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Orientations of professional discretion in the welfare service state

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1 Introduction

If politics is about priorities – 'who gets what, when, how' (Lasswell 1950) – we have to consider not only what the welfare state provides to whom, but also whom it doesn't help and what it avoids doing. This is not as easy a task as it may initially seem. Politics is also about being political; speaking to different constituencies, making conflicting promises, appearing to provide a service or meet a need. We often have to dig below superficially impressive and attractive political claims to understand the real political choice being made in policy decisions.

In this paper, I want to consider the shape of professional discretion in the contemporary welfare state. Welfare services meet needs which have increasingly been characterised as social investments — in young people's potential, the actualisation of employment potential of adults etc. As part of this process, professional discretion has re-emerged as a key strategy as 'personalisation' to tailor and adapt services to individual goals and circumstances in order to realise these goals. However, not all people who need welfare services fit this policy worldview. For instance, users of adult social services, particularly older people, tend to be seen as a cost rather than an investment. While the rhetoric of investment and service often peppers policy documents in social care, it is a thin veneer: scratch the service and underneath are very different expectations of services and the professionals who work within them. Policymakers and senior managers promote the extraction of social and community value from service users and their social networks to support care needs. This underpinning policy logic is reflected in top-down expectation of the discretion afforded to professionals. From the strategic point of view, the role of discretion, I will argue, is to be flexible with policies and procedures; and to lever in community resources and promote individual and family responsibility, filling the gap between grandiose service rhetoric and reduced funds.

Discretion operates in the interplay of freedom to act—having choices about what you can do—and the use of judgement, rather than just acting arbitrarily. Discretion combines these two elements together in a way which leads us to ask not only what the extent or constraints on freedom are, but also what is a reasonable exercise of judgement; what are defensible decisions underpinning the use of freedom (Evans and Hupe in press). In short, what is legitimate discretion? Embedded within the idea of discretion are questions not only about appropriate freedom, but also about its reasonable and legitimate use. These questions are likely to be answered in different ways from particular perspectives — and will be evaluated in different ways from different points of view.

My intention in what follows is to sketch a top-down view of discretion in a particular context: the characterisation by strategic policy-makers and senior managers of the role of discretion within adult social services in England. Top-down perspectives are most readily found in the policy statements and guidance documents issued by policy key actors. A less tangible but equally important source of information about top—down expectation is the day-to-day experience of practitioners. I will draw on both these sources below to draw out the top—down view of professional discretion as entrepreneurial, the moral management of individuals and communities to exploit informal care, and nudging to guide the consumer to make the right choices about care.

2 Adult Social Care

Welfare policies reflect the history and concerns of their wider social and political context. To anchor this discussion about discretion I want to consider it in a particular context: adult social care provision in England. Social care services provide support to adults (eighteen years and older) with physical disabilities, learning difficulties and mental health needs, and 'older people'. Social care is separate from health and social security, and its focus is working with families, groups and communities to support individuals with non-medical care needs, and advocating for service users, carers and communities within the welfare system. Social care also has specific responsibilities for managing risks to and from people with mental health needs, and safeguarding vulnerable adults.

The welfare service state — focusing on prevention, tailored personal service, self-reliance etc. — can be traced back in adult care to at least the early 1990s with the introduction of the NHS and Community Care Act 1990 (NHS&CCA). Hadley and Clough (1996) note that the Act, whose goals were: '... to enhance the independence of people needing care and to centre services on their needs, met with widespread support.' (16) However, as the reforms were implemented, they also note that: 'The government's detailed emphasis on process and output in health and personal social services began to create pressures on organizations to adapt their structures to something much closer to that of the factory, with primacy given to the coordination of the technical task.' (19). Reviewing the progress of the reforms, they note that the underlying logic was budget-led provision: '...the reforms have not altered the basic fact that the/resources available for services are finite and fall far short of potential demand. This inevitably means that in the end only some needs of some users or would-be users can be met[...] As a direct consequence of this, there is a conflict between the duty to be as efficient as possible in helping as many users as they can, and providing choice and quality for a smaller number (Hadley and Clough 1996, p. 186-7).

