

# **A Review of the literature concerning what the public and users of social work services in England think about the conduct and competence of social workers**

## **Final Report**

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The Professional Standards Authority

**March 2015**

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## Executive Summary

The Professional Standards Authority commissioned this review. Key findings from relevant sections of the review are:

### Background

- Social work is a broad discipline with a holistic focus on people and their context. 'Social workers' are those who have undergone approved training and are registered with the relevant country's regulatory body.
- 'Service users' is a common term used for those who receive/are eligible to receive the services of a social worker. However controversy surrounds this term – many feel it is not appropriate for those who are unwilling and reluctant users of health and care services or those who feel it does not infer their equality and rights as a citizen.
- Since early 2000, codes of practice have been developed for social workers, a register of Social work professionals kept and social work education and training has been regulated and supported. Different bodies (first the General Social Care Council (GSCC) and then the Health and Care Professions Council (HCPC)) have had the power to suspend and/or de-register individuals with social work qualifications for a number of well-specified reasons.
- Social work has recently undergone a period of great change. This includes a shift towards 'personalisation' in adult social care, with greater control passed to individuals and increased commissioning of service provision by the private sector. Policy and practice with families and children has increasingly narrowed to be predominantly concerned with child protection
- A further key influence upon social work in the last few decades has been the growth of user movements and campaigns for greater empowerment and recognition of rights, which along with rights based, anti-discrimination and

participation legislation have led to a stronger user voice in relation to social work (including in quality control, research and training).

- Unfortunately social work may be something that the public has strong, often negative attitudes about without actually having a clear understanding of what social work is and what social workers do. This has not been helped by distorted media coverage.

### **Service user views on the setting and maintenance of professional standards**

The bodies involved in the regulation and standards of conduct and practice for social care staff have invested in some specific strategies to gain the views of service users.

- People do consider that standards are important. However prior to taking part in consultations few people had any awareness of the current regulatory bodies, regulation procedures or standards of conduct. Clear, accessible information on the codes must be published in order for people to be clear what the standards are and aware when they are not receiving their entitlements.
- Most people feel that there should be a unified approach to standards across national health and social services and throughout the UK and that standards should be enforceable, monitored and improved.
- People have stressed that service users and carers should be involved at different stages of the process; this includes developing, implementing and monitoring of standards, training and assessment, recruitment, commissioning and the monitoring and evaluation of services. Good practice in relation to service user involvement must be set out in the standards.
- Factors felt to be important in social work practice include personal qualities of courtesy, integrity, honesty, trustworthiness, openness, respect, compassion, reliability, reassurance, empathy and warmth, as well as the maintenance of confidentiality and privacy, equity and fairness, awareness of cultural and

religious differences and clear communication in English. People desire relationships that inspire confidence, are empowering, enable choice and control, are non-discriminatory and non-judgemental and offer informality and flexibility. Continuity in relationships and the provision of clear, up-to-date, factual and comprehensive information and expert, targeted, holistic and efficient help was also listed as important.

- A key theme voiced throughout many different consultations was of ‘putting the person first’ – providing person-centred support that enables people to be fully involved in decision making and fulfil their own agendas.
- A strong emphasis on human rights, the United Nations Conventions on the Rights of the Child and the Rights of Persons with Disabilities and challenging discrimination within the standards was also suggested as important for inclusion in any standards.
- Specification of conduct which is unacceptable in terms of abuse, breaches of trust and neglect of duty should also be included, as well as clear, protective procedures around ‘whistleblowing’. The general public have shown mixed views regarding the specific types of actions, behaviours or practices the public should always be protected from, or that might cause concern about the quality of health or social care. This is particularly the case with regard to off duty behaviour; there tends to be no overall agreement about what behaviours, actions or situations would always bring a health or care professional’s fitness to practise into question. However consistently poor performance of professionals or actions which shed doubt on the professional’s general character traits of ‘trustworthiness’, ‘judgement’ or ‘responsibility’ should be challenged.
- There is concern as to whether the ideals presented in standards can actually be delivered within the constraints of time, resources and budgets.

- Although there has been some research looking at service user views on the setting and maintenance of professional standards for professionals, in general sample sizes have often been small and there has been very little research on the specific conduct expected from social workers. This is an area which needs to be addressed, with inclusion of a wide range of participants.

