# Assessment and Care Management:
# Its history and context within Social Work in Scotland today

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## INTRODUCTION

At the National Forum held by Scottish Government to consider progress with the implementation of the National Care Service, held in Glasgow on 30 October 2023, Maree Todd, current Minister for Social Care, Mental Wellbeing and Sport, stated that she wanted to "*……unleash social workers as human rights champions*". Few in social work would disagree with such an aspiration but to turn that rhetoric into reality will require massive change because of the major (and mainly unchallenged) direction the profession took in the 1990s with the advent of assessment and care management (ACM) as the accepted model for determining many social work services. ACM has become so entrenched that it is rarely questioned although its implications in terms of reducing social work to sets of procedures based around risk assessment and resource allocation based on eligibility criteria, arguably work against all attempts to take the profession back to preventative approaches and relationship-based working.

This short paper looks at the history and trajectory of social work in Scotland since the implementation of the Social Work (Scotland) Act 1968, and explains why ACM emerged, its pervasive influence, and why it is time to replace it with a model that is

both understandable to those outside the profession, and meaningful to those within. The idea that social work might find a voice and direction through the proposed National Social Work Agency, lends urgency to this matter. The process of marginalisation of the profession that this paper contends, has reduced public understanding of the potential of social work as an agency of community development and social change. Support for a rethink about the scope and role of social work practice is unlikely to succeed unless we recognised collectively where things have gone wrong and argue a redirection that can become a baseline for the work of the National Social Work Agency. ACM is one important aspect of the matters we will require to examine.

## SOCIAL WORK AFTER 1968

This narrative will start in 1968 – over 50 years ago. The service that emerged at that time was built on the foundations of public and charitable social welfare provision emerging from the 16th century onwards, with enduring notions of "deserving" and "undeserving" poor that persist to this day. Whilst beyond the scope of this paper, a useful summary can be found in the Social Work Scotland paper by Daniel and Scott 2018.

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. The previous and sparsely resourced functions of central and local government, and health services, to provide public welfare and personal social services, were replaced by social work departments that were run by local authorities. These replaced diverse arrangements, with professionally elevated services under the leadership of powerful directors of social work.

This alignment of provision included some services that had previously been organised through the voluntary sector along charitable lines – typically those involving sensory impairment and some residential care provision. Central to the new social work departments was a commitment to community-based services and prevention[1]. Departments promoted community growth through community development activity, employing community workers and group workers often based alongside social work teams[2] and working in conjunction with council run youthwork services. Section 12 of the new Act empowered local authorities to "promote social welfare" and dispense funds as necessary to fulfil this function.

Section 10 enabled the Secretary of State for Scotland, and local authorities, to grant fund voluntary organisations whose purpose was also the promotion of social welfare. The government agency responsible for supporting social work and providing guidance and policy directive, the Social Work Services Group, took this

[1] (Scott et al 2018)
[2] (Turbett 2018)

seriously and directed social work departments to bring a strong community orientation into their social work services[3].

With the exception of some teams based in institutions (e.g. prisons and hospitals) social work teams were placed in localities and organised along generic lines i.e. social workers typically dealt with children and adults regardless of referral categorisation (a concept that emerged later with the advent of intake teams, followed by increasing specialisation).
Although the early 1970s were years of modest investment, cuts in funding emerged after the 1973 global oil crisis and became a recurring feature thereafter.

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 (CSW) models as a necessary direction of travel for services, did have influence in Scotland and was used to support some initiatives that were celebrated in National Institute of Social Work (NISW) and more recent literature[4]. Barclay, however, was criticised heavily by those close to the Conservative Government as a diversion from the individualised social work models that sought to tackle personal deficits and behaviours (rather than social causes such as poverty) and was quickly sidelined and forgotten; CSW as a concept virtually disappeared with the demise of NISW (a forerunner perhaps of the NSWA?) in 2000.

