Models of Carers: How Do Social Care Agencies Conceptualise Their Relationship with Informal Carers?

JULIA TWIGG†

ABSTRACT
Carers occupy an ambiguous position within the social care system. Services are predominantly structured around the dependant rather than the carer, and this has important consequences for their delivery and evaluation. Many of the problems that arise in thinking about carer issues relate to confusion over the way the relationship between social care agencies and informal carers should be perceived. The paper outlines three models that provide frames of reference for this relationship: carers as resources; carers as co-workers; and carers as co-clients. The tensions between these are then used to explore the contradictions of policy in this field.

INTRODUCTION
Informal carers pose certain problems to social care agencies that are not simply those of resources or of care management, but that have their roots in difficulties that are more conceptual in character. How should one envisage the relationships between agencies and the informal sector? What obligations do agencies have towards carers? How indeed should one term such individuals or groups: as carers, as the informal sector, as informal networks, or simply as the family? Each of these terms has different connotations and will as a result produce a different structuring of the issues.

These essentially conceptual difficulties underlie much of the confusion of purpose and activity in this area. The relationship between carers and social care agencies is an uncertain, ill defined one, and this in turn underwrites the limited, even primitive, character of much of the evaluative work in this field (Twigg, 1988). In this paper I shall explore the roots of these difficulties in the ambiguous position of carers within the social care system, suggesting that agencies have available to them

† Research Fellow, Social Policy Research Unit, University of York.
three major models or ideal types of their relationship with carers. Having developed, rather schematically, the logical elements within these ideal types, I shall go on to use the tensions between them to explore some of the contradictions of policy.

THE AMBIGUOUS POSITION OF CARERS
There are two ways in which the ambiguous position of carers within the social care system can be expressed. First, carers are on the margins of the social care system. They are in some senses within its remit, part of the subject of its concern and responsibility, and yet are at the same time beyond its remit, part of the taken-for-granted background to provision, the 'out-there' against which agencies act.

The second way in which the ambiguous position of carers can be expressed is in terms of their 'off-centre' character. They—or rather their outcomes—are in a sense only 'by-products' of the care system. They are not its main focus. To this degree therefore they exist 'off centre' to it. Often, indeed, they are the means to an end, and their well-being, or concern for the dependant, or level of activity, form only the intermediate outcomes of the system which is essentially focused elsewhere. Inevitably, then, concern with carer welfare has something of an instrumental quality to it.

Because of these fundamental ambiguities, social care agencies such as social service departments have no single, straightforward model of their relationship with carers. Rather they operate within the context of a series of different models, or rather, frames of reference. Each of these different frames of reference conceptualises the subject differently, and each has different implications for policy and for intervention. Agencies operate in the context of a series of such frames of reference, cutting from one to another according to the demands of the particular situation.

The emphases that will be placed on the different frames of reference will vary according to the organisational context. Here I will largely be concerned with the implications of such models for social service departments. However, much of what I say applies also to health care agencies, to voluntary bodies and to other social care agencies within the social policy world that interact with carers, although each of these will have their own particular emphases. There will also inevitably be variation between different local authorities. A department in one area may, as part of a policy initiative, put greater emphasis on the subjective well-being of carers, as opposed to the requirement to reduce the levels of institutionalisation that may be in the forefront of policy in another area. Despite such policy differences, however, all departments, I would
suggest, relate in some degree to the frames of reference for carers that I shall outline. These frames of reference are common to the culture of the social services.

Lastly, there will be important variation in the emphases between the differing levels of the organisation. Thus the pressures upon and conceptual needs of senior managers will be different from those of front-line practitioners. It is likely, for example, that managers will be more alive to resource aspects while front-line practitioners are more concerned with carer well-being. The political pressures upon publicly accountable authority members will produce different emphases yet again.