### **Making complaints about professionals and services**

- People feel that isolated issues with a workers practice are seen as best resolved with an employer; however a significant number of people would want a regulator to have been notified of any warnings or incidents.
- When people have problems in relation to their interactions with professionals and receipt of services they do not always complain or report these issues. Information about complaints procedures can be difficult to obtain, there is also a lack of knowledge of the rights to services that people have, and the standards of care that they should expect.
- Power imbalances between individuals and service providers can also be barrier to complaining. There can be scepticism that a complaint will be responded to appropriately, as opposed to defending the authority or professional against liability.
- People also tend to be fearful of retribution, loss of service, negative scrutiny or media interest. People are often unwilling to appear ungrateful for services or do not wish to be seen as awkward or to be 'moaners'. People in residential care are particularly vulnerable and unlikely to speak up about their rights or concerns for fear of retribution or making matters worse.
- One review suggested that people can be intimidated by having to make complaints in writing and that people prefer to be able to make complaints by telephone. However, research suggests that there is also scepticism about whether or not telephone calls will be acted on and therefore some prefer the

formality of letters, which also allows copies to be kept. Young people may also have a preference for using phone or text messages, rather than writing letters.

- It is recommended that: all organisations foster a supportive environment for its care professionals and a protective environment for the public; advocacy services should always be available to help with any issues or complaints that individuals make; care councils should clearly present themselves as independent; using the code of conduct in practice should be seen as ‘normal’ so that individuals feel able to do so; different mechanisms should be available for complaining, both formal and informal.
- This review encountered a dearth of studies specifically looking at complaints about social work and social care. In our view this is an area which should be addressed, together with further research focussing on public perceptions of the standards and competence of social workers.

### **Regulation of services**

- The clearer and more specific the regulations are governing a service, the easier they are for a service user to make sense of and to challenge when necessary
- There is a danger that as regulatory bodies take on a wider range of services, standards become more universal and simultaneously become vaguer, and more open to interpretation.
- Centralisation of regulatory bodies can also be a disadvantage. Having local inspectors with whom to threaten local service providers, mean that people can more easily be contacted and involved at local level.
- Service users should be routinely involved in inspection visits and the monitoring of safeguarding processes

- There is a danger that regulation or an overriding concern to enforce safety can impact on the quality of care and rights. Safeguarding may be experienced as ‘safety at the expense of other qualities of life, such as self-determination and the right to family life’

### **Service user views relating to social work within adult social care**

- For adults and carers there can be considerable confusion about what constitutes ‘social work’ and what social workers do. Older people generally have overwhelmingly negative views of social work and social workers prior to direct experiences with social workers themselves.
- Unequal access to social work seems to be an issue. Many people experience barriers to accessing social work services, or feel there is discriminatory practice against older people. People do not always know what they are entitled to or how to access this information.
- The attitudes of individual workers can make a real difference to a service user’s experience. Good social workers are seen as those who are helpful, caring, trustworthy, responsive, reliable, accessible, supportive, sympathetic, kind, warm, compassionate, sensitive, empathic, thoughtful, non-judgemental, friendly, committed, good communicators, service user/carer-centred and prepared to listen.
- Many service users do not see some of the positive personal qualities of the social worker as things that could be acquired or learned through training but view these as very much part of the person. Many feel that managers should be recruited from front-line staff. The employment and involvement of service users at all levels of working was also recommended as a way of ensuring the existence of ‘right’ attitudes amongst staff.
- A consistently strong message from service users is a wish to be treated with respect, have their experience valued and be viewed as the expert in their

care. Relationships wanted with staff are those that promoted equality and maximised choice and control – collaborative relationships.

- The importance of social workers' efficiency was noted. This is both in terms of giving advice and information, and in being able to truly take on board the difficulties that individuals and families face and providing clear and effective solutions. People also value recognition of their wide ranging needs and a worker's ability to holistically offer a wide range of social work approaches to suit different needs.
- Another key aspect that people find most helpful about their social worker is the relationship that they have with them. People valued a social worker relationship that was 'on their side', or even was as a 'friend' (characterised by perceptions of shared power and equality, trust and support, 'ordinariness' or informality, reciprocity, firmness and an ability to 'talk straight').
- People show a concern for more openness within and coherence around the profession. Empowerment to challenge their own social workers should be promoted in service users. Systems of adult protection/adult safeguarding could be improved and service providers should take what vulnerable adults report seriously. Confidential whistle-blower schemes are important but could be improved.
- Service users usually feel very strongly that they should be able to take decisions for themselves on matters which impact upon their own lives and wellbeing. They have highlighted the importance of an ability to understand not just risks but also the rights of the individual. Dignity and quality of life can be significantly affected by universal, generalised approaches towards risk.

