



Modernising Social Work and the Ethics of Care

Gabrielle Meagher and Nigel Parton, University of Sydney / University of Huddersfield

Summary

Recent attempts to 'modernise' social work have emphasised the importance of collaboration, partnership, and participation with individual users of services and the wider community. However, technical-rational aspects of managerialism have proved dominant. Managerialist approaches to social service administration and delivery threaten important dimensions of social work; specifically its caring and democratic-transformative dimensions. However, social work theorists have only recently begun to re-engage with ideas of care. We argue that closer attention to feminist debates about the ethics of care can make a significant contribution to not only rehabilitating the ideal of care for social work but also to moving forward the modernisation agenda itself. We develop a feminist critique of managerialism, and argue that the discourse of the ethics of care offers useful ways of framing arguments to counter some damaging impacts of managerial reforms.

Keywords

ethics of care, gender, values in social work, professionalism, managerialism.

Introduction

Recent years have witnessed major change in the organisation of social work and social care services in much of the English-speaking Western world. In England, for example, under the auspices of a New Labour government, reform has been taking place under the rationale of 'modernising' public services (see, for example, Department of Health, 1998). Proponents see the modernisation agenda as countering the inflexibility, inefficiency, and aloofness of both large state bureaucracies and the professionals who play key roles in the delivery of services. Accordingly, 'modernisers' claim that reform will improve collaboration, inclusiveness, and transparency and enhance citizen involvement in decision-making at both the local strategic level and in individual cases. Visions for the future are articulated in the language of community and citizenship, reciprocity and responsibility, justice and fairness, partnership and participation, and—crucially—recognise that state, voluntary, and informal services all contribute significantly to the care and support of individuals and so the health of society more generally. Thus, it seems, some liberatory and radical elements of social work theory and practice have entered the mainstream and received official endorsement.

However, despite their participatory language, modernising governments have implemented their agenda from the top down (Jordan with Jordan 2000) and, in practice, the process of modernisation has furthered the 'managerialisation' of social work and social care. As governments have imposed and refined systems of audit and new operational and administrative procedures, social work practice has become more legalised, and aspirations to 'evidence-based practice' have become pervasive. These developments, which emphasise practitioner accountability to stakeholders other than clients, seem to dominate the nature of what it is to be a social work practitioner, particularly in the public sector. As Stepney has

argued, there seems little doubt that practitioners experience these initiatives as increasing managerial control. Moreover, '[t]he emphasis on technical recording, systematic information gathering, performance indicators, all tend to reinforce mechanistic practice rather than creativity and innovation' (Stepney 2001, 12). Other research explores the tensions between managerialism and the values and practice ideals of social work and social care (see, for example, Carey 2003; Froggett 1996; Langan 2002; McAuley *et al.*; Rogers 2001). New management techniques require social workers to take a more instrumental and impersonal approach to their work, and many perceive that their interaction with service users is little more than labour in the service of economy and efficiency.

In response to these developments, social work theorists have attempted to develop explicitly critical and reflexive perspectives, drawing to varying degrees upon insights from postmodernism (see, for example, Fawcett *et al.* 2000; Fook 2000; Parton 2002; Pease and Fook 1999). Peter Leonard (1997) characterises this work as 'reconstructing the emancipatory project'. Karen Healy (2000, 3; see also Fook 2000) has usefully summarised the emphases of this approach as a commitment to standing alongside oppressed and impoverished populations; the importance of dialogic relations between workers and service users; the significance of social, economic, and political systems in shaping individual experiences and social relationships, including interactions within the practice context; an orientation towards the transformation of processes and structures that perpetuate domination and exploitation, and thus emphasises the importance of social justice and equality.

However, and significantly for our purposes, Healy notes that proponents of critical social work have 'persistently challenged the occupational self image of social work as a *caring* profession by emphasizing the complicity of social workers in the reproduction of the oppressive conditions within the practice context and beyond it' (Healy 2000, 3, our emphasis). Beyond this mention, discussions of care within the critical social work literature have until very recently been remarkable only by their absence, perhaps implying that social work is so tainted by its associations with care that the word should be expunged from both its lexicon and rationale.

In our view this is unfortunate. An *idea(l)* of care been at the core of social work values, theory, and practice since social work's inception, and we argue that rehabilitating the ideal of care can counterbalance pervasive and corrosive managerialisation. Unless care is relocated at the centre of debates, policies, and practices, what makes social work (and social care more generally) distinctive will be lost.

Fortunately, during the early years of the new millennium several texts that underline the importance for social work and social care of engaging seriously with feminist thinking about the 'ethics of care' have been published (see, for example, Banks 2001; Brannen and Moss 2003; Clifford 2002; Froggett 2002; Orme 2002; Parton 2003). In this primarily programmatic paper, we argue that this emerging engagement with the discourse of the ethics of care supports the project of restoring care to the centre of social work in a way that contributes to and builds on important arguments developed within critical social work theory. Specifically, it seems to us that epistemological arguments within the discourse of the ethics of care, together with its more 'politicised' conceptions, can provide an important resource for social work's engagement with the modernisation agenda. Of particular importance is the capacity of the discourse of the ethics of care to offer ways of conceiving and representing the relational dimensions of social work that are obscured by the rational-technical focus of managerialism.

