Social Work in Health Care

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wshc20

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Available online: 12 Dec 2008

To cite this article: Glen E. Randall PhD & Darlene H. Kindiak BSWMSWRSWMA (2008): Deprofessionalization or Postprofessionalization? Reflections on the State of Social Work as a Profession, Social Work in Health Care, 47:4, 341-354

To link to this article: http://dx.doi.org/10.1080/00981380802173855

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Deprofessionalization or Postprofessionalization? Reflections on the State of Social Work as a Profession

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ABSTRACT. Recent literature considering the state of the social work profession has primarily focused on concerns about deprofessionalization. This article provides an overview of the literature on professionalization and professional decline in order to situate the social work profession within a broader context. The article then describes the emergence of a new role for social workers in Canada that crosses the boundaries between clinical, managerial, and legal aspects of client care in the area of mental health forensics. It is argued that the future of social work’s professionalization project around the world may not be as bleak as has been portrayed in the literature.

KEYWORDS. Professionalization, mental health forensics, health human resources, Canada

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INTRODUCTION

Although most occupational groups strive to attain professional status, the journey for social work has been longer than many. This may have been made more difficult by a gender bias (Lyons & Taylor, 2004) or the complexity of social work’s duel objectives of attending to individual distress while challenging the social inequities in which they are rooted (Morales & Sheafor, 1977). In either case, over a long history, social work in most developed countries has achieved many of the traditional milestones that provide evidence of professional status (Barnes & Hugman, 2002). However, despite impressive achievements in the social work field, in recent years the bulk of literature considering social work’s professionalization project across developed countries has been focused on problems within the field and concerns of professional decline (Heally & Meagher, 2004; Orme, 2001; Dominelli & Hoogveldt, 1996).

This article seeks to challenge this generally pessimistic portrayal of the future of the social work profession that has been prevalent in the recent literature. The article begins with a brief overview of the literature on professionalization and professional decline in order to situate the social work profession and the status of its professional project within a broader context. The article then describes the emergence of a new role for social workers in Canada that crosses the boundaries between clinical, managerial, and legal aspects of client care in the area of mental health forensics. It is argued that the emergence of this new role is only one of many examples that social work has reached the point of postprofessionalization. The article concludes with a discussion of the future of social work as a profession.

PROFESSIONALIZATION

Numerous authors have described the process of occupational groups attempting to attain professional status in the literature. Some of the earliest writings on this topic argued that an occupational group becomes a profession when it demonstrates an overriding and altruistic interest in serving the public (Carr-Saunders & Wilson, 1933; Marshall, 1939; Parsons, 1939). Other researchers have expanded on these public service criteria and include the existence of key professional traits. Such traits may include: abiding by a profession specific code of ethics; attaining prestige in a community; earning a high income; and meeting strict educational
standards (Goode, 1969). However, this focus on traits is somewhat tautological and therefore of little theoretical value.

More recent work looking at the medical profession has challenged the view of professionals as being altruistic and only interested in the betterment of society. They see professionals, and physicians in particular, as primarily acting in their own interest in order to gain monopoly control of service provision and related financial benefits (Freidson, 1970; McKinlay, 1973; Larson, 1984). This position is bolstered by the numerous and well-documented examples of physicians putting their own interests ahead of their patients’ interests (McKinlay, 1973).

Perhaps the most widely shared view in the literature is that the underlying claim to both professional status and professional autonomy rests on claims to specialized skills and knowledge (Freidson, 1970; McKinlay, 1973; Larson, 1984; Goode, 1969). Occupational groups have argued that only their members have the necessary knowledge to make informed decisions about how the profession should provide services and what standards should be met. A few authors have argued that the bulk of the skill and knowledge the professions claim to have (including the medical profession) is not that specialized and that artificial barriers to knowledge are created in order to maintain monopoly control over service provision and claims to professional autonomy (Abbott, 1988; Larkin, 1983).