### **The experience of social workers by parents in troubled and resistant families**

- Being involved in a child protection investigation causes immense stress for families at all stages. Many parents feel stigmatised by social workers, although parents can view involvement with child protection services

positively and understand that social workers have to be diligent and persistent to protect children and prevent tragedies such as affected Baby Peter (Connelly).

- Many parents in child protection cases – even those who experience an unwanted outcome - can feel helped or supported by their social worker and many can identify positive qualities in the professionals who supported them.
- Service users sometimes reported struggling to understand what was happening to them and why. Clear information and explanation is essential but absorbing information at the start of the investigation process is difficult for many parents, due to stress and anxiety which can impact on an individual's ability to retain information. Time to absorb difficult communication and repeated giving of information may be needed.
- There were some complaints that child protection processes over-emphasise problems, and that good factors were ignored. Having strengths recognised by professionals can increase morale and motivation.
- As in other fields of social work considered in this review people stress the importance of the social work relationship. Personal qualities valued in social workers include being reliable, supportive, listening carefully, promoting co-operation, being matter of fact and being 'human', promoting trust, communicating openly and clearly and providing mutual understanding and support.
- Feeling listened to and consulted and being shown empathy and respect can particularly lead to a more positive experience of social worker involvement. In addition being open, clear, honest and 'upfront' could help to build a positive relationship and establish trust, even where service users did not like what they were being told. Providing a written copy of all that was discussed between them could help.

- Some people have expressed concern about the balance of power in child protection systems and a sense of not being treated as innocent until proven guilty. It is very important that all people feel they are being treated 'fairly' and with courtesy. A perceived lack of fairness is compounded by a lack of understanding of their rights within the social work system. Social workers should always remain very aware of power imbalances and their impact on individuals.
- Being recognised as a parent even if no longer able to physically care for the child was hugely important to parents of children who are in care or adopted.

### **Children**

- Children and young people often strongly fear the consequences of confiding in their social workers. They want information and help from friendly, non-judgemental professionals, who encourage them to ask questions, listen without prejudice, convey trust, treat information with confidence and act with competence. Great sensitivity and reassurance from a social worker is needed to reduce their fears around whether they will be believed and understood and what will happen with any information given.
- Communication skills involving empathic listening and questioning are particularly valued by children and young people. They appreciate social workers who listen and communicate with them at an appropriate level about everything that is going on for them – especially around child protection procedures, moving into looked after settings and other transitions.
- Children and young people frequently make clear that they want to be treated as individuals. Social workers need to provide flexibility around children's unique and individual needs for support.
- The child's own wishes regarding their situation must be respected and fully taken into account even if the social worker is not able to go along with those

wishes. The evident inequality of power should be respected, acknowledged and not abused.

- Children and young people generally want more opportunities to understand and have an influence on what is happening to them. Children repeatedly state that they want to be given more information about what decisions are being made and why. They want a key say in discussions and decision making especially around placement moves, schools and contact. Particular effort needs to be made with disabled children, privately fostered children, children in kinship care and children in youth custody, as these groups feel even less involved in decision making. Training and skills in communication with children with disabilities is important.
- Social workers should aim to empower children - not just to allow them to voice their opinions more but also to generally take more control of their lives.
- Children and young people frequently complain about social workers being difficult to get in touch with. How much contact and how close a relationship children want with their social worker can vary depending on their needs at particular times and situations. Children would like social workers to give them more time and attention around key events and changes. To meet children's varied and fluctuating needs social workers should be flexible about visits, and attune to children's wishes without following a prescriptive pattern or continuing with a routine that is no longer appropriate. Social workers also need to be easily available and respond to particular needs. They need to be sensitive to a meeting context and ensure it does not single a child out from their peers.
- When holding meetings that children and young people are able to attend there should greater flexibility to allow children to participate in their own way. This includes attending for part rather than all of the meeting, or going through

reports and plans beforehand so that they can have their views passed on indirectly.

- Children and young people want good communication between professionals and support for moving between professionals and services without having to tell their story several times.

### **Black and minority ethnic groups**

- Social workers should be aware of the greater barriers to accessing services that minority groups can experience, particularly with regard to language differences and potential concerns about services' cultural or religious appropriateness. The importance of equal access for all should always be kept paramount and workers must enable and support access whenever necessary. Competent interpreters may be needed.
- Social workers should be aware of the prejudice and discrimination that many people from Black and minority ethnic cultures experience. Time may be needed to gain trust and extra support offered to individuals as necessary.
- Improved and ongoing training for social workers and care workers on cultural issues relevant to the local population is required; however generalisations should be avoided and differences in people within an ethnic group must be recognised and acknowledged.
- A person-centred approach is needed when providing care to a culturally diverse population. There needs to be an understanding of people's cultural, linguistic and religious background but without making assumptions and resorting to stereotype; people from the same ethnic background will not have the same needs. Life experiences, individual differences, identity and other factors will always have an impact; a social worker needs to be culturally sensitive but also sensitive to all other aspects of the service user's circumstances because the impact of ethnicity on their needs is nuanced.