In 2014 Care Act claimed to sweep away the community care reforms, which were described by the Chief Social Worker (Adults) and others as: '... the 'industrialised' process driven social work of the last decade or so, [in which] success entailed timely completion of an 'objective' assessment of whether or not an individual had eligible needs; and of course, the subsequent specification and supply of the services that would meet any identified eligible needs.' (Gollins, Fox, Walker, Romeo, Thomas & Woodham 2016, p. 11). However, look closely and the Care Act reform looks more like a new iteration of the same neo-liberal ethos — the emphasis on markets and individual responsibility and the demeaning of the role of the state (Springer, Birch and MacLeavy 2016) — underpinning NHS&CCA services of the past twenty-five years. Whether it's called 'community care', 'personalisation' or 'Care Act', social care provision has been driven by financial priorities of cost reduction, making individuals responsible and marketization under cover of the rhetoric of consumer empowerment and responsiveness since the 1990s. The Care Act 2014 reforms share two fundamental assumptions in the 1990 NHS&CC reforms — that public support should be residual and that provision will be budget-led. The Care Act builds on the moves within community care as it transformed into Personalisation to cast individuals as their care managers by giving them budgets to purchase care and manage self-directed support. These developments were brought together under the rubric of 'Personalisation' giving service users: '...maximum choice, control and power over the support services they receive.' (Department of Health 2007, p. 2)

The Care Act reforms not only reflect the substance of the NHS&CC reforms; they also echo the style and rhetoric of implementation. Both were premised on broad-brush criticism of existing services, and future vague promises of user empowerment through choice and responsive services (see, for instance, The Care and Support (Eligibility Criteria) Regulations 2015). The Care Act reforms, like the NHS&CC reforms, also promote a one size fits all strategy for social work — albeit strengths-based approaches in 2014 rather than care management in 1990 — that is driven by a fundamental financial rationing logic. The mismatch between the rhetoric of empowering reforms and the reality of austerity rationing is noted in a recent report from the House of Commons Library(Cromarty 2018, p. 13) which quotes the Local Government Association's observation that: 'The consequences of underfunding include an ever more fragile provider market, growing unmet need, further strain on informal carers, less investment in prevention, continued pressure on an already overstretched care workforce, and a decreased ability of social care to help mitigate demand pressures on the NHS.'

This is the context within which we have to understand the apparently positive presentation of professional discretion and the criticism of top-down bureaucratic control in policy statements introducing the Care Act reforms. The idea of professional discretion as promoted by policymakers and senior managers has a particular and problematic character. The rejection of bureaucratised and rule-bound practice ignores questions of service resourcing. Freeing practitioners from bureaucracy and emphasising discretion can be a strategy to atomise service decision-making and mask scarce resources and inadequate provision (Evans 2010, 2013).

In the rest of this paper I want to look more closely at the forms of professional discretion promoted by strategic actors in the context of the Care Act reforms. Discretion is talked about in more positive terms by policy makers and senior managers, but this doesn't mean it's now social work practice without constraint. Social work still operates within the law and policy guidance, and is directed within organisations by local procedures. Discretion allows flexibility and room for practitioners to negotiate between the tensions in policy, and to have more spaces where they are afforded freedom of movement.

3 Policy Entrepreneurs

In thinking about discretion and negotiating the imprecision and tensions within policy, we are in the territory of street-level bureaucracy. Lipsky (2010) describes discretion as inevitable in conditions of conflicting and contradictory policy, and inadequate resources. Discretion in this pervasive form is seldom formally acknowledged but is tacitly accepted as the lubricant that oils the organisational wheels— bridging the gap between prescriptions and the practicalities of providing some sort of service in constrained circumstances. Social workers — front-line workers and managers in adult social care — looking at their own experience of discretion in practice, for instance, talk about the way in which they are encouraged, informally, to be flexible with policies such as eligibility criteria and local procedures: '... there are so many rules and procedures and everything else that ... you know, no-one's got the memory of an elephant, so everybody's got a whole load that they can't remember. So, there's a sort of ignoring of certain things ... And in a sense, I think that's quite tolerated.' (Evans 2016, p. 609)

The question is what is seen as tolerable by senior managers and policy strategists. The experience of local practitioners suggests that it's discretion that's entrepreneurialism — getting more for less — and that manages to do this and avoid blame for the organisation. The local manager just quoted continued: '… the must-do things is [sic] very much centred around money. Anything that causes a problem around money is a definite no-no! Getting expenditure properly authorised and things like that. Making proper orders and so on. Must-dos will be around doing assessments in a fairly recognisable sort of format, a fairly acceptable way of doing it.' (Evans 2016, p. 609)

In short, practitioners are expected to use their discretion to decide which elements of policy to follow and which to ignore and to carry the risk of criticism for doing this. Policy on paper is the stuff of political credibility and reputation; but making policy work in practice is a messy business involving compromises, balancing tensions and thinking on your feet. But it's also a risky business: vague policy can fudge disagreements and evade difficult issues, but doing policy work on the ground can alienate groups—mistakes can be made and groups alienated, and policy makers and senior managers don't want to associate themselves with these potential problems. Hood, Rothstein and Baldwin (2000) have argued that organisations seek to manage the risk to the organisation if things go wrong by using strategies of blame management. One of these, which is particularly relevant here, is where senior managers step back from the formal responsibility for decision-making, and instead locate responsibility in professional discretion.