THREE MODELS OF CARERS
Turning now to the substance of the relationship of departments to carers, I want to suggest that these cross-cutting frames of reference can, for ease of discussion, be condensed into three principal ones. These are: carers as resources, carers as co-workers and carers as co-clients. These represent three ideal types of orientation of agencies towards carers. As such they are intentionally schematic. I should emphasise at this point that I am not attempting to describe in any adequate way the full complexities of practice or the full range of responses found within departments. Social service departments and other agencies operate within highly political environments: political both in the sense of the internal politics of the organisation and the external politics of welfare provision. As a result models of carers and of the agency's relationship to them are multiple and enmeshed in the even greater complexity of the agency's aims and activities. In suggesting these three models, therefore, I am not attempting to provide what Geertz would describe as Thick Description (Geertz, 1973), but rather, a schematic account based on three ideal types of the relationship of the agencies to informal care. Tracing the logical implications of these ideal types will, I hope, allow us to explore some of the inherent contradictions of social policy in this field.

CARERS AS RESOURCES
The first model is that of carers as resources. Recent work on informal care has reinforced our understanding of how it is the informal sector that is predominantly involved in the support of elderly people. Simple ideas about advanced industrial countries failing to support their elderly have been replaced by a better understanding of the degree to which the old kinship patterns of obligation still operate. Anxieties have been expressed about the consequences of demographic trends, particularly in relation to
the dependency ratio; further anxieties have also been expressed concerning social and cultural changes, particularly in relation to the consequences of divorce and of higher rates of female participation in the labour market (Moroney, 1976; 1986; Wicks, 1982; Rimmer and Wicks, 1983). But the majority of analysts would follow Finch (Finch, 1987) in her estimation of the likely continuance of such patterns of responsibility and caregiving, though, of course, Finch views such a continuance as a far from satisfactory one.

The reality therefore remains that the vast majority of care to frail and dependent people is provided by the informal sector. It represents the 'given', the taken-for-granted reality against which services are structured. This simple fact alone requires that departments and other agencies recognise carers as a major form of resource. But they are a form of resource unlike any other, in two particular ways.

First, formal and informal are here not of equal normative status. Informal is prior to formal. Thus, though there may in theory be substitution between the two forms of provision, on the model of the substitution of different resources in the productive process, such substitution is in fact quite narrowly constrained by normative assumptions that give preference to provision by the informal sector. This is true both within the perceptions of agencies and in the wider social world. It is not the case, for example, when we talk about the mixed economy of welfare that the different forms of provision are of equal status, and there is not, therefore, true substitution between the two forms of care. Informal is in this sense prior. Social care agencies like social services thus operate, with regard to carers, an essentially residualist model in which the agency responds to the deficiencies of the care network.

This residualism is itself constrained, as we shall see when we turn to the two other ideal types, by some of the cross-cutting demands implicit in those other, parallel, models. I am not arguing therefore that agencies are exclusively residualist in their approach. Residualism is, however, a central aspect of agencies' perceptions of carers, and it underpins the ways in which, in this model of carers as resources, the informal sector represents 'the given', the—as it were—'out there' backdrop to formal provision that exists prior to and quite separate from those formal services.

The second sense in which carers as resources are unlike any other form of resource is that they are not subject to the formal laws of supply and demand. They are an essentially uncommandable resource that cannot be created by policy decision, nor can they be turned on or off by patterns
of incentives and disincentives. As has become increasingly clear from recent work on the informal sector, it is long-term social factors, notably kinship, that create the potentiality for informal caregiving. Social and cultural factors, in relation to, for example, employment or women’s expectations, in turn impinge on these, determining the actual pattern and levels of such availability (Abrams, 1977; Abrams and Bulmer, 1985; Bulmer, 1987). These factors, however, operate at the level of society in general. As a result the pattern of the availability of informal carers remains in any extensive sense beyond the influence of agencies. This is despite the rather unrealistic hopes of the Barclay Report and the rosier accounts of some of the exponents of community action (Allen, 1983).

Carers are an uncommandable resource in a second, more micro, way also. Whatever moral influence agencies or the wider policy world may attempt to exert on kin or other potential carers, the decision whether or not to take up caregiving responsibility remains with the individual. It is, furthermore, largely taken off-stage, beyond the influence of formal agencies, though not beyond the influence of other kin. Carer involvement is thus not something which any agency can control or even influence to a marked extent. This is even more the case in regard to the sorts of tasks that particular carers are willing to undertake, to the way in which these tasks are performed, and to the emotional tone which accompanies them. Carers are not subject to supervision or control and they are, therefore, an undirectable as well as an uncommandable resource.