Open and continual discussion with service users and their families about such aspects is important.

### **How the general public perceive social workers**

- Public perceptions are generally derived from media representations – which are mostly negative. Much of this relates to views about social workers acting (or failing to act) in relation to child protection and safeguarding issues.
- There is little public understanding of the social work role or what social workers actually do – this tends to change once individuals come into contact with social workers (especially if not related to child protection or control functions). It is perceived, however, that the work done is necessary and ‘worthwhile’.
- There has been little work that has considered public perceptions of standards and competence. One study showed a feeling that social workers needed to be better trained and fully equipped to do their jobs. There are concerns around abuse of power and a strong desire for fairness and accountability.
- More information about public perceptions of what sort of qualities social workers should possess is required. These are generally in the domains of good interpersonal and communication skills, impartiality and fairness, discretion and the ability to attract and maintain trust and respect. There is also a recognition of the need for resilience and emotional strength.

### **Conclusions and recommendations**

For many people – even those who have had or are experiencing input from a social worker - there is considerable confusion about what constitutes ‘social work’ and what social workers do. People generally have overwhelmingly negative views of social work and social workers prior to direct experiences with social workers themselves. Unfortunately the media can present a very distorted picture and is a considerable influence on peoples’ views.

People do consider that a code of conduct and accountability are important and necessary. There are clear concerns around lack of fairness and abuse of power. However few people have any awareness of the current regulatory bodies, regulation procedures or standards of conduct. Clear, accessible information on the codes must be published in order for people to be clear what the standards are and aware when they are not receiving their entitlements.

Research with people who have experienced the input of a social worker has been remarkably consistent in revealing the qualities people value in social workers. From adults and children in all fields of social work there has been a clear desire for social work practice that:

- Approaches the person as an individual with their own unique needs and concerns and without making assumptions as to the impact of their culture, background, status or age.
- Respects the person's individual autonomy and takes into account their needs to be informed about, understand and make their wishes clear about all actions and decisions that will impact upon their life.
- People clearly value a particular type of relationship with their social worker. They seek a relationship characterised by courtesy, integrity, honesty, trustworthiness, openness, respect, compassion, reliability, reassurance, empathy and warmth. People desire relationships that inspire confidence, are empowering, enable choice and control, are non-discriminatory and non-judgemental and offer informality and flexibility.
- Other factors which people see as essential in social work practice are: confidentiality and privacy, awareness of the potential for discrimination and clear communication in English. The provision of clear, up-to-date, factual and comprehensive information and expert, targeted, holistic and efficient help were also listed as important.

- Many people refer to their social worker as a 'friend' and value the 'friendship qualities' that can be shown within a professional relationship. Reciprocity and continuity and a sense of equality (as a human being of equal worth) are key.

Considering the above findings there is a danger that a code of conduct for social workers could be too restrictive. Any code needs to take into account the quality of a relationship with a social worker that is appreciated – particularly in terms of the expressed desire for an informal relaxed and tailored relationship that may in some ways can be seen as a 'friend' and involve reciprocity.

There is also danger that regulation or an overriding concern to enforce safety can impact on the care and rights of the individual. Safeguarding can be experienced as 'safety at the expense of other qualities of life, such as self-determination and the right to family life'.

A key theme voiced throughout many different consultations was that any code of conduct or set of standards should clearly 'put the person first' – promote person-centred support that enables people to be fully involved in decision making.

A strong emphasis on human rights, the United Nations Conventions on the Rights of the Child and the Rights of Persons with Disabilities and the potential to challenge discrimination within the standards was also suggested as important.

Although there has been some research looking at service user views on the setting and maintenance of professional standards for health and social care professionals sample sizes have generally been small and there has been very little research on specific conduct expected from social workers. This is an area which needs to be addressed, with inclusion of a wide range of participants.

There has also been little work that has considered *public* perceptions of standards and competence. More knowledge and understanding about public perceptions of what sort of qualities social workers should possess and the standards that should be maintained are required.

## Acknowledgements

We would like to acknowledge the assistance of Advisory Group members, Sarah Carr and Pete Fleischmann and the support of a number of colleagues during the preparation of this review. Any errors and inconsistencies are, of course, our own.

