SOCIAL WORK IN SCOTLAND IS CHANGING

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Zusammenfassung | In Schottland finden derzeit grundlegende strukturelle Veränderungen der Zusammenlegung der Gesundheitsdienste mit den Diensten der Sozialen Arbeit statt. Die Veränderungen dienen prinzipiell der Neuausrichtung staatlicher Wohlfahrt und der Verlagerung von Ressourcen aus den Krankenhäusern in die Gemeinden, um der zunehmenden Zahl älterer Menschen in der Bevölkerung Rechnung zu tragen. Dieses ehrgeizige politische Projekt eröffnet die Möglichkeit, die Hilfen für Einzelpersonen und deren Familien zu reformieren sowie die Ungerechtigkeiten des Gesundheitssystems in Schottland zu beseitigen.

Abstract | A major structural change is taking place in Scotland which will introduce the integration of health and social work services. This is driven principally by the need to rebalance public service care provision, moving resources from hospital to the community, to take account of the nation's ageing population. It is an ambitious political project which brings with it the opportunity to transform the support provided to individuals and their families. It also provides a fresh opportunity to address long standing health inequalities in Scotland.

Schlüsselwörter ▶ Schottland ▶ soziale Dienste ▶ Gesundheitswesen ▶ Sozialpolitik ▶ Reform

Introduction | This article summarises current developments in social work in Scotland and critically considers the impact that integration with health is likely to have on the profession. It argues that social work is going through a process of radical change which is influenced by three interconnecting revolutions. First, in the governance of the health and social work sector. Secondly, in systems of professional accountability and third in the way in which social work is practised; characterised by the rediscovery of relationship-based practice. This is leading to the delivery of more personalised and outcome-focused services. The paper concludes by arguing that the current review of professional social work education is timely as it will better equip social workers to practise as we enter a new era.

Social Work in Scotland: Social Context | Prior to focusing on the three revolutions described above a summary of the context within which health and social work services are delivered will be helpful.

Scotland, along with England, Wales and Northern Ireland, has been part of the United Kingdom since their parliaments were united in 1707. There are however a number of significant differences. Scotland has its own distinctive culture and identity and a Presbyterian, rather than an Episcopalian religious tradition, and very different legal and education systems.

The Scottish Parliament, which was abolished in 1707, was re-established in 1999 and the Scottish Government now holds powers over a number of legal and policy areas that impact on social work including health and criminal justice. The UK Government continues to retain reserved powers over defence, immigration and taxation. In addition, there are ongoing intergovernmental discussions which will see more of these reserved powers passed from the United Kingdom government to the Scottish Government. The overall effect of these changes is that a federal system of government is beginning to emerge in the UK.

The principle of local representation and local government in Scotland has a long tradition dating back to the 12th century. Scotland has 32 elected unitary local authorities, or councils, which provide a range of services including education, waste management, library and cultural services and local planning. *Bort* et al. (2012, p. 1) argue that local democracy in Scotland is "wrong sized" noting that the number of people it takes to elect a single councillor is ten times the European average.

Social work services are and have traditionally been a key responsibility of local authorities each of which is required to appoint a Chief Social Work Officer who must hold a prescribed degree level qualification and be registered with the Scottish Social Services Council which is the regulatory body for social work. The Chief Social Work Officer is responsible for providing professional advice to the local authority, its Chief Executive and overseeing the quality of services deli-

vered by or, increasingly commissioned, by the local authority concerning:

▲ child welfare and protection;
▲ youth justice;
▲ children who are in the care of the local authority (at home, in foster care or residential care);
▲ community justice (probation and criminal justice);
▲ mental health social work;
▲ care of adults with learning disabilities or physical disabilities;
▲ older people's services including home support, day care and residential care.

Guidance is also provided by central government on how the role of Chief Social Work Officer should be exercised within each local authority. However, the post holder is an employee of the local authority and central government exerts little direct control (*Scottish Government* 2010b). Role of 5(1) of the Social Work (Scotland) Act 1968. Since 1999 several important public services have been removed from local, and at times UK control, and centralised by the Scottish Government on the grounds of efficiency and economy of scale. This has included major public services and has led to the creation of new national organisations, most notably the Scottish Fire Service in 2012 and the Police Service of Scotland in 2013. These bodies now operate with their own boards. Members are appointed in consultation with the Scottish Government and the organisations are more directly accountable to Scottish Ministers.