In these later views, professionalization is seen as the successful outcome of a power struggle between the evolving profession and the state and society, with the specialized knowledge of the profession as its main weapon. A related view of professionalization suggests that there is a symbiotic relationship between the professions and society. Rueschemeyer (1983) argues that,

... the professions “strike a bargain with society” in which they exchange competence and integrity against the trust of client and community, relative freedom from lay supervision and interference, protection against unqualified competition as well as substantial remuneration and higher social status. (41)

Although there has been a general lack of agreement on a definition of what constitutes a “profession” (Abbott, 1988; Freidson, 1994) it is clear that it can not simply be defined by its traits, claims to specialized knowledge, or degree of autonomy in practice. Rather, a definition should encompass all of these in recognition of the complex interrelationship among occupational groups. For the purposes of this article, the definition of
profession used, which comes closest to incorporating all significant ele-
ments, is one developed by Cruess, Johnston, and Cruess (2004). They
define a profession as:

An occupation whose core element is work based upon the mastery
of a complex body of knowledge and skills. It is a vocation in which
knowledge of some department of science or learning or the practice
of an art founded upon it is used in the service of others. Its mem-
bers are governed by codes of ethics and profess a commitment to
competence, integrity and morality, altruism, and the promotion of
the public good within their domain. These commitments form the
basis of social contract between a profession and society, which in
return grants the profession a monopoly control over the use of its
knowledge base, the right to considerable autonomy in practice and
the privilege of self-regulation. Professions and their members are
accountable to those served and to society. (75)

PROFESSIONAL DECLINE

Although the rapid rise in the number and stature of professions in
the twentieth century was dramatic, by the end of the century there were
growing signs that they were losing their salience (Starr, 1982). Once an
occupation has reached the status of a profession, maintaining that
position in the face of threats of deprofessionalization, including those
from government and other professions, may be difficult. The academic
literature suggests that many professions, particularly in the area of
health care, are now in decline or at least under the constant threat of
decline (Haug, 1973; Larkin, 1983; Oppenheimer, 1973; Derber, 1982;
McKinlay & Arches, 1985). The two prominent explanations for the
decline of a profession found in the literature are deprofessionalization
and proletarianization.

Marie Haug depicted a process of deprofessionalization in which a
profession’s monopoly control over a body of specialized knowledge
becomes challenged. This challenge is seen primarily in the form of an
increasingly educated public demanding greater accountability of profes-
sionals. It is also related to the evolution of technology and availability of
technical information, which closes the “information gap” between the
public and professionals (Haug, 1973). The result is that the public is less
willing to defer to the expert knowledge of the professional.
An alternative explanation for perceived professional decline lies in the post-industrial nature of capitalism and the rise of powerful corporate elite. The proletarianization thesis argues that capital is gaining control over professionals due in part to the increasing technological sophistication of the delivery of health care services, as well as in response to the rising costs of providing professional health care services (Larkin, 1983; Oppenheimer, 1973; Derber, 1982). The rationalization and restructuring of health services have taken place in a number of industrialized countries in an effort to control rising health care costs, which have in turn supported a trend toward privatization. In the case of medicine, advances in technology have left physicians dependent on expensive equipment and infrastructure to such an extent that they have lost control over the context of their work, while presumably retaining some control over its content (McKinlay & Arches, 1985).

**POSTPROFESSIONALIZATION**

There is little doubt that both deprofessionalization and proletarianization have placed significant pressure on all professions in recent years. However, despite the unrelenting assault the professions have faced through a rapid growth in technology and bureaucratic control, what is most remarkable is the resilience of these professions and their ability to resist professional decline. Postprofessionalization suggests that an occupational group, having already attained professional status, is in a radically different position than a group that has not attained such status in that it has institutionalized sources of power that make it easier to resist professional decline.

For example, a strong profession such as medicine may be able to resist government policies that it felt were contrary to its interests (Freidson, 1970; Starr, 1982; Tuohy, 1988). Coburn has argued that, in Ontario, the medical profession mediates the relationship between the allied health professions and government, which also gives the medical profession a good deal of control over non-physician health care professionals (Coburn, 1993). This position of strength differentiates the medical profession from the relatively weak allied health professions that may not able to directly challenge the government’s authority. It also suggests that the ability of a profession to maintain professional status is in part due to its power relative to other professions and that gains made by one profession are often at the expense of another (Abbott, 1988).
Two common approaches to resisting professional decline are restrati-
fication within the profession and an expansion of the profession’s scope
of practice. Both of these approaches accept that there may be some loss
of professional control in highly contested areas in exchange for expanded
control in other areas. The literature describes how some of the most pow-
erful professions have been successful in resisting decline through strate-
gies that include “restratification” within the profession (Navarro, 1988;
Freidson, 1994; Annandale, 1989; Coburn, Rappolt, & Bourgeault, 1997).
This process consists of a profession’s corporate body retaining power,
often at the expense in individual practitioners, and it often includes a
profession’s elite moving into managerial positions as a means of main-
taining professional power over decision making.