Gender, Managerialism, and the Rationalisation of Social Work

A powerful way of understanding the challenge of managerialism—and the potential contributions of the ethics of care—to the theory and practice of social work is to look through the lens of gender. Governments have pursued the suite of techniques social scientists call ‘managerialism’ in response to the perceived failure of the ideals of rational bureaucracy and professionalism. Yet feminist researchers have argued that both bureaucracy and professionalism are ‘masculine’ ideals (and institutions), because they are organised around characteristic ways of being, doing, and thinking that are culturally associated with masculinity and men, defined in opposition to ways of being, doing, and thinking culturally associated with femininity and women (Davies 1995a and 1995b; Ferguson 1984; Savage and Witz 1992; Yeatman 1990).

There is much room for confusion here. These arguments do not assume ‘essential’ differences between male and female persons that are then reflected directly in the characteristics and populations making up ‘masculine’ and ‘feminine’ institutions. Rather, the arguments draw on feminist analyses of how hierarchical binary oppositions between reason and emotion, justice and care, public and private, economic and social, objective and subjective, doing and being, separation and connection, and so on map onto the opposition of male/masculine and female/feminine, usually valuing the ‘masculine’ term over the ‘feminine’.

Feminists have argued that, as a normative cultural project, masculinity entails separation from others, the creation of a strongly bounded sense of self, and a drive for power, agency, action, and for being a *subject*—making a difference in the world. Femininity, constructed in opposition to masculinity, is culturally associated with connection, interdependence, and passivity. Masculinity is crucially concerned with establishing relations of domination and ensuring their stability and predictability. From this perspective, emotions, enthusiasms, and vulnerabilities are impediments to action in the public domain. These ‘impediments’, however, have not been done away with—rather, they have been confined to the private sphere seen as primarily dominated by women.¹

Both bureaucracy and professionalism have certainly been profoundly important in the (complicated) history of social work; now managerialism is exercising its effects. Feminist critiques of bureaucracy and professionalism that draw on the ideas outlined above can be extended to diagnose the impacts of managerialism on social work.

Religious convictions about the nature of human struggles shaped the development of social work in the latter part of the nineteenth century (Forsythe and Jordan 2002). Religious ideas were increasingly replaced by ideals of professionalism in social work during the twentieth century. The main protagonists aspired to mimic the traditional professions, particularly medicine. But at no time has social work achieved this level of authority, status, or legitimacy; rather, although its organisation differs internationally, the development of social work during much of the twentieth century is better characterised as a ‘bureau-profession’ (Parry and Parry 1979). As models of organisation, decision-making, and practice, professionalism and bureaucracy have both shaped social workers’ capacity to enact care.

¹ For further discussion of how feminists make these arguments, see our later discussion of the ethics of care, the feminist authors we cite on bureaucracy, and Lloyd (1993) and Nelson (1996).

In its ideal typical form, the bureaucratic approach emphasises formality and distance in rational decision-making. The impartiality of the decision, the impersonality of the bureaucrat, and the unequivocal authority of its hierarchy are the defining characteristics of bureaucracy. It is not difficult to see that the ideal typical bureaucracy is a masculine, not the neutral institutional type its advocates assume. Bureaucratisation is the attempt to enact a normative framework that prioritises the atomistic, autonomous, self-contained individual, thereby obscuring, even marginalising, the relational and contextual dimensions of work carried out within organisations.

In apparent contrast, the ideal typical professional appears to have all the flexibility that the rule- and hierarchy-bound bureaucrat lacks. The true professional acts autonomously, refers difficult cases to a more experienced colleague, and is not required to bow to hierarchy as the bureaucrat would be. However, as Celia Davies (1995a; 1995b) has argued, while bureaucratic and professional approaches may seem at first sight diametrically opposed, on closer inspection the professional ideal is similarly gendered masculine. The ideal typical professional is detached, treating each patient or client with a correct professional concern, and impassive in the face of their crises or their pain. Expertise derives from formal training based on rational science. Perhaps most crucially, autonomy is central to traditional concepts of the professional.

Clearly, the ideal types of professional and bureaucratic practice and organisation share much. Both are oriented to control and mastery and to establishing order with abstract decision-making processes. Both rely on hierarchical relations and promote distance from their clienteles. The application of expert knowledge, whether associated with the office of the bureaucrat or the person of the professional, retains a mysterious character and calls forth deference on the part of the client. Both the bureaucrat and the professional are invested with an authority for decision-making as if they inhabit a sovereign court, where their decisions are rarely questioned, and where those on the receiving end are (or should be) grateful.

In practice, social work has never had this kind and level of authority and power. The designation 'bureau-profession' is simply one sign of its failure to achieve full professional status. The nature of social work, particularly its engagement with the most marginalised and deprived members of society, meant that it has found it difficult to fulfilling the characteristics required to fulfil this status. Traditionally, social work has emphasised the importance of the worker-client relationship (see, for example, Biesteck 1961; Trevithick 2003) rarely falling back on a narrowly defined, autonomous approach to its operations. It is not a coincidence that social work—a predominantly female occupation—traditionally emphasised the relational and caring aspects of its work. But this emphasis does not lend itself easily to either a professional or a bureaucratic model.

