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Common Weal Policy

STRUGGLING TO CARE: WHY SCOTLAND NEEDS TO REFORM THE ROLE OF SOCIAL WORKERS

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Written on behalf of the Common Weal Care Reform Working Group

KEY POINTS

— The role of the qualified social worker should be a vital component in the system of social care in Scotland but instead has been marginalised and its practices distorted as a result of policies and trends that have grown since the 1990s.

— Social workers are trained to assist individuals to realise their potential through helping and caring relationships, advocacy and support. However in current local authority and Health and Social Care Partnership settings social workers are instead focused on firefighting public protection duties, assessment, brokering and review functions – all of which are organised on a highly bureaucratic basis and increasingly located outside of Scotland's communities.

— The emphasis should be on a more community-based prevention role through Community Social Work which holds potential for providing a service aimed at tackling inequalities and countering the growth of social problems in Scotland's communities.

— Social work should be based on well-being, learning and growth and be underpinned by the idea that each person has inherent potential, is valuable, resourceful and can make a meaningful contribution to their wider community if we find ways of including them (social pedagogy). This approach would create continuity in support functions and positive relationship-based practice.

— Despite working against the odds within current statutory frameworks, many social workers provide a valued service with good outcomes for those they work with, providing examples of practice that offer hope for the future of the profession.

— A genuine National Care Service would end present service inequalities across the country and deploy social workers (as with resources more generally) where they are needed.

CONTENTS

INTRODUCTION

This paper emerged from the Common Weal Care Reform Working Group's efforts to produce a blueprint for a comprehensive National Care Service in Scotland that, like the NHS, could provide to individuals and communities "from the cradle to the grave". Social work, it is argued here, is intrinsic to the practical delivery of social care. However, it is our belief that social work requires some reclaiming and that the marginalised position it finds itself in is neither positive, healthy nor inevitable. The paper is designed to be accessible for a readership interested in such issues but not necessarily involved in service provision and delivery. The paper therefore offers an overview of social work and some background in order that the reader might understand how social work in the UK has been shaped by its history.

The Feeley Review of Adult Social Care in Scotland was published whilst this paper was being produced: some of its findings in relation to the importance of prevention and relationships, have echoes in this paper (although Feeley barely discusses the role of social work). However, the trajectory offered here is different in important aspects, and offers an alternative framework for consideration. Early drafts of this paper were shared widely and comments from people and organisations incorporated as far as possible: where they were happy to be identified, their names are listed at the end. The views and opinions in this paper, in the final analysis, represent those of the Common Weal Care Reform Working Group.

WHAT ARE SOCIAL WORKERS AND WHAT DO THEY DO?

There are approximately 11,000 social workers in Scotland most of whom work for the 32 local authorities providing statutory services in the fields of children and family, adults with varying degrees of vulnerability and disability including older people, those with mental health and substance/alcohol misuse issues, and justice – a term that has replaced "criminal justice" which itself replaced "probation and after care" in Scotland many years ago. Such services nowadays are usually delivered through specialised teams – their size, geographical responsibility and scope varying between employing authorities. Other social workers work in prisons and hospitals, schools and in other kinds of specialised team. The term "social worker" is protected by law under the Regulation of Care (Scotland) Act 2001, which requires registration with the Scottish Social Services Council (SSSC) involving a cost (currently £80 per year) usually borne by the registrant. Social workers require to work to professional standards laid down in Codes of Practice, and questions relating to "Fitness to Practise" have to be investigated by the SSSC (see below).

Social workers in Scotland are trained to degree level: this involves a mix of social work theory (including psychology and human behaviour), social science theory, social policy, law and skills training – with practical experience gained through placements assessed on the basis of achievement of the application of competencies. The framework for social work education (SISWE) was established in 2003 following consultation with employers and involves six detailed areas, with an underlying notional regard to human rights, social justice and the tackling of inequalities; the focus on ethics was strengthened in 2020. Once qualified, social workers spend their first year or so of practice with (in theory) a protected workload until they can demonstrate the level of post-qualification competency required by the SSSC. During this period they are supposed to get regular supervision from a suitably qualified supervisor. Throughout their career social workers are expected to undertake continued training and study and are required to demonstrate this by maintaining a personal record of learning, which can be inspected by the SSSC. Registration lasts for three years and must be maintained. Various postgraduate courses are available to enhance learning in the various fields of practice, access often depending upon the willingness of employers to second and provide funding for course fees etc.