It is in this sense also, as well as in the residualism that we noted earlier, that agencies in conceiving of carers as resources are responding to what is a primary and prior reality, rather than attempting to influence or determine that reality. Our picture of carers as resources is one that thus contains certain constraints.

We turn now to the implications for policy and practice of this model. The central aim of agencies in such a resource frame of reference is care maximisation: the maintenance and perhaps marginal increase of levels of informal support. The central task of such an approach therefore is to understand the nature of the informal sector, to appreciate its character and to understand its structure, both in its potentialities and its limitations. Who does what? What sorts of relationships will bear what sorts of tasks? What are the differences between what friends and neighbours will do to give support, and what only close kin will do? What are the demographic constraints posed in different areas? All these are issues that fall within the context of a resource framework, and all bear on the potentialities of the informal sector.
The resource model places its central focus on the dependant. The informal carers form only a background to these—a vital resource background, of course—but one that is not the primary subject of the agency's concern. Thus although agencies may be concerned to understand the character of this objectively given background, they are not—in this model—concerned with the subjective interests of the carers who make up this background. Concern with carer welfare in this model is therefore marginal, and will be overridden by concern lest services undermine or take over from what is seen as the prior family responsibility. Fears of the substitution by formal inputs for informal care will be predominant, and conflicts of interest between carer and dependant will effectively be ignored.

I should reiterate at this point that I am approaching the issue in a deliberately schematic way. The model I have outlined does not represent the approach taken by any particular agency. It is rather one of the frames of reference in terms of which agencies operate. These frames of reference, as I have already suggested, are held in plurality, and agencies will shift between them according to the pressures of the particular circumstances and the needs of policy in relation to them.

CARERS AS CO-WORKERS
The second ideal type or frame of reference is that of carers as co-workers. Here agencies work in parallel with the informal sector, aiming at a co-operative and enabling role.

The social construction of the term 'carer', and the rapid growth of its use within social service departments and other social care agencies is itself part of this process whereby kin and friendship relations are semi-professionalised and brought within the orbit of the formal system. Carers here become co-workers in the care enterprise.

This approach stands in contrast to the first frame of reference in which the informal sector was seen as providing an object-like and separate background to agency provision. Here, by contrast, the aim is to overcome the separation and to link the two sectors. The dominant image is that of Bayley's metaphor of the 'interweaving' of the two forms of provision (Bayley, 1973).

Essentially more attractive to the liberal instincts of social service and other front line practitioners than the earlier resource model, it is an approach that still raises considerable difficulties. The roots of these lie in the essentially different normative bases that underpin the formal and informal sectors. The formal sector is governed by the classic features of rational-legal authority: it is universalistic in approach, affectively
neutral, and governed by rules of procedure and accountability by which situations are assessed separately from the status or personal characteristics of individuals. It rests on a formal knowledge base, in which professionals are trained, and acquire particular technical skills. The informal sector by contrast is particularistic, marked by strong affect, frequently characterised by long-term reciprocity or by effectively inalienable relationships, and by ascriptive status judgements. Its knowledge base is rooted in daily experience and assumed to be open to all. It is a knowledge of persons and of localities.

It is because of these essential differences that the two systems do not mesh easily or happily together. Abrams, and others, have explored some of the difficulties in this field (Bulmer and Abrams, 1986; Froland, 1981; Bayley, 1982).

Turning again to the implications for policy and practice, the aim of intervention in this co-worker model is a mixed one—certainly to maintain and enable informal care, but in ways that recognise the importance, particularly the instrumental importance, of carer morale.

Good carer morale clearly contributes both to the likelihood that care will continue to be offered, and to the quality of the care that is offered. The co-worker model therefore encompasses the carer’s interest and the carer’s morale within its concerns, but based on what is essentially an instrumental motive. Maintaining high carer morale and involvement thus represents an intermediate outcome on the way to the final outcome of increased welfare for the dependent person.

In unsophisticated versions, conflicts of interest in this model are either ignored, with the assumption (based on some reality) that carers do predominantly want to care for their dependants, or are seen as something that can be collapsed into individual negotiations—perhaps social worker enabled—at the micro level.