More recent years have seen an important shift in the trajectory and context of social work's development. The alleged failures and problems of social work became apparent in a series of child abuse tragedies and public inquiries during the 1970s and 1980s (Parton 1985; 1991). These failures and problems prefigured the increasing criticism of most health and welfare professional occupations that emerged in the political and public arenas during the 1990s. Both the bureaucratic and professional approaches to health and welfare which had become so dominant in the post-war period were seen to be wanting. Simultaneously, the welfare state itself came into question, and a new approach to health and welfare emerged, with

managerialism at its centre (Clarke and Newman 1997; Clarke, Gewirtz and McLaughlin 2000; Newman 2001).

While social work theorists responded to these developments with new frameworks such as anti-oppressive and anti-discriminatory practice (Trevithick 2003, 165), governments have sought to remedy the apparent failures of social work with a new governance model: managerialism, also often referred to as the 'new public management' (Horton and Farnham 1999). While the thrust and emphases of policy differ under different political regimes, managerialism has risen to dominance in recent years in most advanced liberal societies in the Western world, particularly North America, the United Kingdom, and Australia.

From the managerialist perspective, professionals and bureaucrats are self-interested and untrustworthy. Both need to be 'managed' by new mechanisms that establish clear lines and criteria of accountability, to restore the integrity of and community trust in public services. Amongst other innovations, managerialist governments have developed and implemented practices designed to monitor, assess, and regulate the performance of both organisations and workers delivering public services, and those in receipt of them. These practices and their supporting ideas aim to promote a cost-conscious performance culture. Concepts—and often practices—of competition between providers and choice for customers have proliferated, as if service provision occurred in a quasi-market.

Proponents claim that these innovations remedy the problems of the old bureaucratic or professionalised approaches. However, importantly for our argument, the social relations managerialism represents and aims to institutionalise have many of the masculine characteristics already discussed. Like the bureaucrat and the professional, the ideal new manager remains distant and controlled. He takes a critical stance towards the arguments presented and the established practices of others, drawing his own conclusions based on designated general decision rules (risk assessment, cost-benefit analysis, and so on), rather than being swayed by sympathy to particular cases. Managerialism seems to celebrate critique, distance, and the ability to make difficult decisions, with no attempt to hide potential conflict in the way professional and bureaucratic approaches might have. The cultural codes of masculinity seem even more explicit and are celebrated in a much more obvious way in a climate driven by concerns about risk, increased globalisation, and the recognition that no one can be seen to fall back on traditional notions of authority. In this context debates about the ethics of care can contribute to understanding some key elements of the current contexts and realities of day-to-day practice, and to help us move beyond them.

Gender and Moral Knowledge: An Overview of the Ethics of Care

In the early 1980s, feminist philosophers and political theorists began to overcome their historical uneasiness about engaging in debates about morality and ethics, to develop an explicitly gender-sensitive approach to moral inquiry. Perhaps the most significant product of feminism's engagement with moral philosophy has been the discourse of the ethics of care. In the ensuing twenty years, debate about the ethics of care has itself burgeoned. Our purpose here is not to provide a detailed exposition of the evolution of the discourse of the ethics of care or to account for the emergence of different strands (for which, see Held, 1995; Sevenhuijsen, 1998). Rather, we aim to set out the shared assumptions and characteristic ways of thinking of proponents of the ethics of care, to highlight some points of contention of particular importance to assessing the usefulness of the ethics of care for the theory and practice of critical social work, and to demonstrate its potential for providing both a

counterweight to the managerialist dominance to current attempts to ‘modernise’ social work and social care in England and elsewhere.

The shared assumptions of the ethics of care are a set of interwoven arguments about the nature of the good in human interactions, and of how moral subjects generate and act on knowledge about the good. First among these shared assumptions of care ethics is what Selma Sevenhuijsen calls a ‘relational ontology’ (2000, 11): the ethics of care places at the centre of moral inquiry the *interdependence* of humans and their responsibilities to each other, rather than individuals and their rights. Second, the ethics of care recognises the equal moral worth of all persons, and holds that their informal and interpersonal relations are an appropriate object and ground of moral deliberation. Third, the ethics of care emphasises caring as moral posture or *disposition*: moral subjects should attend to others with compassion, responding to each person as unique and irreplaceable, and recognising each moral decision as taking place within a specific context. This contrasts with conventional rights-based ethics, in which the aim is to ‘rise above’ personal attachment, to consider right action from the standpoint of a disinterested and disengaged moral actor (Tronto 1993, 9). Fourth, the nurturing at the heart of care ethics requires that caring is also a *process* that fosters the growth of those participating in caring relationships, and their willingness to take on open-ended responsibilities in regard to each other. Significantly, these assumptions reject the masculinist norms of traditional rights-based moral theory, norms shared with the culturally masculine forms of organisation discussed in the previous section.