So what do social workers in general do and what are the common features of their practice in

the various settings they work in? Social workers are trained to support people who require help beyond their own means and capacities, or who are deemed to pose a risk to themselves or others. This is achieved through relationship-based practice that explores and opens up avenues for:

— practical support and assistance (advocacy and brokering functions)

— help to change patterns of activity that are impeding desired progress (casework and counselling functions)

— safeguarding the most vulnerable against abuse and exploitation (public protection or safeguarding functions)

— as a key part of this process, assessing concerns and identifying issues requiring attention, and working out plans to resolve or overcome them (assessment functions)

The Codes of Practice state that in general terms social workers must respect the rights, privacy and dignity of service users, and promote their independence. Social work training places value on upholding these values through partnership and agreement, but also ensuring (as do the Codes) that choices made do not harm others. Many of the tasks of social workers are determined by statute – particularly those protective functions in relation to children and vulnerable adults. A particular specialism requiring postgraduate statutory training is that of "Mental Health Officer", whose duties and functions are precisely laid out in legislation and relate to statutory detention and treatment in hospital and the community. Social workers in Justice settings generally undertake work determined by the Courts, for whom they also provide reports used to assist sentencing. Although there is a tendency to specialise from an early career stage (a choice often being made during university training), the commonality of skills required in work that is, at least in theory, relationship-based, allows social workers in Scotland to change specialisms – and many do.

A BROKEN FRAMEWORK

Social work is now regarded by many who work within it and understand its direction of travel, to be broken and in need of reform both in the UK as a whole (BASW 2019, Rogowski 2020) and in Scotland. The well-intentioned but rapid pace of legislative output from the Scottish Parliament (26 Acts so far impacting upon social work practice between 1999 and 2019) has not improved matters, and neither has "integration" with Health-led services. So what has happened?

The Social Work (Scotland) Act 1968 was an all-embracing single piece of legislation that was generally regarded in its day as progressive in intention and realisation (Brodie et al 2008). Social Work Departments were established in every local authority, large and small, and brought together previously diverse social work functions on the basis of a requirement to address needs at community level. Social workers soon enjoyed a minimum standard of training and, based in local teams and working across specialisms, were to be provided with the resources needed to tackle Scotland's social challenges. Statutory interventions were to be used sparingly and social workers were able to use their skills, and the supports they could mobilise, at an early stage and often by voluntary agreement. Social Work Directors were influential figures and enjoyed broad political and public support (Brodie et al 2008). During the 1970s and 1980s the size of generic social work teams increased and included experimentation with "community social work teams" in some localities (Turbett 2018) and community workers in social work offices in many urban settings.

Dramatic changes took place in the 1990s that shaped the services that we know today (Rogowski 2020). Social work was under public attack and subject to criticism by the Conservative Governments of the day. The rapid growth of the number of older people requiring support and care was also felt to be overwhelming resources. Changes, which were interlocking, took several strands that might be summarised as follows:

1. **Reform of the Care of Older People.** The entitlement to DHSS funding for private-

and third sector-provided residential and nursing home care (subject to a funding ceiling) was ended following UK Government concern about escalating costs. Arguably DHSS funding had served the purpose of helping to create a large private sector, and funding responsibilities were transferred to local government. Social workers who had previously assessed eligibility for local authority care homes were (from 1993) required to assess the needs of people for private and voluntary care home placement as a condition of any means-tested financial assistance with placement funding. The market was introduced into this mix and social workers engaged in such work were now regarded as "assessors and care managers" – bringing a business language and ethos into their work for the first time (Harris 2003). Home care services became similarly commissioned, leading to a reduction in directly-provided local authority home care as well as (particularly) residential care. All this fell within the NHS & Community Care Act 1990 which amended the 1968 Act in Scotland. This social work role in assessing financial circumstances was increased with the introduction of Free Personal Care in 2002 – those who had previously self-funded were often now eligible for a needs assessment.