Centralisation has accelerated since 2007 when the Scottish Nationalist Party (SNP) first took office. Whilst the SNP Government are recognised as being very able administrators they have, as might be expected in any healthy democracy, also been criticised by many because of some of the radical changes they have implemented. Critics have called into question whether newly established large scale national organisations including police and fire services are able to operate effectively. Others have argued that, because the main objective of the SNP is to obtain independence for Scotland, centralisation of services is being carried out primarily to demonstrate that the government has the capacity to manage important centralised institutions effectively. The SNP's key intention being to demonstrate to the electorate, by the creation of a state within a state, that the country has the ability to run its own affairs.

The National Health Service | The UK National Health Service is held in high regard by the general public. When the service is examined more closely, however, it becomes clear that it is not a national service in the true sense. Whilst services are paid for from general taxation and free at the point of delivery, there are significant differences between the four UK countries for example in what drug treatments are available to address particular conditions, between individual Scottish health boards and between professionals most especially those who work in Acute (hospital) and Primary Care (community) settings.

Scotland's National Health Service has its origins in the National Health (Scotland) Act 1947 (*Scottish Government* 1947) sharing similar legislation with that which governed the formation of the Health Service in England and Wales. Services to patients are delivered through 14 regional NHS Boards and a number of Special national NHS Boards. For example, clinical education and ambulance care which are responsible directly to the Scottish Government.

The integration of health and social care is underpinned by the Public Bodies (Joint Working) (Scotland) Act 2014. This act was based on the far reaching recommendations of the Christie Commission on Public Service Reform (*Christie* 2011). The act requires Scotland's 32 local authorities and 14 Health Boards to jointly plan integrated health and social work services. These services must be delivered against nine national outcomes. These outcomes focus on a range of issues including the promotion of self-care, recognition of the role of carers and health inequalities. This change has been described as the most significant reform to the way health and social care is delivered in Scotland since the creation of the NHS (*Scottish Government* 2016).

An Ageing Population | Population size is a key factor when planning public services and populations' sizes vary from 21 590 (Orkney Islands) to 600 000 (City of Glasgow). Social policy also regards the age profile of a population as being of central importance and more relevant as an indicator of social need than total population size alone. Over the last ten years, in Scotland demographic change has been the main policy driver influencing the integration of health and social work services.

The UK population is currently 64,5 million with Scotland's share of this being 5,2 million; the highest ever recorded. The population increase is due largely to growth as a result of net in-migration and a modest increase in birth rate (*National Records of Scotland* 2015). Overall, however, Scotland has an ageing population. One with an increasing average age, where the proportion of older people is increasing and the proportion of younger people is decreasing. Whilst the UK, and Scotland in particular, face demographic challenges in the coming years, other European countries, most notably Germany, and Italy are facing a more severe situation.

Scotland anticipates that it will have a 50 percent increase in over 60s by 2033. In addition, there is a strong urban/rural dimension to Scotland's ageing population problem. Although currently 17 percent of the population are over 60, this age group makes up 21 percent in several of the more rural local authorities. In addition, Scotland's "dependency" ratio is also projected to increase from 60 per 100 to 68 per 100 by 2033. (*Scottish Government* 2010a, p. 15).

Health Inequality in Scotland | Overall life expectancy has increased in Scotland in recent years but mortality rates remain stubbornly linked to deprivation. People in the least deprived areas still live longer than people living in the most deprived areas. Life expectancy can also vary widely *within* individual Health and Social Care Partnership areas. For example, between 2006 and 2010, the average life expectancy among males in the most deprived areas of one community was around 66 years which was nine years less than the rest of the local authority area. In relation to females the gap was found to have increased by a year (*Audit Scotland* 2012, p. 15).