The emphasis on caring as a disposition and a process has several corollaries. From the perspective of care ethics, certain emotions, particularly empathy and compassion, are not fetters on clear and objective moral judgement, but rather are fundamental to the development of moral understanding itself. Moreover, if a moral subject is to attend to another in their concrete specificity—that is to say, to take into account both the uniqueness of the person, and the complex details of their life situation—moral decision-making will require much more than the application of principles. Feelings, the capacity to recognise ‘the separate consciousness of another making its own sense of the world’ (Ruddick 1984, cited in Walker [1989] 1995, 141), and communication are all required. This adds up to what Margaret Walker calls:

an *alternative moral epistemology*, a very different way of identifying and appreciating the forms of intelligence which define responsible moral action. This view does not imagine our moral understandings congealed into a compact theoretical instrument of impersonal decision for each person, but as deployed in shared processes of discovery, expression, interpretation, and adjustment between persons’ ([1989] 1995, 140, emphasis in original).

Although theorists of the ethics of care agree on these matters of substance and method in moral reasoning, there remain several significant, well-recognised, and related points of contention. These include the way the role of gender, particularly femininity, is conceptualised in different strands of care ethics, the relationship between the ethics of care and traditional justice or rights-based ethical theories, and the extent to which a framework for moral reasoning modelled on personal relationships can address broader social problems of injustice and oppression. It is worth exploring different views on these issues among theorists of care ethics, because different constructions of these aspects of care ethics pose different opportunities and risks for social work.

Some theorists of care ethics such as Nel Noddings ([1984] 1995) construct an avowedly 'feminine' ethic of care in explicit opposition to rights-based ethics. Noddings, Sara Ruddick, Virginia Held, and other influential early contributors to the discourse of the ethics of care were motivated to counter the at best patronising, at worst entirely dismissive way women and the feminine had been treated in conventional ethical inquiry. These thinkers relied heavily on the mother-child relationship as a model for thinking through an alternative model of moral reasoning, placing personal relationships in the private domain at the centre. Nel Noddings, for example, in a web of arguments about gender, human nature, and moral obligation, constructs a naturalistic and expressly anti-rule and anti-political ethics of care. The central role of the mother-child relation, and her observations about gender differences in approaches to moral problems (that is, women's preference for making moral decisions based on contextual information and personal ideals, rather than abstract rules) prompt Noddings to call her ethic of care a 'feminine ethic'. Although she does not 'imply a claim for all women or ... exclude men' ([1984] 1995, 24) from her ethics of care, Noddings does argue that 'there is reason to believe that women are somewhat better equipped for caring than men are' ([1984] 1995, 24). Thus the ethics of care are tied, in her formulation, to femininity and women's experience of the private sphere.

Noddings's account is naturalistic because she links the development of a 'moral imperative' to care to what she sees as an innate 'impulse to act on behalf of the present other' ([1984] 1995, 12). This innate impulse is fostered into the capacity for moral awareness and judgement by a cycle of caring relationships that starts with the natural care a mother gives a child. When we are confronted with someone in need, she argues, the 'memory of our own best moments of caring and being cared for sweeps over us as a feeling—as an "I must"—in response to the plight of the other and our conflicting desire to serve our own interests' ([1984] 1995, 10). However, she continues:

we are not compelled by this impulse. We have a choice; we may accept what we feel, or we may reject it. If we have a strong desire to be moral, we will not reject it, and this strong desire to be moral is derived, reflectively, from the more fundamental and natural desire to be and to remain related ([1984] 1995, 13).

When we are faced with moral decisions about how to act as 'one-caring', Noddings argues that reference to moral principles can be a positive barrier to care; hence our designation 'anti-rule'. Discussing moral conduct by exploring language and reasoning, she contends, takes us

away from an assessment of the concrete events in which we must choose whether and how to behave morally. Indeed we are often led far beyond what we feel and intuitively judge to be right in a search for some simple and absolute guide to moral goodness ([1984] 1995, 22).

We characterise Noddings's approach as anti-political because of the way she constructs the scope and limits of our obligation to care as 'limited and delimited by relation':

We are never free, in the human domain, to abandon our preparedness to care; but, practically, if we are meeting those in our inner circles adequately as ones-caring and receiving those linked to our inner circles by formal chains of

relation, we shall limit the calls upon our obligation quite naturally ([1984] 1995, 15).

Constructing the scope of moral action in this way emphasises the local and contingent, placing a strong imperative on moral agents to engage practically with our fellow human beings in very day-to-day ways. This leads Noddings to express active hostility to institutions ([1984] 1995, 26), and to claim that a child whose mother teaches him moral reasoning well will go out into the world ‘skeptical, vulnerable, courageous, disobedient, and tenderly receptive’ ([1984] 1995, 21).

Other feminist theorists of the ethic of care criticise approaches like Noddings’s, which emphasise the role of natural care and the mother-child relationship, suspect reasoning and rules in moral inquiry, and narrowly circumscribe the limits on the obligation to care to personal relationships. Instead, more recent contributions by Selma Sevenhuijsen (1998; 2000) and Joan Tronto (1993) to the discourse of the ethics of care have emphasised the need to move beyond oppositional thinking (masculine versus feminine, care versus justice, relationship versus rules) in debates about feminist ethics, to ‘denaturalise’ the ethics of care, and to integrate thinking about the ethics of care with political theory and activity on a much broader stage than interpersonal relationships.