2. **A Profession Under Attack.** Generic practice within social work teams came under fire for not being focused on areas requiring particular expertise. This followed a perception across the UK that social workers had made errors of judgment in a number of well publicised child protection cases where children had died or suffered multiple abuse. Similar criticism was made in relation to users with mental health problems. At the same time the Courts were critical of the standard of reports and the low priority given to work with offenders. By the end of the 1990s generic teams had been almost entirely replaced by teams of social workers specialising in children and family, adult assessment and care management and criminal justice. Further fragmentation in many authorities led to additional specialisation, including the establishment of reception or duty team to work with service users approaching social work services either for the first time or after a significant gap in service.

3. **Local Government Reorganisation.** Local authorities themselves were criticised by the Conservative Government for their complicated two-tier nature (implemented through previous reorganisation in 1975) and the enduring control of the largest (particularly Strathclyde Region where half of Scotland's population lived) by the Labour Party. A few years earlier Strathclyde Social Work Department had drawn criticism for its financial support of striking miners and its Director taken to Court where he was ordered to ensure all loans were repaid. One intended effect of the subsequent local government reorganisation in 1996, creating 32 unitary authorities, was that such confrontations might never happen again. Within social work, the new authorities were no longer required to appoint Directors of Social Work (who would have to be qualified social workers) to lead their social services functions, but had to appoint a Chief Social Work Officer to uphold standards, but who did not require to have management responsibility. Social Services in many areas continued to be merged with other local authority functions, reducing social work in terms of influence and importance (Brodie et al 2008).

Over the decade of austerity following the banking crash in 2008, and the new Conservative-led Government from 2010 seeking to roll back the State under the guise of reducing the government debt created by the bank bailouts, these changes resulted in increasing fragmentation of social work services into silo-type service provision. Local authority social work teams were now focused on the most pressing need – moving them away from preventative work and onto a concentration on individuals and families requiring statutory interventions. Assessment (and recording) functions took precedence in an attempt to avert risk to organisations as well as service users and much other support activity was delegated to commissioned third sector providers – or not

done at all. With work pressures mounting as a consequence of focus on situations where breakdown had already or was about to occur, much effort was placed on diverting referrals elsewhere. This was done through signposting – often through remote centralised call centres rather than dealing with issues at the point of first contact. All this led to an over-preponderance of social worker time spent on writing reports, recording and meeting bureaucratic demands, with little left (20-30% according to many reports, e.g. BASW 2019) for face-to-face contact between service users and social workers. Job satisfaction plummeted and turnover of staff increased (UNISON Scotland 2019).

Social work interventions now are typically for as short a time as necessary so that space is available for new work, leading to a dearth of capacity for the type of continuity and long-term supportive relationships some individuals and families most need. The field often considered under most pressure, children and families, suffers recruitment problems in many localities. Social work teams have also become remote from communities, often located in large warehouse-type buildings where hot-desking in open plan offices works against team support and identity - again increasing stress levels (Ramalier & Boichat 2018). Numbers of social workers have grown but supporting fewer people whose issues and problems are highly complex and difficult to successfully resolve. Recent research suggests that whilst the public perception of social work in Scotland is positive this is based on ignorance of what social workers do (McCulloch & Webb 2020). We know that ignorance can breed unwarranted criticism and scapegoating, both coming quickly in the wake of publicised cases of harm to vulnerable children and adults where social workers were in some way involved. Without doubt and against the odds, many staff do provide a high level of service and undertake very good work, with good outcomes for service users.