# 1. Introduction

*The process of getting a service and the way in which it is delivered can have a major impact on a user's experience of a service... This view is contrary to the prevailing view among academics and professionals, who have focused primarily on outcomes in terms of the end result of a service. (Beresford et al., Shaping our lives – from outset to outcome, p3)*

## 1.1 The purpose of this review

This review has been completed in response to the Professional Standards Authority (PSA) for Health and Social Care Tender: *Service Users' and Carers' Views of Social Workers*. The PSA for Health and Social Care (the Authority) promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. The Health and Social Care Act 2012 expanded their role to include overseeing the regulation of social workers in England and accrediting voluntary registers for care occupations. To fulfil these new responsibilities the PSA identified a need to bring their knowledge of the social care sector up to the same level as our extensive knowledge of the health sector. This literature review aims to assist with this and inform how the PSA can:

- Promote the interests of users of social work services through their oversight of the Health and Care Professions Council (HCPC) which regulates social workers in England
- Respond to HCPC consultations about their conduct and education standards for social workers
- Set standards for organisations that hold voluntary registers for health and social care occupations and accredit those that meet them
- Facilitate debate and research on professional regulation and registration.

## 1.2 Research objectives

1.2.1 The main questions this literature review aims to explore are:

- What do users of social work services in England (including carers) think about the conduct and competence of social workers and what improvements do they want to see in the standards social workers maintain i) whilst 'on duty' and ii) at other times?
- Is there any evidence the general public in England hold different views to service users on this? If so, how do views differ?
- Is there any evidence that service users or the general public want social workers to maintain different standards of conduct than those they want from other professionals?

1.2.2 The secondary objectives are:

- What training do users of social services in England (including carers) and the general public expect social workers to have had? How does this differ, if at all, from their expectations about the training of unregulated social care staff?
- What evidence exists about public awareness of the fact social work is a regulated profession?
- Has any research been done to explore the public's views on how social workers and social care staff in England should be held to account? If so, what does it tell us?
- What gaps in the existing research evidence base might the PSA need to consider addressing in order to help answer the above questions?

This review is structured firstly with chapters looking specifically at service user and general public views of conduct and professional standards. Later chapters look at general perceptions of social workers within different service user groups and the wider population.

## 2. Methodology

2.1 The study consisted of a review of relevant literature relating to the area of service user, carer and public perceptions of social workers. Both academic literature and grey literature were included in the review. Given the multiplicity of settings and roles in which social workers may be found, the scope of the review was necessarily broad and encompassed many areas. Therefore from the earliest stages, the review, including the strategy for the literature search, was developed to reflect and capture this diversity. Although due to evident constraints (time frame and budget) this study did not comprise a systematic review of the literature, a systematic approach to the review was taken. This approach was agreed with the PSA in the initial and early stages of the review in order to establish an appropriate framework within which the review was undertaken, and to establish principles for the review. These adhered to a number of the core principles of systematic reviews but also contained room for reflexivity and some flexibility in the process. Essential elements of such a framework included, for example:

- Identification of literature according to an explicit search strategy
- Selection of relevant literature according to well-defined and explicit inclusion and exclusion criteria

The study also included the review and analysis of documentary evidence, such as would be obtained through the search for relevant grey literature, as well as information obtained from relevant websites and reports.

We were also guided by the report produced by the Social Care Institute of Excellence on the use of systematic reviews in social care (Macdonald, 2003) as well as guidance from other relevant sources. A detailed research plan for the review was established and agreed with the PSA during the initial stages of the study.

## 2.2 Inclusion criteria

Literature that:

- Is UK based
- Covers service user perspectives of social workers (individuals that have had contact with social care services that included interaction with a *qualified* social worker)
- Covers general public perceptions of social workers
- Considers *qualified* social worker roles in a range of fields in children's and adult social care services
- Focusses on conduct and competence of social work professionals and potential improvements in standards
- Was published since April 1992 when community care changes were implemented up until current period (including unpublished work in progress that may come to the researchers attention)
- Preference given to empirical, peer-reviewed studies of all research designs
- Grey literature and documentary evidence including reports in the public domain, and available from relevant websites

## 2.3 Exclusion criteria

- International literature findings – however such articles may be briefly considered to search for relevant references to UK literature
- Literature that only considers service provision or policy related issues
- Literature published prior to April 1992, unless of major significance