Some professions have also resisted decline by expanding their scopes
of practice, often encroaching on what other professions have seen as
their exclusive territory. These professions often have an educational
curriculum that promotes a broad base of competencies that provides indi-
vidual practitioners with the knowledge, skills, and abilities to seize
opportunities beyond their traditional scopes of practice. This may be
despite the absence of specific specialized knowledge in the new field.
For example, nursing has moved into areas ranging from anaesthesia
administration to mental health counselling even though other profes-
sional groups may possess greater knowledge, skills, and abilities within
the area. In some instances, professions that have evolved to a state of
postprofessionalization have not only resisted professional decline but
have demonstrated their ability to flourish.

**SOCIAL WORK’S PROFESSIONAL PROJECT**

Although there are many measures that provide an indication as to
whether professional status has been attained, it is commonly accepted
that social work, in most developed countries, is recognized as being a
profession (O’Neill, 1999; Holosko & Leslie, 2001). Some of the typical
milestones that have been reached in most developed countries include:
reaching agreement on core competencies for the safe and effective practice
of the profession; the development of standards of practice; and the avail-
ability of graduate education, to name a few (Wong, 2001; Holosko &
Leslie, 2001; Rubin & Parrish, 2007). To some, the ultimate evidence of
an occupation achieving professional status is professional self-regulation
through government legislation that formally delegates regulatory authority
to a profession (Larson, 1977; Wilensky, 1964). In a growing number of jurisdictions around the world, social work has also met the standard of achieving self-regulation.

Despite having achieved recognition as a full profession in most developed countries by the 1970s, commentators almost immediately began raising concerns that the profession was under threat of decline. For example, in the United States researchers began to question whether social work was in “crisis” and if we were witnessing “the death of a profession” (Richan & Mendelson, 1973). It was noted that social work was experiencing “the most distressing of storm signals to any profession: the fact that it no longer has a key role, or indeed any role, in some fields to which it previously laid claim” (Richan & Mendelson, 1973, 42).

Since then, there has been a steady flow of literature considering the state of the social work profession in developed countries that has focused on concerns about growing pressures toward professional decline (Heally & Meagher, 2004; Orme, 2001; Dominelli & Hoogveldt, 1996). In particular, concerns of deprofessionalization have become commonplace. For example, Orme (2001) raised the issue of growing government involvement in the regulation of social work noting that, “the regulatory systems as currently envisaged represent a fragmentation of responsibilities and a proliferation of lines of accountability” to organizations external to the profession (612). Dominelli and Hoogveldt (1996) raise concerns about the fragmentation of social work into “discretely identifiable parts . . . [which] permits complex social work tasks to be undertaken by less highly skilled practitioners at lower rates of pay” (52). Heally and Meagher (2004) focus on the loss of professional autonomy and decision-making power of social workers due to bureaucratic intrusions. However, although these issues are real they are neither exclusive to social work nor an indication of the inevitability of a loss of professional status.

**THE EVOLUTION OF A NEW ROLE FOR SOCIAL WORKERS**

One specialized role that has been filled by social workers in some hospitals in Canada is that of the Clinical Legal Coordinator in the area of forensic mental health. Although the various organizations use different job titles for this position, for the purposes of this article we will refer to the position as “Clinical Legal Coordinator” as it provides the clearest description of the role. This role is a unique position because it
requires the blending of clinical, managerial, and legal knowledge, skills, and abilities.

Although social workers have long provided front-line care in the area of forensic mental health (Whitmer, 1983), filling the role of “Clinical Legal Coordinator” is relatively new for social workers. This role has traditionally been carried out by hospital administrators, psychiatrists, and more recently, lawyers. Although some such positions continue to be filled by physicians, the mounting legal complexities of the role and associated increasing time commitment has made these physicians the exception. Over the years, in some hospitals lawyers began to replace physicians in this role because they were able to deal more effectively with the legal aspects of the position. However, the absence of clinical knowledge of most lawyers has led some organizations to seek an alternative mix of skills. In more recent years, some hospitals have come to appreciate that social workers can bring a skill set to the position that allows them to blend the necessary mix of clinical, managerial, and legal competencies in order to excel in this role.