At base level social workers have always been good at networking (it was promoted in training), particularly within teams located within the communities in which work was undertaken. This is evident in informal but important relationships with other agencies as well as key community activists and voluntary organisations. In recent years perceptions about how the absence of close co-operation and working practice might be impacting upon services, particularly older people who were inappropriately being kept in hospital, has led to mounting and popular calls for the integration of health and social work services. With the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014, this is now compulsory. The health service in its many forms is a giant compared to social work and social care and this partial merging of functions has not served social work well. It has only led to further marginalisation of its role and functions, additional to the processes already taking place since the 1990s. Health and social work have different underlying philosophies and, rather than complimentary and mutually beneficial practices developing, the former has become dominant. Co-location of staff and mixing of management functions has not necessarily improved service delivery, and has muddied the waters of professional supervision and accountability. The regular appointment of Health managers (and those from other disciplines outside social work) in positions of responsibility for social work services has served to marginalise its place further. Extra bureaucratic complexity and protocol formalisation has not helped relationships between front line workers and many report that these have actually suffered where less formal arrangements had previously worked well. HSCPs have not worked and a strong question mark hangs over their value and that of the Integrated Joint Boards (IJBs) that provide their direction (this is discussed in accompanying Care Reform Working Group discussion papers). Their function as discussion forums and for management liaison might be better carried out in other ways.

The emergence of the 32 local authorities since 1995 has resulted in huge differences in provision across Scotland. The employment and deployment of social workers is dependent entirely on the decisions of HSCPs and the budgets of local authorities. The areas with most pressures (as reported by staff to the trade union UNISON) are obvious when comparisons are made between SIMD statistics concerning deprivation, and social workers per head of population. Glasgow, with 29% of the worst deprivation in Scotland, had 115.9 social workers per 100,000 people in 2018, a figure that had

reduced from 148 since 2009 due to austerity-driven cuts. Shetland, at the opposite end of the scale with levels of deprivation that barely achieved a score, had 143.5 social workers per 100,000 people, an increase from 114 since 2009 – almost an inverse reflection of Glasgow's reversal over the same period (SSSC 2018). This use of SIMD statistics is crude and the whole matter requires further examination beyond the scope of this paper, but is nonetheless telling. Inconsistent allocation of resources can be found across the country and explains varying waiting lists and eligibility criteria for services. Since the demise of nationally-negotiated rates many years ago, pay for social workers is also determined locally – areas with the most pressure (especially Glasgow) offer comparatively better renumeration in order to attract staff. Whilst not unwelcome this drains scarce resources still further. Pressures are dealt with by passing as much work within teams as possible onto staff with other qualifications, typically social work assistants and community care assistants. Whilst "complex assessments" (including such matters as child and adult protection investigations) are only to be undertaken by social workers, much else is passed to these other staff. Social workers therefore tend to have workloads consisting of the most difficult and prioritised work, leaving them without capacity to undertake the (by definition non-statutory) preventative social work they have trained for. Social work and community care assistants are not presently required to register with the SSSC: as the dividing line between complex and other assessments varies, paradoxical inconsistency is built into the system.

The career-ending risk to the worker of wrong decision-making is very real – transgression of the SSSC Codes of Conduct can result in suspension and removal from the register – and SSSC staff are involved at any one time in large numbers of "Fitness to Practise" investigations involving the various groups of the wider social care workforce who require to be registered. In 2018 the SSSC received 3,617 referrals concerning Fitness to Practise, of which 1764 resulted in no further action – suggesting a negatively wrong interpretation by employers (who are normally the ones to report such matters) of Fitness to Practise issues (SSSC 2019). This is apparently a UK wide phenomenon – a recent study found that social workers were more likely to encounter a punitive response at Fitness to Practice Hearings than doctors or nurses, suggesting that the response from the registration body in both their cases is more about public protection than recognising that they are a public asset and can change problematic behaviours (Worsley et al 2020). Whilst the SSSC try and promote an image of supporting the workforce and raising standards, the perception of most who require professional registration focuses on the disciplinary function. The Scottish Codes of Practice also lack specific reference to the social justice and liberating aspects of social work laid out in the ethical principles statement of the International Federation of Social Work (IFSW 2018), unlike other national similar codes including Northern Ireland and perhaps a reflection of real rather than aspirational agendas in Scotland.

