concepts.

A social model of care emerged from optimism that medical advances could enable people with severe and complex health problems to live safely in the community, and from positive outcomes in rehabilitating veterans with chronic conditions (Gursansky, Harvey & Kennedy, 2003). Professional discourses embraced the 'normalisation' principle of helping people 'establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible' (Wolfensberger, quoted in Fine 2007, p. 78)—a 'social valorisation' approach that defended, enabled or maintained a person's valued social role. People in need of long-term care were offered a mix of community-based services specific to the population group; for instance, mental health or disability. The mix typically included small-group residential accommodation; services specific to the identified need, such as sheltered employment, mobility and transport and day centres; and access to mainstream services.

Case management literature documents the shift from an institutional to a community locus of practice as an imperative for change (Gursansky et al., 2003), with case management the strategic 'glue' that facilitated individuals' access to the increasingly complex service mix. Social work and nursing both contributed and were again closely aligned in their community locus of care and ethos. Weil and Karls (1985) describe case management then as a model of 'service co-ordination' marked by practice innovations of multidisciplinary case conferences, one-stop shops and aggressive service provision to identified multi-problem clients. Systems were focused on organisational goals of reducing excessive and ineffective service system exchanges through written contracts that specified services and timelines, and joint planning between clients and practitioners (Weil & Karls, 1985).

Although enthusiastically embraced by social workers in the USA, in the United Kingdom there were reservations about the shift from a medical to a social model of care (Challis & Hugman, 1993), with scepticism about government preparedness to provide resources needed to support people with high dependence needs in the community.

In Australia, various 1980s reviews of service provision in mental health, disability, child welfare and aged care, undertaken variously by federal and state/territory governments, recommended deinstitutionalisation. That needed resources did not always follow is evidenced by Rosen, commenting on mental health: 'by 1984, virtually 90% of people with severe mental illness in NSW were living in the community, whereas approximately 90% of public mental health staff and funding were retained in hospitals' (2006, p. 83). The shortfall in resources for community mental health continues to be a subject of media reports arising from personal tragedies and evidence of systemic failings. Successive federal–state/territory agreements on resources and standards have informed the evolution of contemporary case management systems; in particular the mix of allied health disciplines of nursing, psychology and social work, and their roles and approaches.

In contrast to mental health, governments committed policy effort and funds toward the implementation of social models of aged care. The convergence of concerns about crises of demographic ageing and economic affordability rendered aged care a site for significant change.

## The transformation of aged care support

'In almost every country, the proportion of people aged over 60 years is growing faster than any other age group, as a result of both longer life expectancy and declining fertility rates' (World Health Organization, 2016). Australia's mean life expectancy has increased from 57 years in 1910, to 82.2 years in 2013 (Australian Institute of Health and Welfare, 2015).

As with disability and mental health, the preferred site of social care has shifted from the public to private spheres of family and home—displacing hospitals and nursing homes, and the accompanying medical model. The ascendant social and ecological health care models together emphasise broader determinants of health; inter-sectorial collaboration; social inequalities; empowering individuals and communities; enabling access to health care; and acknowledging the interactions between health and behaviour, the complex systems involved, and the need for a comprehensive, multifaceted approach at the individual and environmental levels (VicHealth, 2016). Consistent with deinstitutionalisation in other sectors, the development of effective and efficient social-ecological models of aged health care requires increased resources. Community aged care reform was underpinned by government resources in planning and implementing new service arrangements, including case management.

Gursansky et al. observe: 'Community care is the policy area in which case management has the longest history as the specified and primary approach to service delivery' (2003, p. 30). In the 1970s, the USA led the transformation of long-term aged care—the emphasis on home-based services was intended to reduce demand for government-funded nursing home care (Dill, 2001). In the United Kingdom, the pursuit of this model was guided by principles of service comprehensiveness, coordination, access, acceptability, efficiency, effectiveness and accountability. It was introduced through evaluated pilots that generated evidence that in turn informed developments in case management (Challis, 1994). Initial shortfalls in government resourcing of services fuelled professional scepticism. A perception that the objective was economy rather than effective care (Challis & Hugman, 1993) delayed implementation until the *National Health Service and Community Care Act 1990* (UK) eventually named case management the 'cornerstone of high quality care' (Lewis & Glennerster, cited in Gursansky et al., 2003, p. 31).