## THE 1990s AND ADVENT OF NEOLIBERALISM IN SOCIAL WORK

Although Margaret Thatcher's era of power had passed by the time social work became marketized, there is no doubt about her lasting influence and the scope of dramatic change that overtook the profession in the 1990s – and the survival of these ideas into the present era. By the end of the 1980s, social work was on the defensive: criticised for not getting it right with the protection of children (a notion that accelerated with the publication of the Clyde Report and its findings on perceived failures in Orkney) and for failing to divert adults with disabilities and enduring mental illness away from institutional care[5]. Social work was also faced with rising costs in social care with an ageing population at a time when government were set on reducing the size and range of the public sector in the name of liberalisation, consumer choice and citizen empowerment. At that time those without means only required a social work assessment if they opted for local authority care – admission to voluntary and privately owned care homes was simply means tested by the Department of Health and Social Security (the forerunner of the Benefits Agency); the only assessment for suitability being undertaken by the provider.

[3] (Turbett 2019)
[4] (Smale and Bennett 1989, Turbett 2018)
[5] (Brodie et all 2008)

Sir Roy Griffiths, a supermarket executive and adviser to the Conservative government, was tasked to report on this and find ways to reduce costs – considered to be tied up in expensive residential provision (increasing from £10m in 1979 to £1.2 billion in 1990). Griffiths had no social work background but was considered an expert in the business methods that could be harnessed to bring in market solutions. Issues included the failure of previous commitments to reduce reliance on institutional care, and the need to develop community-based services. With its neoliberal underpinning, it is arguable whether the reforms achieved anything in relation to developing community supports, but surprisingly, given tensions between local and national government, kept responsibility within local authorities for providing and commissioning community care services[6].

Griffiths was clear that community care would require considerable investment, and whilst this did take place initially through Resource Transfer Monies (savings made from the closure of long-stay hospitals), it soon dried up and local government was again left with responsibility for providing services for which it was not being funded.

Importantly for this paper, Griffiths also sought amongst his recommendations to turn social workers into managers of care, who would develop skillsets to buy in services, utilise accounting systems and effectively use information[7]. This was considered by Harris, a leading critic as the changes evolved, to take social work:

> "…… *away from approaches that were therapeutic or which stressed the importance of casework, let alone anything more radical or progressive. Turning professionals into managers involved making them responsible for running the business. It meant that the quasi-capitalist rationality of social work's quasi-business discourse was to become their business. They were to be different people, with the capacities and dispositions the social work business required…."*[8]

The proposal for a purchaser (state) / provider (voluntary, private, and state) split which would create a marketplace and reduce state responsibilities, marked a turn away from the premise of the 1968 Act, and its duty to promote social welfare. It was not initially welcomed by the Association of Directors of Social Work (ADSW) or the trade unions[9].

However, some of the reforms suggested by Griffiths were persuasive – the idea that existing frameworks were encouraging the placement of older people in residential care even when this might be avoided through community-based services (implying that people were being railroaded into such settings), and the language of choice

[6] (Barnes 1993)
[7] (Griffiths 1988)
[8] (Harris 2003 p66)

[9] (Brodie et al 2008)

and consumerism, all suggested citizen empowerment: this “challenged the profession’s view of itself as a force promoting social change and greater equality.”[10]

The ADSW effectively capitulated with a cautious public welcome of the changes, abandoning principles of universal and comprehensive state services in favour of a mixed economy of care.[11]The issue of choice in particular, was used to justify the growth of the private and voluntary sectors, and move services away from the public sector in the years to follow.

The Griffiths Report was followed by a White Paper, and soon afterwards by the NHS and Community Care Act 1990 – with UK wide application. The Act immediately created an internal market within the NHS, and through local authority commissioning, a broader marketplace for social care services.
Local authority social workers were now to formally assess people in need of supports offered under previous legislation and then arrange services from both state and non-state sources.

With parameters on funding now determined by local authority budgets (rather than previous central government sources that were available as of right), implementation of the act introduced eligibility criteria and resource allocation processes that reduced the autonomy of social workers. As remarked earlier, the impact was initially disguised through the pump-priming of re-allocated central government funds (which gave a huge impetus to private sector growth). Once this dried up, local authorities were left to manage the burden (and funding of this new market opportunity) through their own diminishing resources.