CARERS AS CO-CLIENTS
Thirdly, there is the frame of reference that regards carers as co-clients. The definition of the client is itself a problematic one; and within social services at least ‘the client’ remains an essentially contestable concept. This is illustrated, more generally, in some of the debates concerning the status and treatment of elderly people in the care system. In the medical sphere ‘patients’ can be defined—at least in the formal model—as people with medical needs or people in the context of their medical needs. In the area of social care, however, the definitions are much more problematic. ‘Social care’ lacks the boundary keeping that elite medical knowledge and professional groupings provide. As a result, social work definitions
remain disputed, open to social and political scrutiny, criticism and redefinition.

This general quality of social care definitions applies particularly strongly to questions of the conceptualisation of carers, and the appropriateness of the application of the term 'client' to carers. For here departments are beyond the normal, essentially substantive, definition of their remit, and involved in areas that merge imperceptibly into general social life and its responsibilities. To regard carers as co-clients, therefore, threatens, on the one side, an imperialistic take-over of what are normal processes of life; and on the other, a swamping of the social care system with 'ordinary misery'.

Parallels with child care work where the family may be taken as the focus of the welfare intervention, though more useful in the context of the carers of disabled or mentally handicapped children, from which much of the carer literature derives, are less helpful in the context of carers of adults where the normative assumptions concerning the relationships are essentially different. In child care cases, parents have rights over the child, rights to the child and responsibilities for the child, all of which are relatively well-defined and assumed. By contrast, in the case of disabled adults and elderly people, even where highly dependent, they retain the moral status of adults. Their relationship with their carers is by its nature more voluntaristic and open to negotiation. This voluntarism is both a fact of social life, and a moral principle that agencies recognise in their own dealings with the carers of adults. It also compromises the degree to which the family as a whole, in the case of adults, can be taken as the unit of intervention.

The major exception to this relates to spouse-carers, who form a distinctive sub-group of carers. Here the normative ties of obligation are more clearly defined and are stronger. In the case of elderly couples, the age and possible disability of the spouse carer means that they are often defined as a form of co-client. With younger, fitter spouses, the definitions are less clear, and the carer is more likely to be perceived as a resource or 'co-worker'.

The general criteria whereby carers do or do not become defined as clients are complex. In practice, the usage tends to be focused on the 'heavy end' of caregiving and on the most heavily stressed individuals. Even here, however, their status as clients is never a fully equal one, and carers remain at best secondary clients rather than fully co-clients.

The aim of intervention in terms of this framework is the relief of carer strain; the concept of strain is sometimes here reinterpreted in terms of a medical model of stress. This operates as a means of legitimating the
Models of Carers

definition of the carer as client or patient and thus of policing the boundaries of normal life referred to earlier. This is the frame of reference, of course, in which conflicts of interest between carer and dependant are fully recognised.

The Relationship of Formal and Informal

We have thus moved, rather schematically, between three frames of reference. In these frames of reference the relationship between the formal and informal shifts. In the first—the model of carers as resources—the informal sector provides the objective background to provision. It represents the given against which agencies act, and against which they structure their services. It is a frame of reference that has a neutral quality to it. Agencies relate to the informal sector as an object-like reality. They read the situation, and act in its context. Their primary concern is to understand the nature of the phenomenon, but they have essentially no obligation towards it.

In the second model—that of carers as co-workers—the informal sector has, as it were, moved over from its object-like and separate status into that where there is a slightly uneasy intermingling between the formal and informal sectors. Here the world of informal care is still something separate from that of formal provision, but it has become the object of social service support. Agencies here no longer simply aim to observe and understand a phenomenon, but relate more actively to it, enabling, encouraging and supporting carers, but in an essentially co-opting and instrumental way.

Lastly, in the third frame of reference—that of carers as co-clients—the informal sector has moved over into the ambit of agencies, and carers have become fully integrated into the concerns of agencies. With this they become the subject of obligation for the agency, which can no longer simply regard them as resources to be exploited or workers to be co-opted, but has to recognise a different and essentially obligatory relationship.