In Australia, two successive changes in aged care service arrangements saw case management assigned a different role. First, the 1985 Australian Home and Community Care (HACC) program assigned case management a central service coordination role (Challis & Hugman, 1993). In Chapter 15, Carmel Laragy and her co-authors focus on the 2015 model of 'consumer-directed care' that positions case management as a purchasable service type.

The HACC program was established through a commonwealth–state/territory government agreement, with non-government not-for-profit and for-profit organisations competing for contracts to provide particular services that contribute to the mix of in-home aged care. This mix of services included nursing and allied health care, meals and food services, domestic assistance, personal care, home modification and maintenance, transport, respite care, counselling, information and advocacy, and assessment. Determination of eligibility was by Aged Care Assessment Teams (ACAT) connected with hospitals. Case managers in contracted organisations, such as Community Options (COPs) in New South Wales, implemented a 'brokerage' or 'service coordination' model, facilitating the development of an individualised service plan that integrates a mix of services.

Consumer-directed care, while retaining some features of the HACC program, involves a transition to individualised and marketised principles. With service users allocated individual budgets and having the options to self-manage their budget and services, there is room for cautious optimism about the emerging system's ability to deliver the conditions needed for older people, including those with cognitive impairment, to participate at all and/or equitably.

Commenting on the longevity and global adoption of case management, Gursansky et al. note that its adaptability makes it attractive, albeit for different reasons, to 'practitioners,

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consumers, carers, service providers and policy makers' (2003, p. 16). It has, they argue, assumed a 'chameleon-like' quality as a result of its wider uses: 'The second phase of case management has colonised and capitalised on the generally progressive underpinnings of the first (meaning here the applications that linked to the shift to community care) ...' (Gursansky & Kennedy, quoted in Gursansky et al., 2003, p. 15).

The final focus in this chapter is on the transformation of social care and case management systems and practices wrought by neo-liberal conservative strategies, previously summarised in Box 1.1

## NEO-LIBERAL CONSERVATISM AND CASE MANAGEMENT

Within Australia, there are few critics of deinstitutionalised approaches to social care, or even—as posited by Gursansky et al. (2003)—case management *per se*. However, there are many critics of governments' neo-liberal conservative transformation of the nature and arrangements for social care. The bipartisan adoption of neo-liberal conservative policies is implicated, specifically its application of individualism that locates responsibility for risk with individuals and families. This has been achieved through increased emphases on residual provision and service user compliance, together with NPM (McLaughlin, Osborne & Ferlie, 2005) strategies that have structured service provision within a contractualised quasi-market framework. Spies-Butcher observes: 'Social programmes that were once designed to shield citizens from the risk of losing market income can instead expose citizens to the risks of market fluctuations and discipline workers back into the labour market' (2014, p. 86).

### Compliance: the social control and social care balance

A recurrent theme in the following chapters is the practitioner's ethical dilemma of balancing social care and control. This is cogently expressed in Chapter 3 by Wendy Bowles and her co-authors who exemplify it with reference to an individualised system of care that balances carers' duty of care with attainment of personal autonomy. In child protection and welfare, this dilemma is further complicated where the attainment of child safety can conflict with the exercise of parental autonomy. Lynda Campbell and Menka Tsantefski's Chapter 17 show how practitioners can approach this dilemma in striving for effective practice, and in Chapter 18, Elizabeth Fernandez provides a broader account of the competing interests, knowledge base and regulatory frameworks that practitioners must understand and effectively navigate.