“Assessment and Care Management” (ACM) now became the universal model for social work practice with adults. The Dictionary of Social Work and Social Care defines this as:

> *…. An integrated and circular process for identifying and addressing the needs of individuals within available resources, which recognizes, at least rhetorically, that those needs are unique to the individuals concerned*.[12]

Guidance issued by the Department of Health and Social Services Inspectorate (1991) broke care management down into seven stages, and these were adopted generally as a template:

1. **The publishing of information** – designed to inform members of the public (consumers) what to expect and how to access services;

[10] (Brodie et al 2008 p707)
[11] (ibid)
[12] (Harris and White 2019 p356 - Kindle edition)

2. **Determination of the level of assessment** – i.e. scaled according to levels of need perceived at the outset, which in practice tended to pre-determine outcomes.
3. **Assessment** – in Scotland this was written in as an amendment to s12 of the 1968 act and became a duty to those requiring most services (i.e. people had a right to a community care assessment); such assessments were intended to be done once and to be all embracing (the concept of the Single Shared Assessment);
4. **Care Planning** – this concerned the drawing up of an individual care plan based on the particular needs of the individual subject to assessment, and the services they required to meet their needs. The Care Plan would match eligibility criteria (see below) with available services, and record "unmet need" (a factor often overlooked or not collated); the assessment and care planning stages would be undertaken by a "care manager" (see below) who might come from a variety of professional and para-professional backgrounds (i.e. not necessarily a qualified social worker).
5. **Implementation of the Care Plan** – the commencement of services agreed to meet identified needs;
6. **Monitoring** – the responsibility of the care manager. This could involve ongoing relationship-based work between worker and user, but not necessarily or indeed required;
7. **Review** – this was a duty on the local authority and might be undertaken bureaucratically by a specific team on a routine basis. It was assumed this would involve a face-to-face meeting, but this was not required to meet the statutory obligation.

It can be seen from this list that bureaucratically driven practice to meet legal and agency expectations would inevitably come in the wake of such a procedurally driven model. Contemporary commentators warned of this but also pointed out that there were possibilities within ACM for progressive practice if relationships were seen as significant to the journey of the individual, and if the duty to organise preventative services was taken seriously[13]. For a time, this was the case, and Strathclyde Regional Council, for example, collected data on both "met" and "unmet" need in order to plan services.

However, with increasing pressure on budgets the actuality was probably just as its architects intended: rather than upholders of individual rights to support and services, care managers (the title mirroring Griffith's vision), became gatekeepers of scarce resources. This principally involved the application of "eligibility criteria" (typically categorising need on a scale from low to high) with local authorities given leeway to determine their own according to their available resources, so long as these were applied consistently and in line with published criteria. Eligibility criteria became refined over the years by legislation and legal judgment as well as local

[13] (Payne 1995, Thompson 1998)

variation, but their essence remains the same – the finance-driven cloaking in a managerial guise of decisions that should be determined by moral, political and ethical considerations[14]. Applied on an ever-changing and individual basis away from public view, the process averts public concern from resource deficits affecting whole populations[15]. They are often subverted by intense lobbying, including the intervention of elected politicians at local authority and parliamentary levels.

## THE IMPACT OF ACM ON SOCIAL WORK PRACTICE

After over thirty years of operation, consideration must be given to the impact of such practice on social work as a profession. Reducing social work to managerial tasks has produced several generations of workers who have found themselves unable to practice the relationship-based models they learned in training. Some have adapted to this, including many who have become managers – essentially senior gatekeepers.

The first impact of growing managerialism in response to criticism of the profession was specialisation and the disappearance of local area teams that operated on a generic basis. Even before this started many area teams had established their own "intake teams" to relieve caseload carrying social workers from duty rotas and enable them to focus on families and individuals allocated to them. By the 1990s such teams were becoming centralised and taken away from localities. In the same period, children and family work, adult work and criminal justice work all became specialisms in all but the most remote rural settings.