The 1968 Social Work (Scotland) Act was preceded by the (at the time) visionary and widely praised *Kilbrandon Report* of 1964, and its complimentary 1966 report *Social Work and the Community*. Although the next all-embracing Scottish social work report did not appear for another forty years, it is worth noting that the England/Wales *Barclay Report* of 1982, which promoted community social work (see below), did have influence in Scotland. It was, however, criticised heavily by those close to the Conservative Government and was quickly sidelined and forgotten. The Scottish Government-sponsored report, *Changing Lives*, of 2006 was significant as it served to consolidate the changes heralded in the 1990s discussed above and set out to provide for the needs of Scotland's most vulnerable in the new century. Its emphasis on personalisation and the commissioning of services within a mixed economy of care pre-empted (and perhaps excused) the massive cuts in service that came with austerity a few years later. Its "tiered intervention" model of social work ensured that social work teams would see their principal focus as the hard end of statutory social work, largely leaving what it described as "preventative work" and "building community capacity" to others at the bottom rung of the four-tiered ladder.

Changing Lives also stated that registered social workers should operate as "autonomous

professionals within a framework of accountability" – a controversial and almost self-contradictory contention that offered employers and the state an excuse for not furnishing the working environment with sufficient resources to undertake good practice. Although the report discussed relationships and their place at the core of social work its emphasis reduced scope for their supportive and sustaining role across the spectrum of need (for a broader critique see Clark & Smith 2012). More than a decade and a half after *Changing Lives* it is time to recognise that it unintentionally promoted a negative marginalisation of social work. It is time to move on and develop a framework for services that will serve our populations better. This is not to suggest a return to some mythical golden age of social work but about facing the challenges of the present and future: climate change, an ageing population, and the need to reduce inequalities and promote social justice, all being formidable 'giants' in the wake of Covid-19, and akin to the 'Five Giants' that the Beveridge Report of 1942 sought to address in the aftermath of the World War.

UNLEASHING POTENTIAL AND FIXING THE PROBLEM – COMMUNITY SOCIAL WORK

The creation of a National Care Service whose scope (however delivered in organisational terms) should include all the social care and social work workforce, offers opportunity to take social work back to what it should be doing: supporting members of Scotland's struggling communities to tackle their collective and individual problems and build better futures. The key to such a move lies in the notion of *Community Social Work* (Turbett 2020).

In adult care the removal of market and cost-saving considerations by making social care free at the point of delivery would release capacity to support individuals requiring services through their journeys of care. The social worker would no longer be limited to assessment, brokering and review functions – and could move from care management back to the social work role of relationship-based support and advocacy. Within children and family teams a move upstream to an approach based on community social work could enable social workers to engage with individuals and families at an earlier stage to prevent the breakdown point at which interventions often (too late) begin. This would be difficult at the start but would begin to pay off and eventually reduce statutory referrals based on family breakdown and the need to remove children. Exactly the same argument applies to work with adults. Assessments in all these situations would be based on shared ownership and real co-production with service users involving agreement on goals. There is evidence already that such approaches do work, and ultimately save resources and reduce the need for costly compulsory interventions (Cottam 2018; recent and evolving work in Aberdeen City involving the local authority and Children 1st is also believed to be proving the potential of such upstream preventative approaches). This would involve the building of ground-up mechanisms rather than further top-down initiatives. One outcome of all this might be the removal of the stigma that nowadays accompanies social work involvement – especially with children and families.

It follows that the people trained to degree level to mobilise resources and challenge the blight of social problems should be social workers, and that they must not be left to ineffectual attempts to address issues that should have been attended to at a much earlier stage. Based in local teams that offer easy access, networking with other agencies and community activists, and the building of trust with local communities, social workers could do what they train for. With working conditions and expectations that can produce results, a more rewarding environment might breed continuity of service and end the rapid turnover of staff currently experienced. Only then might the relationship-based service demanded by care-experienced young people as laid out in "The Promise" (2020) stand a chance of becoming reality. A pedagogical style of social work, based on continuity and relationships sustained over long periods, will also meet the needs of all those with vulnerabilities that cannot be effectively 'cured' through the type of short-term interventions favoured in recent times (Lorenz 2008, Smith & Monteux 2019). This is

based on a contention that social workers can be essential components of an educative and self-realisation process that leads to lasting positive change within individuals and the communities they make up and contribute towards.