See Chapter 3



See Chapters  
17 and 18



Social control and the protection of others inevitably have primacy in the systems and practices of juvenile and adult criminal justice interventions. Here, the social care and case management focuses are ‘criminogenic’ risks—factors in one or more life domains assessed as conducive to criminal behaviour. At the extreme social control end of the spectrum, criminal justice provides a context for the care/control dilemma, an extreme form of assertive case management more widely adopted in support of people experiencing one or more adversities of homelessness, substance abuse or mental ill-health, which share a potential (but not necessary) risk of harm to oneself or others. This comes into sharp focus in Chapter 13, in which Robert Bland and his co-authors provide an overview of the theoretical, policy and practice underpinnings of contemporary mental health case management.

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Considering the contemporary system of support to unemployed people, the conflict between neo-liberal conservative reforms and the social justice, equity and care principles that constitute the foundation of case management are brought into sharp focus. While not presenting a risk to personal or community safety, commencing in the 1980s unemployed people have been subject to a disciplinary model of income and job-seeking support. The system incorporates restricted eligibility for government benefits, stringent work and training conditions, and breach action for non-compliance with conditions and the consequent withdrawal of income support. Case managers with contracted not-for-profit and for-profit Job Network organisations assist with job-seeking and training in a system that also enables organisations to place corporate economic goals foremost, undermining its integrity as a social care mechanism (Bessor & Russell, 2015). This environment facilitates what Catherine McDonald and Louise Coventry described in Chapter 18 of this book’s previous edition as ‘the worst’ that case management can be: ‘It has abandoned any pretence of adherence to the values and objectives in which case management was originally conceived. ... [P]ositive and developmental relationships between the case manager and the unemployed person are actually impossible to create, much less sustain’ (2009, p. 417). They introduced the YP<sup>4</sup> pilot, ‘joined-up case management’—an innovation that strove for the best of what case management could be in supporting hard-to-reach homeless people, with the practitioner–service user relationship foremost. Here, in Chapter 22, Marty Grace and her co-authors report their findings of the pilot YP<sup>4</sup> evaluation. One of few effectiveness and outcome studies, it evidences the value of the primary case management relationship to assist people with complex needs. Together, these contributions mark the imperative for innovation in the development of systems and practice, and evidence of their impacts and outcomes.

See Chapter 22



## Marketisation of social care

The Job Network example of reform is informed by NPM economic and political ideas that, since the 1980s, have transformed the relationship of the state with vulnerable citizens and organisations involved in their care (McLaughlin, Osborne & Ferlie, 2005).

The contraction of government's role in social policy, welfare and service provision—through contracting out service provision to not-for-profit and an increasing number of for-profit organisations—is led by economic and political ideas, rather than knowledge of effective intervention. Government is protected from escalating costs associated with need and service delivery, and also retains control of service provision through competitive tendering, contracting and auditing mechanisms.

Case management operating in Australia's mixed economy of welfare is increasingly led by goals of economy and efficiency, with insufficient attention to effectiveness. The descriptor of the transformed social service sector as a 'quasi-market' means that social services can only mimic the free market because its principles are not in operation (Baldock & Ungerson, cited in Hugman, 1998). In the quasi-market of social services, in contrast to other areas of free market operation, government can determine what will be provided, to whom, at what cost, for what duration and through what mechanism, and consumers lack a voice and real choice (Hirschman, 1970). The transformation in 2010 of disability and aged care services into individualised budgets, while influenced by consumer advocacy and aligned with consumer choice ideology of citizenship, choice and control, will also be implemented using a quasi-market model. This model presents challenges for operationalising principles of social justice, equity and personal autonomy.

Individualised disability support under the National Disability Insurance Scheme (NDIS) is addressed in Chapters 14 by Susan Collings and Michele Wiese and 19 by Leanne Dowse and Michele Wiese. The first of these chapters demonstrates person-centred practice and the second highlights potential risks for eligible service users—including those with cognitive impairment—of slipping through holes of the marketised social safety net. There are parallels between reforms to aged care and disability support systems that allocate individual budgets with assistance of 'support planners', whose efforts contrast with those of complex case management in being truncated in scope, time and professional discretion.