This, it was said, would allow social workers to develop skills in their chosen field of practice. However, whilst this had some attraction, what it meant was that the procedures attached to these specialisms became more important than the generic basis of relationship-based work. Because they were often, as already noted, centralised, they lost the relationship with the communities they served. Services became fragmented and difficult to navigate if, as often happened, a family or individual's needs were complex and cut across referral categories.

As described elsewhere, social work became diminished in authority with the changes in local government in the mid-1990s[16]. The emphasis on managerial tasks soon made it commonplace for managers to come from outside social work, typically from health disciplines and health management backgrounds, a trend that has accelerated with the integration of services that became an enduring policy imperative from the early 2000s onwards.

Social work was always a very junior partner within integrated services, health resource concerns always being the driver – quite explicitly as time went on (as per

[14] (Harris and White 2019)
[15] (ibid)
[16] (Brodie et al 2008, Turbett 2021)

the Public Bodies (Joint Working) (Scotland) Act 2014). In this context crisis management has become the principal function of the formalised partnerships that have been developed on a local authority boundary basis across Scotland. A significant driver of that "crisis management" at the interface between health and care has been the focus on "blocked beds" and "delayed discharge" from hospital which has bureaucratised assessment and care management processes still further.

Siloed structures have developed around the requirement to speedily process referrals and arrange services from commissioned and constantly changing third sector and private providers delivering social care and residential services. This fragmentation of services into supposedly complimentary teams that served different aspect of the purchaser/provider ACM matrix, was encouraged by some commentators as a necessary model for efficient service delivery[17].

However, the dangers of such fragmentation were also highlighted early on as inherent within the care management model:

- routinised working – swift assessment, unimaginative practice and cursory review;
- large caseloads – with the emphasis on processing a high volume of work rather than client outcomes;
- proliferation of forms for various aspects of practice;
- tasks are split, and provided by different workers, leading to a general deskilling of the workforce;
- emphasis on formal services rather than the linking of formal and informal services;
- discouragement of the counselling and interpersonal aspects of social work.[18]

As care management became embedded there has been little room in a context of scarce resources for either preventative support, community approaches, or seeing the social work relationship between assessor/care manager and service user as of prime significance. Instead, signposting and re-referral from one team and service to another have become commonplace – perplexing and frustrating to the people and their carers seeking support, dispiriting for social workers. This has also led to employers valuing and developing a new breed of worker – technocratically proficient, working often from home (especially since Covid) in isolation from colleagues, and engaged for up to 70% or more of their working lives in computer-based form filling. Such workers are typically expected to follow protocol and fit people into eligible or non-eligible boxes rather than find effective supports. This gatekeeping role permits them to bury their empathy and people seeking support feel

[17] (Ovretveit 1993)
[18] (Sturges 1996 p49)

even more powerless in trying to communicate with faceless managers who control resources[19].

The social work role in care management has become diminished and, in many cases, de-professionalised, as ACM has "shackled the profession"[20]. Thompson (1998 p314) warned a long time ago that "A narrow focus on service brokerage can remove much of the job satisfaction of social work, thereby acting as a demotivating factor and a possible source of low morale.", a theme echoed by Lymbery a few years later (2004).

This is indeed what has happened – some social workers adapt and get captured by this narrow vision of social work's possibilities, with many becoming managers and inevitably influencing those junior to them (see also reference to Jane Fenton's work below); for others who came into social work with idealism and expectations of relationship-based practice, this is a contributory factor to the recruitment and retention crisis being experienced today[21].

All that said, there is no doubt that good relationship-based practice has survived through the efforts of many individuals and in teams where this is encouraged and celebrated.

Social work in Scotland was subject of a wide-ranging review published in 2006 - Changing Lives – the 20th Century Social Work.[22] With an emphasis on personalisation and the commissioning of services within a mixed economy of care, the report pre-empted the massive cuts in service that came with austerity a few years later. One of the unintentional consequences of the review was to consolidate social work's place at the crisis end of public welfare systems: Tier 4 in the "Tiered Intervention" model[23]. Although social workers were noted as having skills to bring to the preventative and support-based tiers that lay below, it is no surprise that local authority managers saw such tasks and duties as something for the Third Sector rather than as core responsibilities: the 1968 Act's promotion of social welfare was sidelined[24].