## 2.4 Search Strategy

- We used a combination of searches from databases, citation indexes and hand searching
- We sought references to additional material via the advisory group members and existing professional networks of the research team
- For electronic searches we developed a list of appropriate search terms based on inclusion criteria and related to the research questions. This list was considered and added to by the PSA. The initial search terms were:

Perceptions	Service users	Social work	Social workers
Perspectives	Adult service users	Social care	Social care
Views	Parents	Foster care	Professionals
Experiences	Children	Adoption	
Opinions	Young people	Child protection	
Regulation	Care leavers	Adult safeguarding	
Accountability	Families	Safeguarding	
Competence		Palliative care	
Conduct		Hospital	
		Hospice	

- Identification of relevant databases and citation indexes followed by initial searches. This included: psychINFO, ASSIA, EbscoH, Childlink, Google Scholar, Pubmed, IBSS, JSTOR, PsycARTICLES, SCOPUS, Social Care Online, SSCI
- Searches of local library catalogues and digital depositories were also made
- The results of the search were sorted in two stages. In the first stage the RA compiled a list of abstracts and removed any duplicate studies, together with

any that were clearly not relevant. Following this, the sorted search results were further reviewed and any remaining abstracts not considered relevant were rejected. Decisions taken were based on an explicit set of criteria including issues such as size of the study, relevance to current practice as well as to the research questions. Any abstracts that did not meet the inclusion and exclusion criteria were normally be rejected, but could be subject to discussion between the researchers to reach a final decision

- Studies left after this second sort were usually obtained for full review and evaluation
- The assessment process inevitably involved a degree of subjectivity. The extent to which a study met a particular criterion and the likely impact of this on the reported results from the study was dependent on the context and inevitably the judgment of the individual reviewers. Both researchers appraised the methodology of studies selected for full consideration. The subjective nature of critical appraisal made double-checking essential to minimise the chance of bias and to ensure consistency.
- In relation to the inclusion of material such as reports from relevant websites (in particular Service User and related organisations), it was also important to ensure that there was a rigorous examination of relevance to the key research questions.

## 3. Background

### Key Points

- Social work is a broad discipline with a holistic focus on people and their context. 'Social workers' are those who have undergone approved training and are registered with the relevant country's regulatory body.
- 'Service users' is a common term used for those who receive/are eligible to receive the services of a social worker. However controversy surrounds this term – many feel it is not appropriate for those who are unwilling and reluctant users of health and care services or those who feel it does not infer their equality and rights as a citizen
- Since early 2000, codes of practice have been developed for social workers, a register of Social work professionals kept and social work education and training has been regulated and supported. Different bodies (first the General Social Care Council (GSCC) and then the Health and Care Professions Council (HCPC)) have had the power to suspend and/or de-register individuals with social work qualifications for a number of well-specified reasons.
- Social work has recently undergone a time of great change. This includes a shift towards 'personalisation' in adult social care, with greater control passed to individuals and increased commissioning of service provision by the private sector. Policy and practice with families and children has increasingly narrowed to be predominantly concerned with child protection
- A further key influence upon social work in the last few decades has been the growth of user movements and campaigns for greater empowerment and recognition of rights, which along with rights based, anti-discrimination and participation legislation have led to a stronger user voice in relation to social work (including in quality control, research and training).

- Unfortunately social work may be something that the public has strong, often negative attitudes about without actually having a clear understanding of what social work is and what social workers do. This has not been helped by distorted media coverage.

### 3.1 Definition of 'Social workers'

3.1.1 Social work is a professional and academic discipline that seeks to improve the quality of life and well-being of individuals, families, couples, groups, and communities through research, policy, community organisation, direct practice, crisis intervention, and teaching. It is focussed on those affected by social disadvantages such as poverty, mental and physical illness or disability, and social injustice, including violations of their civil liberties and human rights. An agreed global definition, as set out by two bodies representing international social work - the International Federation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW) - is as follows:

*Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing.*

(International Federation of Social Workers, 2014)

3.1.2 A person who practices social work is called a social worker. In the UK, the title "Social Worker" is protected by law (under s.61 Care Standards Act 2000) and only those who have undergone approved training at university either through a Bachelor or Master's degree in Social Work and are registered with the appropriate professional regulatory body (which in England is the Health and Care Professions

Council) may practice social work and be called a 'social worker'. Student social workers undergo a systematic set of training and qualifications that are distinct from those of social care workers or care assistants, who may undertake a social work role but not necessarily have the qualifications or professional skills of a qualified social worker. Although the title 'social worker' has been protected since the introduction of the Care Standards Act (2000) it often remains applied to unqualified staff that undertake a range of social services tasks. Currently, there are no formal qualifications or training to practice as a social care assistant, care worker, or carer, although many people will have undertaken National Vocational Qualifications to equip them for particular roles and tasks, but mostly ancillary staff are accountable to a qualified member of staff, such as a social worker. People using such services may employ the term 'social care' as an umbrella term to include social workers, for example, as in the experiences of service users reported by Beresford and colleagues (2005).