The Clinical Legal Coordinator role is seen in tertiary care psychiatric facilities that are hospitals with specialized resources and facilities, providing care to individuals who have complex and often unstable mental disorders. The population served in these specialized centers includes individuals with serious mental illness who require ongoing, daily contact with service providers. Usually their illnesses have not been successfully treated with routine community care or brief inpatient care. The conditions facing these individuals range from elderly clients suffering from dementia, to clients with schizophrenia who are chronically psychotic, aggressive, and sometimes suicidal.

A small subset of the seriously mentally ill population in these tertiary care psychiatric facilities is forensic clients. These are individuals who are accused of serious and often violent crimes and are being held in custody in a psychiatric facility either pending an extensive assessment of their mental capacity prior to a court trial or ordered to be detained in hospital following the assessment process. These clients are held in minimum, medium, or maximum security facilities within the hospital, based on the risk of harm they pose to the community, including staff, other clients, and themselves.

In order to fully understand the unique functions of this Clinical Legal Coordinator role, it is important to provide a brief overview of how the legal and hospital systems interplay. Individuals who are in conflict with the law, who may be suffering from a mental disorder, are sent by the
courts to a designated hospital that has a tertiary care psychiatric forensic facility. Initially, such individuals would be sent for a comprehensive psychiatric assessment to determine if they are “fit” to proceed with a trial. An assessment would typically focus on the risk of violence and criminal recidivism. If a court returns a verdict that the accused is either unfit to stand trial (not able to understand the proceeding or their consequences) or not criminally responsible due to his or her mental status, the Review Board has jurisdiction over these individuals. Although the Review Boards are established independently in each province, each Canadian jurisdiction functions in a similar manner. Those individuals who are not fit to proceed with a trial and those who at the conclusion of a trial are found to be not criminally responsible for an offense are placed in custody at a hospital’s forensic facility.

Despite diverse terminology being used by different organizations for this position title, the functions and responsibilities remain similar across organizations. Although legislation technically requires the hospital to ensure that: psychiatric assessments are conducted; Review Board hearings are scheduled; hospital representatives testify as required at Review Board hearings; and the police be notified when forensic clients are released into the community for even limited periods of time, the reality is that a large component of these responsibilities fall on the shoulders of the Clinical Legal Coordinator.

To assist a Review Board in its decision-making, a thorough report needs to be prepared in advance of a formal hearing. This hospital report would typically include standard background information about the patient and his or her family. In addition, a full medical, psychiatric, and legal history of the patient is included. A report will also include a diagnosis, prognosis, and recommendations relating to the patient’s threat to the community. A sound clinical knowledge is essential for ensuring that reports are accurate and that their recommendations are consistent with the findings.

Each of the psychiatric facilities that are permitted to provide care for forensic clients are required to hold Review Board hearings for individuals who are detained under the Criminal Code of Canada. The proceedings may include: initial disposition hearings for unfit and not criminally responsible accused; annual reviews of dispositions; additional mandatory or discretionary reviews; placement hearings; and transfer applications (Watt & Fuerst, 2006). It is at these Review Board hearings that the Clinical Legal Coordinator typically represents the hospital administrator as a party to the proceedings. Although the forensic patient’s Attending
Psychiatrist is commonly the hospital key witness, who provides the verbal testimony that supplements the hospital report, the hospital Clinical Legal Coordinator may be responsible for the following functions: preparation of the hospital’s case by calling and preparing witnesses; leading evidence; cross-examining the witnesses of other parties; and summarizing the hospital’s submission of evidence.

The Clinical Legal Coordinator also has a significant risk management function within the hospital. As forensic patients gain some privileges to reenter the community (often on a limited and gradual basis), he or she has an obligation to ensure that legal authorities are notified of the release parameters associated with each forensic client. Failure to do so could place the hospital at risk of legal liability should harm come to any member of the community.