Again, the metaphor of a web is useful to capture the key arguments and their relationships. Much that distinguishes the contributions of these theorists ramifies from their position that care is necessarily a *political* as well as a moral concept, such that *power* and *difference* are central. From this perspective, answers to the questions of ‘who cares?’ and ‘whose needs are met?’ go well beyond identifying the dyad of the ‘one-caring’ and the ‘present other in need’. Rather, at the ‘macro’ level of society as whole, and at the ‘micro’ level of interpersonal relationships, the ‘politicised’ approach to the ethics of care explores how the ethics of care both can illuminate problems of power and difference in existing social arrangements (including arrangements for the giving and receiving of care), and can help overcome some of the characteristic problems and dilemmas of care that unequal power engenders.

At the macro level, answers to these questions explore how class, gender, ability and race interact to distribute both the getting and giving of care. Typically, the powerful ‘are more often in a position to receive or demand care than to provide it’, while those with less power often find themselves ‘in situations in which they provide care without much power over the conditions and the means, and often in positions of invisibility and voicelessness’ (Sevenhuijsen 1998, 24).

This recognition also allows these theorists to shed light on the ‘dark side’ of care at the micro level. Tronto highlights two ‘dangers of care’: paternalism/maternalism and parochialism. She describes the first as follows:

Often care-givers have more competence and expertise in meeting the needs of those receiving care. The result is that care-givers may well come to see themselves as more capable of assessing the needs of care-receivers than are the care-receivers themselves.

...Especially when the caregivers' sense of importance, duty, career, etc., are tied to their caring role, we can well imagine the development of relationships of profound inequality (1993, 170).

Parochialism results from care when we see the caring relationships in which we are engaged, and which we know best, as the most important (Tronto 1993, 170). Here Tronto highlights the particular hazard of the use of the mother child relationship as the founding metaphor of the ethics of care. She writes 'A Mother who did not think that *her* child's needs were more important than another child's would seem incompetent', yet if we construct a political ideal on this basis, care 'could quickly become a way to argue that everyone should cultivate one's own garden, and let others take care of themselves, too' (1993, 171).

However, Tronto and Sevenhuijsen argue that a *political* approach to the ethics of care also offers remedies for these problems of care. For example, the relational ontology of the ethics of care exposes the inequality and oppression in the existing social division of caring by highlighting that all humans are dependent on others; yet the distribution of the costs and benefits of care does not adequately reflect need and capacity to give. In a similar vein, the emphasis on what Walker, cited above, called 'shared processes of discovery, expression, interpretation, and adjustment between persons' reflects the democratic impulse of the ethics of care. As Tronto puts it, care

can serve as a political concept to prescribe an ideal for more democratic, more pluralistic politics...in which power is more evenly distributed. ... care can [also] serve as a strategic concept to involve directly the relatively disenfranchised in the political world (1993, 21).

Finally, in addition to linking caring to critiques of current social structures, and to new ways of thinking about negotiating power, privilege, and difference, politicised constructions of the ethics of care do not reject rights and justice as categories of moral and political discourse. Rather, theorists like Tronto and Sevenhuijsen both seek to bring to bear the insights and methods of the ethics of care to reframe justice ethics, and see that care requires rights to be fully realised.

Rethinking Social Work Through the Ethics of Care

Engagement between social work and the ethics of care involves both opportunities and risks for both social workers and service users. In this section, we tease some of these out, to contribute to the emerging debate about the ethics of care and social work.

The ethics of care as opportunity:

1. to recognise and affirm practitioner self-understandings and aspirations, and service-user evaluations of service quality.

One clear benefit social work theorists and practitioners gain from engaging with the ethics of care is recognition of both their practical self-understandings and their intuitions about the impact of managerial reform on their practice. Many social workers recognise their working relationships with service users either in reality or in aspiration in the descriptions of the nature of moral response and action offered in the discourses of the ethics of care. Many also see the strong contrast between the ideals of the ethics of care and the ideals of

managerialism, although they may not put it to themselves in those terms (see, for example, Carey 2003 and Froggett 1996).

That many social work practitioners value care, and perceive that their desire to prioritise it in their practice is not shared by governments is illustrated for us in a recent study comparing practitioners' perceptions of their own and their funding department's priorities in non-government family support services (Meagher and Healy 2003). Meagher and Healy's survey instrument offered experienced family support practitioners a list of eight characteristics from which to choose those they considered to be the three most important characteristics of effective services. The listed characteristics included client, legal, management, and worker orientations. Practitioners ranked first the client-oriented characteristic that 'the service enables clients to achieve their goals' (80 per cent of those surveyed (n=59) included this criterion in their top three). By contrast, practitioners perceived that the funding department's top priority was the legally-oriented characteristic that 'the service complies with legal obligations, such as child protection legislation' (91 per cent of practitioners included this in their list of the department's top three, as they saw it). Whereas 44 per cent of practitioners included the characteristic 'workers are compassionate and caring' among their top three, only five per cent perceived it to be a priority for the department.