Neither was the impact of the proceduralised practices associated with ACM, restricted to adult care services. It was also felt in children and family, and justice services. To look in particular at children and family work, the same 1990s and early 2000s trends of criticism of standards and practice, and consequent defensiveness affected work at front line level as noted earlier. With assessment of risk a paramount consideration in response to failures, proceduralised processes became the norm – tying children and family social workers as much to computers as their

[19] (James et al 2020)
[20] (James et al 2020 p24)
[21] (Miller and Barrie 2022)
[22] Review (Scottish Government 2006).
[23] (ibid p30)
[24] (Turbett 2021)

community care colleagues. Over-bureaucratisation and compliance were observed as a corrosive influence by Munro in her influential Review of Child Protection (2011). Fenton (2019) explores the accommodation to procedural and even oppressive practice demonstrated by social workers who emerge from professional training with little in the way of values that will lead them in the direction suggested in Maree Todd's words quoted in the introduction to this paper. They become "cogs" in a bureaucratic machine that has become "…..value poor, punitive and authoritarian…"[25], and in a view that the author and many others would subscribe to, should challenge such systems so they can be "…a different sort of cog…"[26]. Of course, this is easier said than done – the purpose of this paper is to influence those who have the power to change such systems, to do so as a matter of urgency.

## SEPARATING OUT ASSESSMENT FROM CARE MANAGEMENT

Assessment has always been an appropriate and essential social work task. Smale and Tuson (1993) in a book on ACM as it was first evolving, formulated models in a format probably most quoted by students and those studying assessment in social work to this day (it is quoted widely in other texts)[27]. This states that there are three forms of assessment: the *questioning model*, *the exchange model* and the *procedural model*. There is no doubt that the last one, which these authors describe in pejorative terms, became the predominant form used in care management because it suited agency function and the use of eligibility criteria. However, the Oxford Dictionary of Social Work and Social Care opens its more recent definition thus:

> "*Collecting, analysing, and recording information about people, their circumstances, and the context of their lives in order to reach an understanding of their situation and to inform decisions about whether further intervention is necessary and, if so, to propose what form(s) it should take*."[28]

There is nothing in this that implies lengthy written reports that are unlikely to be read by anyone in full and whose purpose is questionable. A typical community care form set will include Referral, Initial Assessment, Assessment (often described as a Single Shared Assessment implying that its content will be widely shared amongst professionals), Review, Financial Assessment, Care Plan – and often a checklist to ensure it is all there, signed off and up to date….

The maintenance of such processes can, as described earlier, become an end in itself: the author of this paper has experienced systems where paperwork was routinely thrown back by remote resource allocation committees because something

[25] (Fenton 2019 p43)
[26] (ibid)
[27] Smale and Tuson (1993)
[28] (Harris and White 2019 p208 – Kindle edition)

was said to be missing – the real purpose being to defer a decision that would involve cost. All this of course is linked to the use of eligibility criteria to determine whether expense is justified: in other words, the main purpose of all this paperwork is to gatekeep and protect budgets, with a subsidiary one being to protect managers from the consequences of having to consider people who do not receive support with their care needs.

In children and family settings it is not unusual in Scotland to see reports that are fifty and more pages long – social workers using computerised systems simply add updates to existing text, so the reports get longer and longer. This might sound like lazy practice – perhaps it is in part, but it also saves valuable time. There is also a well-founded fear of missing anything out that might be deemed significant should anything go wrong and records are closely scrutinised in a Significant Case Review. Again, as with care management, the emphasis is on risk avoidance and risk management rather than prevention and support. Such practice is neither child nor family friendly and is rightly being challenged through the work of "The Promise", the latest initiative to improve the experiences and outcomes of children in the care system.