According to research (for example Beresford *et al.*, 2005; Branfield *et al.*, 2005; Beresford 2007) people seem to value the ideal of social work as a profession that considers and responds to people holistically in their wider context, in contrast to, for example, health professionals which focus on the individual in isolation from their social world. Social workers are appreciated for taking into account and helping to support individuals around their circumstances and the issues and barriers they face. People also value the wide range of approaches that can be used by social workers (including work with individuals, families, group and community work) and the range of tasks they undertake. In Beresford's (2007) literature review people had experienced social workers who gave information, advice and advocacy; counselling and other psycho-therapeutic support, practical guidance and help, referrals to other relevant agencies and service providers, help accessing financial support, housing and other services.

### **3.2 Definition of 'service users'**

3.2.1 In this review we use the term ‘*service users*’ to denote people who receive or who are eligible to receive social work and social care services. This embraces people included in a wide range of categories – individuals with mental health difficulties, people living with HIV/AIDS, heart disease or other chronic illnesses, people with physical disabilities, older people, people with learning or intellectual difficulties, people who misuse/are addicted to illegal substances, alcohol or prescribed drugs, families, children and young people with extra needs, with disabilities or in need of protection and children in state care or adopted.

3.2.2 It should be noted that many studies involving ‘*service users*’ have uncovered issues with this terminology used to describe their participants. One early consultation aiming to define quality and standards in social services practice (Harding and Beresford 1996) reports how some participants felt that the terms ‘*users and carers*’ inferred a caring and supporting profession, and excluded those who didn’t feel they were being cared for and supported by services. Those that considered themselves to be unwilling and reluctant users of health and social care services identified themselves as not ‘*service users*’ but were instead ‘*recipients*’ or ‘*people subject to the regulatory and controlling role of local authorities*’. Some participants, who had used mental health services, identified themselves as *survivors* rather than users of the mental health system.

Barnes and Cotterell (2012) provide a list of terms that people who are included in what is commonly referred to as ‘*service user involvement*’ would like to be identified by:

*‘consumers or users of specialist health and social care services, citizens with rights to fair and equal treatment; as experts in their own lives, the conditions, the experience and the management of their treatment; as partners in the design and delivery of services; as ‘ordinary people’ who can bring a lay perspective to health policy making; political activists; as researchers involved in the generation of new knowledge’* (Barnes and Cotterell 2012, p xxii).

The General Social Care Council consultations with people with experience of social care services (*General Social Care Council, 2012*) also noted that some people preferred not to be referred to as ‘*service users*’ but as ‘*citizens*’ to emphasise the point that they were not ‘different’ and that they had rights. In the end the GSCC, along with the other national social care bodies, agreed to use the term ‘*people who use services and their carers*’. This was still contentious at times but was thought to reflect the perspective that people who have experience of using health and social care services are people first and are not (and should not be) primarily identified by their health and social care needs.

Due to the disagreement in this area, the problem that alternatives can be lengthy, and to fit in with the term predominantly used in the UK literature, ‘*service users*’ is used throughout this review. However this is done with the acknowledgement that it is not appropriate for all who have experienced the involvement of a social worker. It should be acknowledged that for researchers, the different terminologies used in the literature present challenges when using electronic search engines to locate research articles focusing in this area.

### **3.3 Setting Standards and monitoring quality**

3.3.1 The Care Standards Act 2000 led to the establishment of the General Social Care Council (GSCC) and the Commission for Social Care Inspection (CSCI). One of the first tasks for the GSCC (based in England) and the other Care Councils in the UK was to develop codes of conduct practice for all social care workers (including social workers), which would apply across the nation. The GSCC and other Care Councils also compiled a register of professionals; and regulated and supported social work education and training. Registration was a seal of approval of competence and safety to practice and the council also had the power to de-register individuals with social work qualifications in a number of well-specified areas.