In general, Scottish citizens in more affluent areas live longer and have significantly better health (*ibid*). In addition, some sources argue that two percent of the population use 50 percent of the nation's health resources (*Bishop* 2015, p. 5). As elsewhere in Europe health inequalities are linked to a range of factors that are interconnected. For example, genetic factors and poor living conditions have a significant impact on someone's life over time. These are exacerbated by harmful behaviours including poor diet, smoking, substance misuse and a lack of exercise. Public services can address some of these factors through public health measures including improving housing and increasing access to sports facilities. However, global factors such as recession and deindustrialisation also contribute to maintaining health inequality.

It is known that life expectancy reduces as deprivation levels increase. The incidence of low birth weight and respiratory diseases are both higher in deprived areas in Scotland. Other conditions including high blood pressure and high cholesterol whilst not directly associated with deprivation are additional risk factors for major illnesses which are strongly linked to deprivation, for example, cardiovascular disease. Excessive alcohol consumption is more common among men living in Scotland's most deprived areas. Gender differences also contribute to inequality. With women who live in more deprived areas being more likely to be obese; a pattern less evident among men.

It is recognised that reducing health inequalities requires effective partnership working across a range of organisations. Health and social care integration policy has been designed to improve the distribution of primary care services across Scotland so that allocation of resources more fully reflects the higher levels of ill health and other needs found in deprived areas.

First Revolution: Health and Social Work Governance | The integration of health and social care will bring together a range of professionals, including medical consultants, community nurses, social workers, voluntary sector colleagues and mental health nurses, who will work to support service users and patients in the community. Some sources describe the integration of the two services "as the single biggest reform to the way health and social care is delivered in Scotland, since the creation of the NHS" (*Scottish Government* 2016).

Earlier discussion has highlighted the level of centralisation of major public services that has taken place since the SNP government first took office in 2007. The centralisation of the fire and police services has certainly been radical; however, centralisation of health and social care has been more radical still, both in terms of scale and complexity (*Black* 2015). Integration in this instance brings two very different sectors together. Each has their own culture and history and each has traditionally been governed in completely different ways; centrally in relation to

health, whilst local authorities have been managed locally. The new partnerships create a hybrid model of central and local governance.

Conflict is a given during any period of radical change and as *Black* notes significant differences will emerge in relation to a range of issues including the political landscape (as competing national and local agendas are addressed within the new partnership boards), financial management (over the last decade local authorities have been subject to severe budget cuts whilst the NHS has continued to receive significant investment from national government) and staff management. In general terms of employment on health service contracts are more attractive in terms of salary, job security and other employment benefits.

Similarly the Chief Officer of the new partnerships has multiple accountabilities; to their own partnership board and chair-person, the Chief Executive of the Local Authority and also the Chief Executive of the relevant Health Board. Responding to this challenge and those set out above will require major culture change. The scale of these challenges is only now beginning to be felt and it will take time to address each of them effectively. There is now, however, a genuine opportunity to address long standing health inequalities to bring about a revolution in the way that care services are currently delivered, most especially to "improve the wellbeing of those who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time" (*Black* 2015, p. 2).

Second Revolution: Professional Accountability | The second revolution that is taking place in Scotland is in professional accountability through the creation of a coherent social services workforce. This has led to an improvement in public understanding and confidence in social services (*Scottish Social Services Council* 2016). This has been achieved through the creation of the Scottish Social Services Council which is one of four regulators in the UK responsible for the registration of social service workers. Each of these organisations has different functions and priorities, however all share the same Codes of Practice for Social Service Workers and Employers. First published in 2001, the codes of practice set out the standards that are expected of workers and employers (*Scottish Social Services Council* 2003). The codes are primarily used by regulators of qualifications, higher and further education providers and other awarding bodies to approve professional education and training programmes.

The codes are also used to provide people who use services with information on what they might expect from the services they receive. This is achieved by the SSSC working with the Scottish Care Inspectorate and other regulators to provide advice on how services are graded by inspectors according to:

- ▲ quality of care and support;
- ▲ quality of environment;
- ▲ quality of staffing;
- ▲ quality of management and leadership.