**DISCUSSION**

The fact that social work has reached the status of a profession in Canada is clear by most conventional measures. It is equally clear that, as with most professions, it is under constant threat from its surrounding environment, including from government (which often equates controlling professions through health care reforms with controlling health care costs) and other professions (which compete for exclusive control over the use of specialized knowledge). Any resulting professional decline may be exhibited as a loss of autonomy, power, and status of both individual members of the profession as well as the profession’s corporate body. What is less clear is the extent to which social work has been able to resist pressures toward professional decline.

Threats of proletarianization have been felt by social work as we see growing privatization and corporatization within the health care sector. To some degree, social workers have been somewhat insulated from this threat because they are not as dependent on high priced technology to perform their duties as many other health professionals such as cardiologists or laboratory technologists. However, the rising costs of health care have encouraged governments to attempt to restrict professional autonomy through standardizing care in order to help control costs. As a result, proletarianization has had only a moderate impact on the profession, especially in comparison to other health professions.

On the other hand, threats of deprofessionalization have been much more pronounced. These threats stem largely from the loss of control over
a specialized body of knowledge. This may result from the encroachment of another profession (or occupation wishing to attain professional status), as well as from a better-educated public which is not as willing to defer to professional knowledge. In the case of social work, other professions have had some success in expanding into its traditional scope of practice. Furthermore, the nature of the profession makes it more susceptible to an increasingly educated public challenging the expertise of social workers.

At the same time, the broad based educational preparation of social workers has been of assistance in resisting professional decline both through restratification within the profession as well as taking on new roles. In many of these instances social workers have taken on management positions in which they have supervisory roles over a wide range of health professionals rather than just other social workers. This suggests some degree of restratification within the profession, in which professional power is retained through managerial, rather than simply individual practitioner, control.

The Clinical Legal Coordinator role for social workers in Canada is just one of many possible examples of expanding roles for social workers. Social workers have also expanded into numerous new roles including in acute care, home care and the community sector. Goldstein (1996) traces the evolution of social workers in clinical practice and Cox (1992) described how social workers were beginning to play key roles in the provision of home care services in the United States. Additional examples of expanding roles for social workers include perinatal interventions to reduce postpartum depression (Walther, 1997), end-of-life care (Christ & Sormanti, 1999), disease management (Claiborne & Vandenburgh, 2001), and members of hospital disaster response teams (Pockett, 2006).

As a profession evolves and expands its scope of practice, it often upsets the delicate balance that has been created between it and the professions that operate at its fringes. Making gains over a competing profession is a difficult task that requires a confluence of factors. One such factor is that professional education must include a broad base of competencies and transferable skills. Professions that focus almost exclusively on technical skills will face a much greater challenge in attempting to expand its scope of practice. However, educational factors alone are rarely sufficient to support professional expansion and generally require the convergence of institutional factors such as the presence of a misalignment of human resources with organizational need.

The hospital sector has been particularly susceptible to shifts in scopes of practice due to ongoing shortages of some professionals and ongoing
efforts to restructure the delivery of services (Levin, Herbert, & Nutter, 1997). The creation of “new” or non-traditional positions helps to justify and minimize opposition to what the negatively impacted profession might see as an attack on their turf. Often these new positions may be open to competition from professionals from a variety of disciplines and backgrounds (Pockett, 2006; Sulman, Savage, Vrooman, & McGillivray, 2004; Holliman, Dziegielewski, & Datta, 2001). For example, in recent years we have witnessed the creation of Risk Managers, Professional Practice Leaders, and specialized clinician roles such as Clinical Educators and Physician Assistants.

The Clinical Legal Coordinator role for social workers is an interesting example in that social workers compete with multiple professions, including a non–health care profession, in a way that requires a blend of clinical, managerial, and legal attributes. The Clinical Legal Coordinator does not help to retain power within the profession due solely to its managerial functions but due to its ability to transcend the traditional boundaries of other professions, thus creating an opportunity for possible expansion of the social work scope of practice. This example provides an indication that the profession has reached maturity and is now experiencing a period of postprofessionalization in which it may deal with the ongoing challenges it faces, in part, by expanding its boundaries. This example is intended simply to demonstrate that, despite valid concerns about deprofessionalizing pressures facing social work around the word, future prospects for the profession are not as bleak and one might imagine based on a review of the literature.

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**DATE RECEIVED:** August 2, 2007

**ACCEPTED FOR PUBLICATION:** January 25, 2008