## ALTERNATIVE MODELS

As assessment in community care settings has become inextricably linked with care management, it is time to challenge assumptions and bravely bin unnecessary bureaucracy. Elsewhere this has already happened: in Leeds a lengthy assessment form for adults was replaced by a blank sheet of paper where the social worker was asked to write only what was necessary, and outline solutions that were legal and affordable. The emphasis in the Leeds model of "Strengths based social care" is on conversations rather than forms – looking at what people can do rather than on what they cannot[29]. A similar approach has been adopted in Northumbria which they call the "Liberated Relational Method" governed by "two unbreakable rules – we do no harm and we do not break the law."[30]. Both models involve commencing a journey with the user of services that, unlike care management, does not have a beginning, middle and end.

The writer has come across similar approaches to adult services in Torfaen Council, South Wales – again involving the abandonment of eligibility criteria and complicated assessment tools. At the time of writing the Torfaen Blaenavon Wellbeing Team are in their seventh year of operating a model that involves their own front door, a commitment to finding solutions and not passing on, conversations and a welcome given to re-referral. The team is stable, staff are proud of what they do, welcome students, and practice as a team embedded in their local community. Contrary to the warnings of sceptics, they are not overwhelmed with referrals, have no waiting list, and staff have manageable caseloads. They also report that as they operate

[29] (Leeds Council undated)
[30] (Changing Futures Northumbria 2023)

preventatively and upstream, commissioned services (homecare, respite, residential care etc) are often avoided.

It is noteworthy that the changes in Torfaen followed new legislation in Wales (the Social Services and Wellbeing (Wales) Act 2014) – with some Councils using the opportunity within a new framework based on prevention and co-design to rethink services[31].

## MOVING FORWARD

The creation of the National Care Service in Scotland offers a moment to think about how to do things differently and innovate on a nationally agreed basis. Indeed, this is the best opportunity since 1968 to reset social work in the revolutionary manner that took place over fifty years ago.

The establishment of the National Social Work Agency could provide a mechanism for doing just this. Key will be a vision for social work that will encompass all aspects of the profession and will set out what it is that social workers must do to provide relationship based, strength based, community focussed practice, and what kind of leadership cultures and resources they need to bring this to life. The setting up of a new structure, and the publication of the proposed national standards, will not in themselves achieve change. There are numerous challenges and issues to be tackled, and this paper has focused on just one – assessment and care management.

Moving away from care management and procedural processes requires an orientation towards whole communities and a focus on local and neighbourhood strengths and assets. Innovations in other parts of the UK suggest that taking out eligibility criteria has not resulted in overspend and collapse of services but instead has released the potential of social work staff to work creatively alongside others – bringing co-design to life. Scotland could again be the beacon for necessary change in social work, and the words of the present Minister quoted at the start of this paper, might then be realised.

Self-Directed Support could and should have introduced a new model: with people in receipt of care services and their informal carers being empowered to manage their own services along with the staff working for them. Unfortunately, gatekeeping has impeded this aspiration, so that people who pass the eligibility tests then become frightened of asking for their services to change in case they lose them completely. Instead of flexible services to meet needs which may vary daily and over time, care management systems have locked people into fixed services with significant wastage of resource. Outsourcing has led to difficulties ensuring private sector providers comply with the intentions behind care plans, rather than simply extract profit. Ensuing problems are difficult to resolve and this has added further layers to

[31] (Turbett forthcoming)

care management, surveillance and sometimes “protection”. The contrast with the NHS in Scotland, where GPs work on the basis of trusting those providing services is striking. While in the NHS services could arguably be better co-ordinated, there is no need for care management because most services are public.

The big question for those viewing social work from the outside might be: “if you don’t do assessment and care management to assess people and arrange services, what do you do?” This paper has tried to answer this from a premise based on not just pre-ACM times, but current initiatives that are bringing in more effective and rewarding forms of practice. These need to be explored further on a local basis to reflect geography and need, so no firmed-up template is offered here. Such changes will help bring social work back to the preventative community-based basis of the 1968 Act that was firmly embedded in the values and aspirations of the profession and might also address the recruitment and retention crisis.

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