An example in the current Care Act reform is the Department of Health and Social Care's approach to the new statutory responsibility for safeguarding. It's a responsibility placed firmly at the front-line: 'People have complex lives and being safe is only one of the things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved. Professionals and other staff should not be advocating 'safety' measures that do not take account of individual well-being...' (Department of Health and Social Care 2018, p. 14.8).

Safeguarding, the government acknowledges, is a field of tensions: of potentially conflicting rights, responsibilities and (positive and negative) risks (and with the overriding concern that spending public money should be avoided). The recognition of these tensions in one way is an acknowledgement of the value of the role of professional discretion in sensitising broad principles to individual circumstance. However, when we look at the situation concerning the expectation of discretion — and the more general aspirations of policy (discussed in the next section) to withhold public services — the role of discretion has a more problematic character: locating blame for difficult decisions in difficult circumstances with individual professionals. In a classic 'Catch 22' situation, practitioners have to cut corners ('red tape') to provide a service; but can't challenge the policy and financial context that forces them to cut, because the courts make decisions on the basis of individual cases, and practitioners know that the policy issue will: '...get lost in a whole load of stuff about someone didn't do this, or they didn't fill in that form properly.' (Evans 2016, p. 610)

4 Extraction of Social Resources

As mentioned above, the focus of adult social care policy in England since 1990 has been couched in the rhetoric of empowerment and user-responsiveness, but it has been driven by a political goal of reducing central government spending '... in a way that would minimise political outcry and not give additional resources to the local authorities themselves. Most of the rest of the policy was for the birds.' (Lewis and Glennerster 1996, p. 8)

Attempts are periodically made to square the circle of cost-cutting and empowerment, focusing on the idea that consumers operating in a market for care are best placed to know what they want, and will seek this most efficiently. In the first decade of the community care reforms, for instance, there was a particular push to 'monetise' care needs and use direct payments to enable service users to buy their care. In the next decade, the idea of individual budgets moved centre stage, and came to underpin the idea of Personalisation, in which consumers can use their care budgets to choose and tailor care to meet their personal needs: 'The time has now come to build on best practice and replace paternalistic, reactive care of variable quality with a mainstream system focused on prevention, early intervention, enablement, and high quality personally tailored services. In the future, we want people to have maximum choice, control and power over the support services they receive.' (Department of Health 2007, p. 2)

However, in practice anti-paternalism is a significantly constrained principle within Personalisation: '... the right to self-determination will be at the heart of a reformed system only constrained by the realities of finite resources and levels of protection, which should be responsible but not risk averse.' (Department of Health 2007, p. 2)

The community — families, friends, neighbours, community groups etc. — has always been the primary provider of care for vulnerable (and in fact all) adults. Few would disagree that professional social workers should support individuals to realise their own goals and draw on their potential and the support of families and communities to enable members to help each other. At times, public authorities have sought to work with communities and support them in their caring role (e.g. Barclay 1982). However, since the 1990s, communities have been recast by policymakers as an alternative to state support, a resource to take the pressure off public spending. Over the past decade this has been accelerated in the wake of political choices in the UK for austerity. The Care Act reforms reflect this ideological assumption and promote it: that independence — a central aspect of well-being — is not being dependent on the state, and that public support should be actively avoided (ref). Public service provision, for instance, is pathologised as undermining independence and personal and community resilience:

Prior to a targeted service response, adult social care needs to make sure that everything is being done to maximise the resilience of the individual across the three resource domains discussed earlier: personal skills and knowledge, the immediate circle of support and links to the immediate community. Only then, after the resilience of the individual has been maximised through a relationship with the social care worker should targeted services be identified. If this order of events is not followed there is a risk that services will be put in place that, at best, may be unnecessary, and at worst, may reduce rather than increase the independence of the person concerned (Gollins et.al 2016, p. 42).