The Definition of Carers

I have in this paper deliberately used both the terms 'informal care' and 'carers', although they have, of course, different emphases and significance. This is because the definition of the subject is itself prone to shifting emphases according to the particular frame of reference in operation. Thus a perception of carers as resources or as co-workers requires agencies to recognise the potentialities of the informal sector as widely as possible, attempting to work with and co-opt all potential
sources of informal support. Here the definition of 'carer' is drawn very wide, and indeed is merged into concepts of the 'informal sector' or—more politically—'the caring capacity of the community'.

By contrast, where the emphasis is on carers as co-clients, a quite different and much narrower definition is employed. Here the emphasis is no longer on fluidity or the interpenetration of formal and informal sectors, but upon boundary keeping and on the close definition of a limited set of heavily burdened carers.

THE CONTRADICTIONS OF POLICY
I want to turn briefly now to the ways in which these different models of the relationship between carers and agencies expose some the contradictions within policy. I should emphasise here that in talking about contradictions, I am not implying any easy criticism of policymakers. The contradictions I shall refer to are inherent ones, implicit within the structure of the various relationships and the demands placed upon them, and there is no simple resolution to these tensions.

The first form of tension is that between prevention and substitution. Agencies often express a wish to act preventatively to support carers, providing services that will ease their lot and strengthen their involvement. But at the same time anxieties are expressed that such services will substitute for informal care and will encourage people to do less for their dependants. This latter fear has been strengthened by the recent criticisms of the New Right with their emphasis on family obligation and the need not to undermine this by incentive systems that 'encourage' people to substitute welfare provision for their own activities. Concrete evidence to support the existence of such patterns of trade-offs is, however, notably absent. Nonetheless, this tension between supporting and substituting relates in many ways to the distinction made earlier between regarding carers as co-workers, in some way co-operatively involved in the care enterprise, and regarding them as resources whose levels of activity must not be undermined.

It is certainly a familiar criticism expressed by many carers that if they appear to be managing, they get praise from practitioners, but no practical help to support the continuance of that managing. The system appears therefore to 'reward' failure rather than success. Services in this view come too late and are focused too narrowly on situations that are already near to collapse. This is an argument put forward by Fennell et al. (1981) in their evaluation of day care, where they question the appropriateness in certain cases of using the service to shore up situations, often at considerable cost to the carer, that are essentially on
the edge of breakdown. Such action, they argue, merely prolongs an intolerable situation. Gilleard et al. (1984) make a similar point in relation to the intervention of a psychogeriatric day hospital.

This brings us to a slightly different aspect of the same problem of acting preventatively. The emphasis in service provision on those near to collapse is one of the consequences of taking passage into residential care as a crucial service indicator. The relatively high cost of residential care, its general unpopularity as a form of support and its clear and objective character as an event all contribute to making it a particularly widely used service indicator. But such potential residential care cases are by definition those on the borderline, close to collapse. A policy targeted on them is therefore open to the criticisms voiced above concerning the inappropriateness and almost, in the case of certain carers, the cruelty of focusing resources on shoring up such essentially unstable situations.

The consequences, by contrast, of focusing on 'successful' care situations is to place resources where there may not be the greatest immediate need. It can mean in effect abandoning certain very stressed situations as beyond 'real' relief and essentially unstable in their character. Where the situation concerns an elderly person alone, this harsh decision does occur and does indeed often result in institutionalisation. Social service departments and health care agencies do effectively determine the point at which they will not support a person in the community, though such support might theoretically be possible. Though it is a resource-based decision it tends to remain hidden behind practice considerations. Where informal carers are involved, however, the ramifications are in a sense less clear. A failure or refusal by agencies to support at these levels of pressure, because once again they are deemed to be situations unstable in their character and beyond 'real' relief, may indeed result in care breakdown, but it may more simply result in the redoubling of stress for the carer, for some period at least. There is a genuine tension, therefore, and one that has difficult ethical consequences in relation to carers, between focusing on preventative support or on marginal situations.

The second major form of contradiction concerns the tension between supporting carers so as to ensure the continuance of caregiving and supporting carers to increase their well-being. This is the major tension that runs through policy in relation to carers, and it underlies the subsequent areas of contradiction that I shall refer to below.