Other studies aiming to imagine ideal organisational arrangements for caring work emphasise how professional and other caregivers need room to exercise both their *judgment* and their *emotional commitment* to those they care for (see, for example, Brechin 1998). That service *users* highly value care is confirmed in numerous studies demonstrating the importance of the relationship and the caring approach of the worker to service user experience of social service quality (see, for example, Howe 1993; Beresford and Croft 2001; National Institute for Social Work 2000).

In our view, critical social work theorists could engage with practitioners' self-understanding or aspiration to enter relationships of care with clients via the ethics of care. As an account of decision-making in interpersonal interactions, the ethics of care provides a gender-sensitive, moral ground to concepts of reflective practice, and can develop further existing critical (and psychodynamic) alternatives to rational-technical models in practice theory. Thus, the ethics of care offers social work theory and practice what might be called an 'epistemological' opportunity.

Despite the tendency for theorists in the critical social work tradition to repudiate the idea of care, we believe that key themes in the discourse of the ethics of care strongly resonate with—and amplify/complement—defining characteristics of new approaches to critical social work. In contrast with modernist or structural approaches to critical social work—in which macro-structural processes are both the cause of social distress and conflict, and the object of transformative action (see, for example, Mullaly 1997)—theorists writing in the critical poststructuralist paradigm seek to revalue the local, contextual aspects of social work practice as sites of transformative action. One way these theorists express this aspect of their project is by emphasising the importance of dialogic relations between service providers and workers. The ethics of care can provide a bridge between practitioner self-understandings, client need and aspiration (see de Winter and Noom 2003), and new critical approaches to social work in education and training. In describing interactions as 'shared processes of discovery, expression, interpretation, and adjustment between persons' (Walker [1989] 1995, 140), the ethics of care supports social work's commitment to dialogic relations between social workers

and service users. The ethics of care could enhance social workers' capacity to achieve the goals of those with whom they work by reinforcing the political and moral foundations of existing formal (theoretical) and informal (practitioner self-understandings) social work ideals.

By contrast with critical poststructuralist approaches, relationship-based or psychodynamic practice theories in social work are more accommodating to the language of care and quite explicitly express analogous ideas. Relationship-based approaches, which emphasise 'the importance of the relationship and the quality of the experience we seek to provide' (Trevithick 2003, 163) are currently enjoying a renaissance (see, for example, Howe 1998, Rogers 2001; Sudbury 2002; Trevithick 2003). The ethical underpinnings of this strand of social work theory would be the subject of an entire paper. However, it is worth noting here the resonance between psychodynamic practice ideals and some versions of care ethics. Sudbury, for example, concludes his recent case for attention to the use of relationship in social work practice by saying 'In every piece of work, what matters is the live details of the human contact between worker and user of services [and] the human care and concern ...' (2002, 162). However, this approach pays less attention to broader social relationships such as those expressed in macro-social structures. In our view, political variants of the ethics of care can provide a 'values bridge' between psychodynamic or relationship-based practice ideas and the more socially-oriented critical social work approach.

2. to identify, criticise and reform (masculinist) managerialist institutions and processes.

Social work theorists and practitioners can also use the framework provided by the ethics of care to identify, criticise and propose reforms of managerialist institutions and processes both in their broad expression in social policy and in their more specific manifestations in the way social service organisations are managed. Social policy analysis employing the ethics of care is beginning to appear (see Caputo 2002; Sevenhuijsen 2000, 2003; Williams 2001). Here we offer a more specific example. One of the hallmarks of managerialism is the profusion of instruments for assessing need, assigning services, and monitoring performance. This 'checklist' approach constrains the construction of service users' needs, and can exclude information crucial to adequate needs assessment (Dill 1993, cited in McAuley *et al.* 1999). From the perspective of the ethics of care, managerialist checklists cut across practitioners' capacity to respond to each service user in their concrete specificity, and so to offer high quality services, despite the invocation of 'customer focus' so common in managerial discourse. The ethics of care provides a framework both for arguing for decreasing managerial control of needs assessment and service allocation and evaluation, and for supporting ethical decision-making by practitioners with increased discretion to exercise their judgment and emotional commitment.

Mobilising arguments from the ethics of care can also enhance recognition of the value of social work as both a service discipline and a set of practices. The ethics of care offers a sophisticated framework for including aspects of social work practice and experience that managerial frameworks make difficult to encompass. Because managerialism reduces both the visibility of and the capacity to care, it also makes care more difficult to teach, learn, justify, and develop. By counterbalancing (masculinist) managerial ideas with the (feminist) ethics of care, aspects of care that are being 'squeezed out' of social work practice can become more visible, and so easier to teach, learn, justify, and develop.

The insights of the ethics of care support and articulate social workers' self-understanding as moral agents in caring relationships with service users. As a feminist discourse, the ethics of care provides the conceptual space and a vocabulary for recognising and valuing care absent from rational-technical approaches to knowledge and practice, whether professional, bureaucratic, or managerialist.