The Care Act reforms not only continue but add a turbo-drive to the idea that the state's role in social care is to extract resources in kind and cash from individuals, families and communities that are in need of care and support, to replace social care funding. Practitioners in this context are being freed from bureaucracy—to do what? Rather like the Munro criticism of overly bureaucratic processes in children and families services and the need for greater professional freedom, the advocacy of discretion is premised on an acceptance of inadequate funding and a leitmotif that it will give rise to greater efficiency (Evans 2013). Discretion — as freedom to act — is constrained by the imposition of a budget-driven logic as the legitimate basis of discretionary judgment. This move is illustrated by the heavy promotion of 'strengths based' and 'asset based' approaches as the right way to do social work by the central government, agencies and supporters, and local authorities (e.g. Social Care Institute for Excellence 2015, Gollins et al 2016, Association of Directors of Adult Social Services 2017).

One local authority (Essex), for instance, has coached staff in undertaking ‘conversations’ that emphasise citizens’ responsibility to organise their own care:

How can I connect you to things that will help you get on with your life – based on assets, strengths and those of your family and neighbourhood? What do you want to do? What can I connect you to?’ ... and... ‘What is a fair personal budget and where do the sources of funding come from? What does a good life look like? How can I help you use your resources to support your chosen life? Who do you want to be involved in good support planning? (quoted in Gollins et. al. 2016, p. 24)

Reviewing the impact of this change, advocates of the approach in Essex explain: ‘Despite all the pressures and challenges, it’s an exciting time! If we can halve the number of people in social care organisations who have ongoing recurring packages of support, doesn’t austerity go away? (quoted in Gollins et. al. 2016, p. 27)

But austerity doesn’t go away. The burden of care is privatised — and who bears the cost? The expectations of care are being exploited and manipulated in the interests of austerity. The role of the state in a society both draws on, and also seeks to influence, the norms of care (who is expected to do what for whom): ‘… the state’s role in either weakening or strengthening existing norms about care.’ (Daly & Lewis2000, p. 285)

Perhaps one of the most concerning things here is the imposition on practice, by policy makers and senior managers, the idea of family, friendship and community support networks as ‘natural’ caring entities — and of public support as risky interventions undermining the natural resilience norms of informal support (Gollins et. al. 2016). This distorted ethic of ‘natural’ caring communities fails to engage with the deeply gendered expectation of caring (Daly & Lewis 2000), and masks the driving financial logic of budget-led provision underpinning the social leverage state, using resources to extract commitments and exploiting social obligations to minimise public provision.

5 Nudging Choice in The Right Direction

Personalisation in social care policy foregrounds consumer sovereignty, and it’s a commitment by the government to give people: ‘...maximum choice, control and power over the support services they receive.’ (Department of Health 2007, p. 2). And behind this is a belief that: ‘If delivered effectively personalised support can be a route to efficient use of resources, offering people a way to identify their own priorities, and co-design and focus the support they need.’ (Department of Health 2008, p. 7) However, as the policy has become a mainstay of provision, the connection between consumer choice and efficient and effective service choices has become less obvious.

The Care Act Guidance (2018: 1.14), for instance, suggests a tension rather than a congruence between choice and making the ‘right’ decisions about care. The Guidance states that individuals are best placed to judge their own well-being and should play a central role in decisions about their care. But there is an equally strong emphasis on the maintenance of independence from public support as a keystone of well-being and a strong concern that individuals should avoid developing care needs, health needs, requiring hospital admission etc. (as well as risks of abuse and neglect). Local authorities, the Guidance adds, should intervene where it can to reduce the level of need or additional needs developing.

Choice, it seems, is a good thing when the right choice is made; but where decisions go awry, they have to be corrected. To understand the logic behind this position – and its implication for understanding the top down view of the right use of discretion—we need to consider the role of Nudge and behavioural insights in public policy in the UK. In 2010 the government set up a Behavioural Insights Team — the Nudge Unit—to provide policy advice on the efficient and effective policy delivery (Johns 2018). The Head of the Civil Service and of the Institute for Government welcomed the unit: '...many of the biggest policy challenges we are now facing...will only be resolved if we are successful in persuading people to change their behaviour, their lifestyles or their existing habits. Fortunately, over the last decade, our understanding of influences on behaviour has increased significantly and this points the way to new approaches and new solutions.' (Cabinet Office and Institute for Government 2010: Foreword)