The social services employment sector is one of the largest in Scotland with approximately 199 000 workers at 29 February 2016 (*Scottish Social Services Council* 2016). Registration which has been phased in began in 2003 with social workers. By August 2015, the Register held 89 875 workers and when all phases are complete in 2020, it will hold approximately 140 000 workers, around 70 percent of the current workforce. All of these workers require set qualifications for registration and continuing professional development (CPD). For its part the health care workforce constitutes about 135 000 workers. There are no plans to integrate the workforce at a national level. One reason for this is that the health care workforce is regulated by a range of organisations which operate across the UK.

It is estimated that one in every 13 workers in Scotland is a member of the social services workforce; either as a social worker, residential child care worker, adult day care or residential practitioner or manager of some form of social services. Equipping this workforce with the qualifications required for registration has been an enormous challenge for employers, university and colleges and staff themselves (*Scottish Social Services Council* 2016).

Some of these changes have been criticised most especially the use of competency-based qualifications (*Heron* 2002). There are also questions about the extent to which the possession of professional qualifications does in fact impact on the quality of service provided. Qualifications, when aggregated across the workforce, are regarded at best as only a proxy mea-

sure for quality. Nevertheless, Scotland compares very well when numbers of registered workers are compared with other regulators in the United Kingdom.

Third Revolution: Rediscovering Relational Practice | Turning now to our third revolution: the rediscovery of relational practice. It is this last change, together with a focus on user-defined outcomes and self-directed support, which offers the greatest hope for the development of social work in the coming years.

The public service paradigm which continues to dominate the UK social services sector, New Public Management (NPM), stresses the importance of measurable outputs, targets and cost effectiveness in the provision of public services (*Banks* 2011). NPM is commonly understood as a model for correcting the "perceived failings of traditional public bureaucracies' responses to the need for efficiency, quality, customer responsiveness and effective leadership" (*Hood* 2000, p. 4). NPM is strongly rooted in the UK and elsewhere in Europe and impacts on all aspects of local and central government service (*Bain* 2008).

This approach is not without its critics. Writing from a psychoanalytic perspective, *Cooper* and *Lousada* (2005, p. 3) note that whilst rational and scientific approaches are essential if we are to achieve a measured understanding of contemporary welfare policy, we must also link the "rational and the emotional, and the rational and the irrational".

Cooper and *Lousada* have observed that UK health and social work organisations operate between the domain of practice and the domain of policy (*Cooper; Lousada* 2005, p. 41). In health and social care, the operational frontline is frequently the site where policy is both implemented and formulated. *Cooper* and *Lousada* argue that to be truly effective an organisation's leadership needs to change this pattern and allow itself the freedom and capacity to reflect on the impact of any intervention whilst leaving itself space to amend policy in the light of experience. NPM works against this by promoting centralised systems which valorise consistency, standardisation and measurement above everything else and reward or castigate those who deliver or, in the latter case, fail to respond in the way that the system demands. In this way government can be seen to be unconsciously promoting perverse social defences to manage social anxiety (*Menzies Lyth* 1960, *Hoggett* 2010).

Further to this and again drawing upon a psychoanalytic perspective *Frost* and *Hoggett* highlight *Bourdieu's* (1999) concept of social suffering, noting that in Western type democracies health and social work systems arose in the late 19th and early 20th centuries as a response to the existence of social suffering especially human suffering (*Frost; Hoggett* 2008). They highlight that *Bourdieu's* emphasis is not only on inequality, based on the distribution of goods and consequent misery per se, rather he focuses on the feelings that are generated by domination and often somatised; humiliation, anger and resentment. They suggest that a double suffering takes place which they describe thus: "When hurt (social suffering) accrues more hurt (internalised) is re-experienced [...] when suffering cannot be articulated or expressed the internalisation results in destructive behaviour's that harm. This is suffering turned upon itself and it is this double suffering which is often the subject of professional practice in welfare work" (*Frost* 2008, p. 455).