Sceptical about the application of market principles to social policy, the immediate past Governor of the Reserve Bank of Australia, Bernie Fraser, argues:

Markets do certain things well—like allocating resources efficiently—where self-interest is an obvious (and legitimate) driver. But it is not in their make up to afford ordinary people access to quality health and education (for example),

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14 and 19



to clean environments, or to reasonable safety nets if they happen to fall through the cracks. These and other community interests have to be driven largely through progressive government policies (2014, p. xvii).

Subsequent chapters, and particularly those in Part 4, explore social advocates' concerns about contractualisation and marketisation. These include:

- the economic viability of service-providing organisations, particularly where demographic and geographic differences increase the cost of service provision;
- the ability of such organisations to offer services that accord with the range of individual preferences, interagency competition that adversely impacts collaboration essential to addressing complexity of circumstances and supports, reduced practitioner skill, and quality of practice; and
- increased complexity for service users in accessing and maintaining their budgets and service mix in the absence of the relational and practice framework afforded by good case management systems and practices.

The contemporary Australian landscape of social care presents wide-ranging challenges for policy makers, leaders of service-providing organisations, managers, supervisors and practitioners with a commitment to case management principles of social justice and equity that places service user outcomes foremost. Narrowly prescribed service provision, personnel roles and inter-organisational competition are implicated in militating against professional standards. Competition risks undermining quality care by encouraging cost cutting in personnel numbers, qualifications, remuneration and workloads. Contracts that proscribe activities promote a view of practice as discrete tasks and competencies. Skills of analysis, autonomy and discretion—all professional qualities essential to effective intervention involving complex situations and support systems—can become devalued (Dominelli, 1996). The importance of the first-order case manager–service user relationship and second-order inter-disciplinary and inter-organisational relationships can become a casualty of time and outcome performance measures. The time-limited nature of the organisation's contract and the service provided by practitioners cannot accommodate long-term and changing individual care needs. Organisations' accountability to government and uncertainty about future contracts can promote defensive and uncritical approaches to social care, and discourage advocacy (Maddison & Hamilton, 2007). Addressing this organisational and inter-organisational context in Chapter 11, Michael Wearing provides a framework for promoting organisations as sites for deep learning beyond system-wide and organisation-specific procedures—one that attends to the effectiveness of the primary relationship of practitioner and service user.

See Chapter 11



# CONCLUSION

This tour of ideological shifts in social policy and social welfare that have shaped its close allies, social care and case management, provides a context for the contemporary issues and practices discussed in subsequent chapters. While the ascendancy or decline of social democratic or conservative liberal ideas can be traced in time, both are evident in contemporary debates that shape the diverse landscape of social care and case management. It is neither intended nor desirable that this book aspires to be a comprehensive account of the diverse contexts, models and practices of case management.

This chapter introduces the focus on case management that aims to address complexity in adversity and support, principles of personal agency and autonomy, and primacy of the case manager–service user relationship. Evident in antecedents of contemporary case management, these features have been enhanced through progressive policies, and advances in knowledge and technologies. This and the following chapters offer perspectives on the state of play and challenges for operationalising them at the service system and practice levels. The pursuit of effective social care demands that leaders and practitioners adopt a critically constructive lens in exercising judgment about the nature of their contribution.

## *Reflective questions*

- 1 Write down the context in which you aspire to practise and/or have experience. Has your perspective and/or resolve changed as a result of this reading? If so, how? If not, explore the reasons.
- 2 Distinguish the meaning of social policy, social welfare, social care and case management. How are they related?
- 3 Provide an example of the influence of a political, economic and intellectual idea on contemporary Australian social care arrangements.
- 4 List features of case management by philanthropic women. When reading subsequent chapters, refer to this list to identify enduring and new features.

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## ELECTRONIC RESOURCES

ABC TV, *Four Corners*, 'The Jobs Game', 23 February 2015: [www.abc.net.au/4corners/stories/2015/02/23/4183437.htm](http://www.abc.net.au/4corners/stories/2015/02/23/4183437.htm)

Investigative journalists Linton Bessor and Ali Russell report on the Job Network, providing an example of the negative impacts of a system that puts the economic interests of service providers above the needs of service users.

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