Nudge draws on behavioural economics and its criticism of classical economic assumptions that consumers are rational decision-makers who know what's best for themselves (Thaler and Sunstein 2008). They argue, after Kahneman and Tversky (see for instance Kahneman 2011), that there are two systems of thinking –fast and intuitive, and slow and reflective. Most decision-making is fast — guided by crude rules of thumb, biased assumptions and distorted thinking. Usually, this intuitive approach is fine, but it's not the right way to make important decisions. These require a slower, more reflective style of thinking to weigh up all the options and identify the most efficient and effective way to pursue one's interest. One approach to this problem would be to make important decisions on people's behalf — leave it to experts and professionals who know best. But, proponents of Nudge argue, this is paternalistic and restricts the choices of the thoughtful (as well as the less thoughtful) decision makers, and it prevents the less thoughtful for having the experience to develop more reflective approaches. Instead, proponents of Nudge argue for what they see as a more proportionate response - nudging people to make the right decisions: 'taking steps to help the least sophisticated people while imposing minimal harm on everyone else.' (Thaler and Sunstein 2008, pp. 72 fn)

In this way Nudge claims to avoid paternalism. It doesn't make decisions for people; instead it makes it easier to make the right choices: 'when people have a hard time predicting how the choices will end up affecting their lives, they have less to gain by numerous options and perhaps even by choosing for themselves. A nudge might be welcome.' (Thaler and Sunstein 2008, p. 76) It provides a structure for decision-making, the choice architecture, which makes the right choices (identified by the slow decision makers) straightforward and easy and 'dis-incentivises' making the wrong decisions by making them more difficult and effortful. Organising options/choices in this way is their role of choice architects — policy makers, professionals etc. — who can nudge service users into making the right decisions.

However, more recent arguments for Nudge-like approaches argue that paternalism is, in fact, inherent in the approach, and that paternalism—including manipulation and deception—can be justified (John 2018). Where possible people should be involved in decision making and made aware that they are being directed to make the right choices for them; but, just as the definition of a 'right' choice is a top-down 'expert' decision, so the 'right' degree of manipulation and transparency should also be a top-down decision, where: ' ...some of the more extreme nudges, which might involve deceiving people or make them think they are doing better than they really are, say in employment search, can be ruled out or modified as a result of ethical scrutiny.' (Johns 2018, p. 120)

The expectation of discretion here is that flexibility and responsiveness will be used to provide gentle guidance and nudges, directing service users to make the 'right' choices — to construct a choice architecture, making it easier for sovereign consumers to rely on their own and their community's resources, and make efficient choices to avoid becoming a burden on public services. Professional freedom is channelled and directed within the choice architecture imposed by policy-makers and senior managers (Cabinet Office and Institute for Government 2010).

6 Conclusion

I've sought to describe the shape of discretion in contemporary adult social work in England from the point of view of policymakers and senior managers in social care. It's a perspective on discretion presented in public policy and guidance and the plethora of government-sponsored advice to practitioners. Despite the rhetoric of change that has accompanied the recent Care Act reforms, the reforms are largely a reiteration of the neoliberal logics that have underpinned social care policy from the 1990s. The Care Act reforms on the surface suggest a benign environment for professional discretion. But, rather like the Munro review of Children and Families social work, discretion, while lauded, is accompanied by quietism about the inadequacy of resources to provide the service public policy claims to offer (Evans 2013). Discretion is accompanied in this context by an assumption that practitioners' discretion not only makes policy work, but is also entrepreneurial and deployed as moral management to extract care and assets from individuals, families and communities, and to nudge and guide service consumer to decide to make the right choices. In short, the logic of this characterisation of discretion is that it is used to avoid the possibility of citizens seeking public support, except in extremis.

This is a depressing picture of professional discretion, but it's only one – albeit a picture that's actively promoted by policymakers and senior managers etc. The profession of social work has the potential to challenge this assault on people and communities often in the greatest need. 'In a bureaucracy, professionals are those employees who receive some significant portion of their incentives from organized groups of fellow practitioners located outside the agency. Thus, the behaviour of a professional in a bureaucracy is not wholly determined by incentives controlled by the agency.' (Wilson 1989, p. 60). Effective challenge depends on the critical articulation of an alternative picture of professional practice in social care that unmasks the budget-driven logic of the reforms, challenges the 'naturalisation' of contentious and moralising assumptions about relationships of care in communities, and questions the idea that professional decision-making should be a clinical area in which expertise is elided with 'relationship' to manipulate people into making the 'right' choices for the social extraction state. And this is another story — an alternative moral economy written in the ethics of practical reasoning (Evans and Hardy 2017).

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