At its most extreme the impact of this is both distressing and destructive. Writing following the notorious Baby P child protection inquiry which focused on the death of a child who had at several times in his short life come to the attention of health and social work services the social worker and psychotherapist *Andrew Cooper* notes: "[...] Most people who systematically abuse children over long periods *need* to go on doing this. They are expelling something terrible and dangerous in themselves [...] They are dedicated to disguising what is happening and to throwing investigators off the scent. They know that what they are doing is a terrible transgression in others eyes. For such abusers, the stakes could not be higher" (*Cooper* 2008). As *Cooper* states, educating and training professionals to deal with such matters is not a straightforward task. No educational standards based "competency" statement can ever hope to capture the depth of emotional resources required to achieve consistent "performance" under such extreme circumstances (*Cooper* 2009).

There is however room for optimism. New approaches to service delivery have been promoted throughout the UK by the University of York's Social Policy

Research Unit's focus on outcomes. Most especially those which are identified and articulated by service users themselves. This approach recognises that people's lives do not divide neatly to fit with existing agency structures. Rather professionals must engage with service users to help them identify the changes they wish to make in their own lives and assist them to do so.

Similarly *Duffy,* commenting on the Social Care (Self Directed Support) Scotland Act 2013, which promotes the individualisation of funding support, considers that this approach is not about money. It is about wealth in a different sense. It is a "person's gifts, relationships and wider community that offer the most important resources for someone to solve their problems or build a better life" (*Duffy* 2015, p. 49). As *Murray* has noted families who wish to change generally seek out a respectful relationship with a professional who will stick with them and help them identify the solutions they need to find (*Murray* 2010).

Organisations such as Altrum in Scotland (http://altrum.org) have brought a range of service providers together in innovative ways to promote more relational ways of working. *Hilary Cottam*, the founder of Participle, an organisation which was established to transform the way in which services are not only delivered but conceived, has argued that the current systems of health and social welfare are based on an outdated transactional model. They need to be replaced by models which are shared, collective and relational: approaches which cost less and build social capital rather than focusing on institutional reform and efficiency. People and the relationships between us, are the critical resource we have in solving the deep and complex problems of this century. "We must look for ways to support our capabilities – yours, mine and others around us – and foster those relationships" (*Cottam* 2015).

This thinking is also now impacting on even the most risk-laden areas of practice including adult and child protection (*Bates; Lymbery* 2011, *Featherstone* et al. 2014). It is now beginning to influence the support given to families who are in crisis. Relational practice is collaborative and draws from the ethics of care literature which recognises that, "we all give and receive care throughout the life course, dependency and vulnerability are basic aspects of the human condition and we must promote the need for interdependence if we are to support human flourishing" (*Featherstone* et al. 2014, p. 1745).

Encouragingly, the Scottish Social Services Council announced in 2013 that it would embark on a major initiative to develop a new approach to professional learning that will address Scotland's major challenges, its ageing population, and a tendency towards risk aversion, deeply entrenched inequalities and current systems of commissioning services from the market (*Scottish Social Services Council* 2015, p. 3). The review will introduce changes which will promote citizenship and co-production, work towards social justice and stress the importance of personalisation and self-directed support; all characteristic of a relational approach. The review considers that the Scottish system of social work education will be greatly strengthened by the integration of health and social work.

Conclusion | This paper has provided a summary of the context within which health and social work services are delivered in Scotland. It notes that the movement towards integration is driven principally by the need to rebalance public service care provision to take account of the nation's ageing population. The integration of health and social work is an ambitious political project which brings with it the opportunity to transform the support provided to individuals and their families and provides a fresh opportunity to address long-standing health inequalities in Scotland. There are, however, major risks and challenges ahead related in large part to new, untested hybrid, central and local government governance arrangements.

The changes that are taking place in social work have been characterised as comprising three interconnected revolutions. First, in the governance of the health and social work sector through new partnerships. Secondly, in systems of professional accountability which have come about through the creation of the Scottish Social Services Council. Both of these changes are providing opportunities to move away from the New Public Management paradigm which has come to dominate many aspects of social work practice. If successful, the review of social work education will contribute to the delivery of more personalised and outcome-focused services, using a relational approach, by future generations of social workers.

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