The following illustrates the changes required to build community social work approaches and how this might be achieved.

Traditional	Community-Orientated	Changes Required
Reactive: service provided when situation has deteriorated and the user's networks unable to cope	**Preventative/Pro-Active:** social worker intervenes before a service is demanded by user or through statutory referral	— Reactive responses sit alongside and gradually replaced by proactive interventions — Gradual reduction of case by case approach by individual social workers — Close interaction with local community
Services at arm's length: specialised (and siloed) services compartmentalised through institutional and bureaucratic procedures and remote location – monopolised by overwhelming demands of individual service-users	**Services close to community:** social work practice determined by the living conditions, environmental and social situations of users	— Variability and flexibility in conceiving, shaping and evaluating local services — Individuals are considered in the round and not compartmentalised according to service providedInformal networks accorded importance — Professional responses shared
Professional responsibility: practitioner is entirely responsible for solutions to user's problems	**Shared responsibility:** solutions and responses mutually agreed and shared	Social workers replace, in part, their direct responsibilities with activities supporting others who assume part of these responsibilities
Centred on individual service-user: the individual is the only target of intervention. Assessment is based on their internal problems and the degree of pathology	**Centred on social network:** the target of intervention is the social network, including the service-user's. Assessment centres on the distribution of responsibility and capacities to adapt	The social worker develops skills in assessing the weight of responsibility experienced by principal carers, to support them and identify and elicit support from potential service-users and non-users

(Turbett – IRISS 2020)

These ideas can be illustrated with reference to issues of huge national importance as these words are being written. The Covid-19 response within communities in Scotland has involved the establishment of "Community Hubs", typically staffed by redeployed council workers and reliant on volunteers. Without in any way decrying their efforts and indeed achievements, the question has to be asked as to why the very group of people in society charged with such responsibilities, social workers, were rarely involved in Community Hubs. Whilst the efforts of social workers during the pandemic to work imaginatively with the individuals and families they do support was wonderful in lots of cases, no more was asked of them – such arguably is the degree of marginalisation. This is in contrast to other parts of the world where, according to the *International Federation of Social Workers*, there was a central involvement. This includes Wuhan in China where social workers led the response from the outset of the spread of the virus (Truell & Crompton 2020). Similarly the response to Scotland's drug and alcohol misuse issues could involve social workers working at a local and preventative level in communities – alongside youth and other services taking an interest in community members and helping them find a better identity than that of victim of an increasingly unequal society. Relationships with health workers (and others) can be built from the bottom up, just as they were in the past. All this requires enabling and supportive managers, and social workers should be managed and led by social workers...

It follows that investment is required to deploy social workers where they are needed – this can be determined by ending the post code lottery described earlier and employing social workers in the communities where deprivation levels are at their highest. Communities here might not be geographically located – they might consist of ethnic groups whose members may or may not be concentrated in particular neighbourhoods. Social work should take its proper place within a National Care Service, providing an important adjunct to the social care services that would be central: just as hospital services are on a continuum involving multiple community-based doctors, nurses and other health workers, so social workers would play a vital role in preventative services and statutory responses when they are needed.

STEPS TO SOCIAL WORK REFORM

Scotland needs the establishment of a Government-sponsored independent review of the whole of social care and social work, including Health and Social Care Partnerships, whose remit should include attention to the following:

— Investment in the relocation of social work teams back to communities and the facilitation of their role in preventative community social work;

— How (bottom-up) joint working between agencies can be promoted at neighbourhood level;

— The establishment of social work and social care as integrated services provided by local authorities as fundamental to a National Care Service.

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