Risks of rethinking social work through the ethics of care

1. The 'dark side' of care

However, despite the 'opportunities' described above, it is probably not a coincidence that the notion of care has received little recent attention in social work. As the quotation from Healy (2000) in our introduction illustrated, the critical social work literature comes close to identifying care with oppression, or at least as patronising, paternalist, and marginalising. Historically care has been associated with 'the welfare', being 'looked after', or 'protected', with service users positioned as dependent recipients. Care is also associated with charity for which those on the receiving end should be grateful. More recently, service user activism and social work discourses have emphasised the importance of user involvement, partnership, participation, rights, and, perhaps most significantly, empowerment (Thompson and Thompson, 2001). The contemporary use of the term 'service user' as opposed to 'client' symbolises this change in emphasis. From this perspective, 'care' is associated with a past that social work is trying to 'modernise'. To suggest that social work should look afresh at ideas about care, even in the context of debates about the ethics of care, could be seen as at best naïve and at worst dangerous. Not only might it have the unintended consequence of reinforcing the existing prejudices and problems arising from the cultural and political devaluation of the feminine in a context where caring work is female dominated, but it may deflect attention from what service user movements say they want (see, for example, Beresford and Holden 2000; Beresford and Croft 2001).

Focussing on the disability movement, Fiona Williams (2001) has recently explored some challenging critiques of the ethics of care that focus on the risks from a service user perspective of conceptualising service interactions as care. First, she notes that rejecting care, other theorists argue for alternative concepts such as *empowerment* (particularly where it emphasises *choice* and *control*) and *support*. Second, Williams points out that while the ethics of care emphasises *interdependence* and the *relational*, 'disabled people have argued for the strategic centrality of *independence*, tying it to the practical demand for independent living in which autonomy and control over one's life are key' (2001, 479, emphasis added). Third, she considers the argument that to propose that the mutuality and closeness of family life become the paradigm in social life fails to grasp how the power inherent in *extra-familial* care relationships is not attenuated by the tenderness of intimacy. From this perspective, the ethics of care deflects from the paradigm of equality, and it is *equality*, not care, 'that can both contain the demands for civil rights for disabled people, as well as connect to the struggles of other marginalised groups' (Williams 2001, 479).

These criticisms respond to what Tronto identifies as the 'dark side' of care. However, we agree with Williams (2001) that service user critiques of the ethics of care share more common ground with the views they seem to oppose than may first appear, particularly when the diversity of positions within the ethics of care debate is taken into account. Moreover, Williams identifies a problem with some disability movement theory, which, she argues,

overestimates the extent to which relationships are fixedly structured around domination (by carers) and subordination (of the cared for). As proponents of the ethics of care suggest, 'we can in practice be carers or cared-for in different situations and do not always occupy one single position in this binary' (Williams 2001, 480). Further, both the ethics of care approach, as elaborated by Tronto and Sevenhuijsen, and the empowerment approach, as elaborated by writers like Beresford, operate within an equality paradigm (Williams 2001, 480). As we have argued, in their 'politicised' version, both Tronto and Sevenhuijsen stress the importance of the principles of equality and justice in the development and application of the ethics of care. Care is not simply a micro-moral issue but is necessarily political and is intimately related to wider structural issues concerned with class, gender, ability, and race.

Williams also points out that despite different emphases in their understandings of autonomy/independence, writers from within the disability movement and proponents of the politicised ethics of care both make the important distinction between the inadequate—and we would add masculinist—conceptualisation of autonomy as self-sufficiency, and autonomy/independence as the capacity to have choice and control over one's life (2001, 480). Williams herself argues that proponents of the concept of *interdependence*, which is so central to the ethics of care, need to recognise that recent collective struggles around care place a premium on *independence*. She continues:

it is possible to argue that, in the longer term, disabled peoples' (and older people's and children's) interests would be better served by a society that valued interdependence and acknowledged the vulnerability of all, the more immediate strategy for disabled people is for rights to secure the conditions for independence. The task then becomes less one of arguing against autonomy as a liberal concept than one of redefining the concept of autonomy to fit with a notion of interdependence (Williams 2001, 481).

Finally, Williams explores how the issue of professional versus non-professional paid care for disabled people exposes another risk and opportunity of the ethics of care. Too much emphasis on the quality of the relationship between the carer and the person cared for rather than the carer's training and expertise, and the assumption that *professional* carers are 'inculcated with ... paternalism ... overlaps dangerously with arguments that have kept women workers low paid for generations—that they bring with them skills which are 'natural' and need not be valued' (Williams 2001, 482). Rather than seek the putatively unsullied care of untrained carers, Williams argues that the skills of care (described above as the moral *disposition* advocated in the ethics of care) should be claimed as skills, 'and that the issue is how to develop training so that the knowledge and experience of disabled people and other service users influence work practices' (Williams 2001, 282). From this perspective, the risks of the personalised version of the ethics of care can be avoided by a more politicised approach.

Recent work in the UK by the National Institute for Social Work and Peter Beresford and his colleagues is instructive in this context. As part of the debate on the future of social work in England (NISW 1999; 2000), social work practitioners and people whose primary responsibility was to work with and be in close contact with service users themselves came together to identify what they saw as the characteristics of best practice in social work (Beresford and Croft 2001). There was considerable overlap and consistency in terms of: a holistic approach to social and personal problem solving; a relationship based on respect;

attention to the experience of individuals, groups, and communities and to their expertise, culture, and religion; recognition that the process and the relationship is part of what determines a good outcome for service users; access to independent information on which to think through options and reach decisions; service users retaining as much control as possible over their lives and the choices they make. From this, Peter Beresford argues that 'practice that is emancipatory and liberating needs a value base that is shared between practitioners and people using services. A jointly developed human rights and citizenship framework offers this possibility' (Beresford 2001, 305). We would add that, given the aspirations expressed by participants, the ethics of care also has much to offer.