It tends to be assumed in a general, rather liberal, way that supporting carers so as to ensure the continuance of caregiving and supporting carers to increase their well-being go together, whereas they are, in fact,
analytically quite separate. They represent essentially the difference between a focus on carers as co-workers and carers as clients. In the latter models carers have outcomes per se and their morale is one of the final ends of the system. In the former, carer outcomes are only intermediate outcomes, part of the means to the end of client satisfaction and care, which are regarded as the final outcomes.

That there are clear conflicts of interest between carers and their dependants that put at odds the aims of maintaining care and increasing carer well-being, has been well demonstrated. Just how stark these conflicts of interest can be has been explored by, among others, Levin in her study of the supporters of elderly mentally infirm people. She found that the single greatest improvement in the mental health of such supporters came from the death or institutionalisation of their dependant (Levin et al., 1983). This is not to say, of course, that these supporters would necessarily have wished for such an institutionalisation. This point raises yet another complexity, which is the difference between people's wishes—and quite genuine wishes, not simply those they express publicly—and the consequences of situations for their well-being. People can and do choose to continue to do things that cause them considerable distress. Concentrating on the reduction of carer stress in isolation from wishes and values is therefore not effective.

This leads us to the third form of contradiction which relates to an issue of targeting. Should services be targeted on the most highly stressed carers or on those most liable to withdraw caregiving? As a number of studies have indicated, there is a relationship between stress and the likelihood of the withdrawal of the carer, but the relationship is not an exact one. Deciding that caregiving is more than one is able, or wishes, to manage can clearly occur at a number of levels of involvement. It may indeed be that the most crucial of such breaking points occur at the early stages, when few, or more likely no, service providers are involved. A policy targeted on the prevention of the marginal erosion of care may therefore find itself focusing resources on some very lightly burdened, and relatively unstressed carers, who are yet at this turning point.

There is, furthermore, some evidence from studies suggesting that male carers abandon caregiving at lower levels of both objective burden and subjectively experienced stress than do female carers (Levin et al., 1983; Wright, 1986). If this is indeed the case, a policy targeted on those on the margins will once again be predominantly focused on the less heavily burdened. It will, furthermore, raise major issues of equity and gender discrimination.

This brings us to a fourth area of tension which concerns the problems
of generalisability. This is in a sense an extension of the previous issue concerning the aims of targeting.

If an agency targets on particular marginal situations, how can it explain the apparent breaches of equity involved in not providing help to other individuals who appear in terms of activity, burden, responsibility, even stress, to be in a similar situation? How can a public agency say that family X, who appear to be threatening to withdraw support, are to get services, but not family Y, who are in the same objective circumstances, but not expressing such a likelihood? What is the role in this, moreover, of ‘manipulation’ of the situation by the carer? How does one deal with the differential ability of different social groups to work the system?

There are parallels in this issue of generalisability with the problem of the costs of community care. Transferring people from institutions into the community appeared to be, if not cheaper, at least a comparable level of cost. But this is to a large extent a product of the inadequate provision of current services in the community whereby large numbers of comparably frail people receive little or no support. We cannot assume therefore that community care as a whole will be a cheaper or cost comparable option, since the implications of extending to all frail people currently living in the community, the levels of services that it is suggested are required for the support of those being deinstitutionalised, are very great indeed. So too, one can argue, would be the costs if one were to extend to all carers in the relevant category, the levels of support that have been suggested as a means to prevent breakdown in certain cases. Focusing on a particular outcome—deinstitutionalisation in the case of community care, or, here, the prevention of the marginal erosion of caregiving—can raise serious problems for a policy that has in fact much wider ramifications within social care generally.

CONCLUSIONS

In this paper I have tried to draw out some of the tensions in policy that relate to informal care. These, as I have suggested, have their roots in essentially conceptual problems, and they relate in major part to the ambiguous position occupied by carers within the social care system. As a result there is no single model of the relationship between agencies and informal carers; rather, a series of models or frames of reference are in operation. Concentrating on three of these—carers as resources, co-workers, co-clients—enables us to draw out in a schematic way some of the elements that underlie the current contradictions of policy in this field.
REFERENCES