2. Enacting the ethics of care in managerial institutions

Some might argue that a second risk of promoting the ethics of care among social work theorists and practitioners is simply failure: managerialism is a juggernaut crushing everything in its path, and to promote yet another oppositional discourse is to doom social work practitioners to yet further frustration. Against such pessimism, and writing on incorporating feminist ethics (broadly defined) into aged care case management programs, McAuley *et al.* propose 'five actions that can strike a reasonable balance between the regulatory system paradigm [what we have called managerialism] which is typically employed in social services and the feminist ethical perspective' (1999, 19). McAuley and his colleagues had found (by 'retrospective categorisation') that *both* models had informed the case management pilot programs they had evaluated. However, although both models had informed programs (variously in program design, organisation, and practitioner modes of working), neither had been explained or rationalised. The actions they propose aim to ensure that both the 'regulatory system' and 'feminist ethics' models are identified and explicated from the earliest stages of policy development and planning, and that institutional means to enable ongoing negotiation between the models exist to enable the best balance between them (1999, 19-21).

Significantly, one 'action' McAuley *et al.* identify is that 'administrators must be open to the values of both approaches and should be willing to explore the benefits and problems of current or potential policies arising from either perspective' (1999, 20). If pessimists are right, this 'action' will be the most difficult to achieve because its obverse is precisely the problem social work faces: managerialists are simply not open to the values of other approaches. In our view, despite the force of managerialist rhetoric, it is unlikely that social service organisations do (or can) run on entirely managerialist lines (see Scott 1998), despite their impact in recent years. (Indeed, evidence from studies of social work and social care practice we cited above demonstrate the co-existence of caring and managerial practices in social service organisations.) Like McAuley and his collaborators, we support vigorous, *explicit* debate about values and practices within social service organisations as part of the process of limiting the adverse impacts of managerialist governance.

Conclusion

Debate about the ethics of care has been significantly informed by fundamental criticisms of the individualised liberal ethics of rights (Held 1993). However, it is our view that, in drawing on the politicised variant of the ethics of care, it is not helpful to see approaches based on rights/empowerment in such stark antithesis to those based on care. As Orme (2002) has recently argued, drawing on Gilligan (1995), Jagger (1995) and Hekman (1999), justice and care are logically compatible and indispensable to each other, and that a dialogical approach

challenges binaries not only of the carer/cared for, the public/private, but that between care and justice and rights—as well as that between masculine and feminine approaches to social policy and social work practice. Justice without care becomes a harsh and impersonal justice, while care without justice is inconceivable in the politicised ethics of care we have argued for here.

It is in this spirit that we believe the ethics of care provide a key critical framework for both analysing and moving beyond the current dominance of the managerialist approaches to social work. In doing so not only are we more able to see the central relevance of grappling with care theoretically and practically, but the attempts to ‘modernise’ will themselves have a greater chance to deliver key objectives and principles currently in danger of being lost. The aim to overcome the divide between rationality and the emotions in much moral, political, and epistemological thought can prove productive in the current climate. As we have shown, it proposes a different kind of moral decision-making, in which both a different ‘cognitive attitude’ and a different ‘form of action’ (Sevenhuijsen 1998, 4) underpin different kinds of moral decision-making where experience, relationships, and contexts become central.

We have emphasised arguments and ideas here. We have not laid out a strategy for implementing the ethics of care in social service organisations; we have not seen that as our role. Such things are worked out by interactions between writers (like us), practitioners, and organisations. Challenging managerialist ideas and practices is not easy. Philosopher Rosemary Tong points out that the ethics of care is a virtue ethics: this approach demands something of its advocates and adherents. She concludes her article about the ethics of care for health care practitioners as follows:

Whether healthcare practitioners are up to the twofold task of eliminating the oppressive structures that characterize the contemporary world of medicine and challenging themselves to be caring persons, I do not know for certain. However, I sincerely hope that they are for, in my hours of greatest vulnerability, I will need more than skilled hands. I will also need a *caring* heart. Is this really too much for one human being to ask from another human being in his or her time of greatest need? A moral imposition? Or is it simply what we should expect from each other? A feminist virtue ethics of care provides an demanding answer to this fundamental moral question (1998, 151).

Social work faces a similar fundamental moral question. We look forward to further theoretical and more explicit practical engagement with the ethics of care in social work, as we challenge managerialism.

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Authors' addresses:

Dr Gabrielle Meagher
School of Economics and Political Science
University of Sydney
NSW 2006
Australia
E-mail: G.Meagher@econ.usyd.edu.au
Tel: +61 2 9351 6610
Fax: +61 2 9351 8596

Prof Nigel Parton
Centre for Applied Childhood Studies
University of Huddersfield
Queensgate,
Huddersfield
HD1 3DH
UK
E-mail: n.parton@hud.ac.uk
Tel: +44 (0) 1484 472761

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