3.3.2 On 1 August 2012, the Health Professions Council (HPC) took over the regulation of social workers in England from the General Social Care Council. The HPC was renamed the Health and Care Professions Council (HCPC), reflecting its new responsibilities for "regulating health, psychological and social work professionals". The UK Government introduced these changes as part of the Health and Social Care Act 2012 and it was intended to promote a more integrated and cohesive framework across the different disciplines that work in the sector, and an opportunity to maximise the efficiency, effectiveness, consistency and transparency of regulation. The HCPC keeps a register, available to the public, of all professionals who meet the standards for training, professional skills, behaviour and (personal) health and who are entitled to use the title social worker. There are 15 other types of professionals also on the HCPC Register.

The GSCC codes of practice for social workers had first been published in July 2003 were reviewed in 2008. At the time of transfer from GSCC to HCPC the standards and requirements for social workers were incorporated into the HCPC standards. All professionals registered with HCPC must adhere to the standards, which indicate levels of expected professional behaviour and also provide protection for people using their services. As with the GSCC, the primary aim for HCPC as the regulator is to protect the public. Having more enhanced powers than the GSCC the HCPC can investigate concerns raised about social workers in England, including those raised by the public. In serious cases, they can suspend a social worker whilst an investigation is carried out. The HCPC can consider more grounds for complaints, including lack of competence and have a wider range of sanctions. The HCPC can also impose conditions of practice orders and have powers to demand information from employers and others if needed for a hearing, something that was not available under GSCC.

### **3.4 Cultural change and the context of personalisation**

3.4.1 Social work underwent considerable changes from the 1980s as a result of ideological, political and economic developments. Following the introduction of the community care reforms with the implementation of the NHS and Community Care Act 1990 (from April 1992), social work with adults became more concerned with assessment and the development of care management processes with the result that adult service users had more limited face to face contact with professional social workers. Adult service users became more likely to have contact with residential, domiciliary and day care social care workers than qualified social workers (Branfield *et al.*, 2005) and the former were also much less likely to be professionally trained or have occupational qualifications. Social work practice often starts with an assessment of eligibility and application of the Fair Access to Care Services (FACS) criteria, and can be undertaken by non-professionally qualified workers following structured and inflexible procedures. Many people's experience of social care does not progress beyond this point as they may be deemed to be ineligible for any further assessment of need.

3.4.2 Although the community care reforms of the 1990s were in part designed to offer service users more choice about the services available to them (through the development of the private sector and with less reliance on public sector provision), it is comparatively recently (effectively since 2005 and the publication of the policy paper Independence, Well-being and Choice, Department of Health, 2005) that there has been a further shift towards personalisation. This has entailed the development of more person-centred approaches to care and support for individuals in need of such assistance, with the intention of enabling individuals to have as much control over their lives as possible. Since that time the development and introduction of Direct Payments and personal budgets, together with provisions for people receiving individual budgets to employ their own (unregulated) personal assistants has seen the potential further diminution of regular contact by individuals with social workers as opposed to social care workers (or personal assistants).

In relation to social work with children and families, in recent decades there have also been marked changes, especially in relation to child protection policy and practice – for example the shift from foster care to adoption, changing views with regard to the appropriateness of foster care and adoptive parents (particularly in relation to issues concerning different race/sexual orientation/marital status/age of carers). This has occurred together with a changing philosophy related to removal or maintenance of children to stay with families, concerns about possible drift in care proceedings and for children in the care system.

Policy and practice with families and children has increasingly narrowed to be concerned with child protection. This has placed more emphasis on social work's controlling powers and provided much less opportunity for social workers to undertake ongoing direct support work with families and with less ability to undertake preventative work that might be needed.

Commissioning service provision by the private sector, and policy developments for the 'personalisation' of social care and the increasing reliance on personal budgets has also been a more recent influence on service provision. At the heart of the personalisation agenda is the idea that people who use services should be empowered to take control of their lives and viewed as *active citizens* rather than as *passive recipients* of services. See for example *Putting People First* (HM Government, 2007) and more recently in *Thinking Local, Acting Personal* (PPI Consortium, 2011).

### **3.5 Increasing user involvement**

3.5.1 A further change key influence upon social work in the last few decades has been the growth of user movements and campaigns for greater empowerment and recognition of rights. Disabled people and the disabled people's movements have regularly stressed the negative reactions, barriers and disabling effects of society that have a detrimental impact on their lives above and beyond actual physical

issues. It has been argued that this 'barriers based approach' can be applied to other groups of service users also; Beresford (2007) stated that poverty, created and perpetuated by inadequate levels of benefits, inferior access to employment and education and the costs of disability and charging for community care services, have all been highlighted by service users as a key barrier they face.

The growth of user movements and organisations, along with rights based, anti-discrimination and participation legislation has led to a stronger user voice in relation to social work. There is increased feeling that the social work profession should be influenced by those with direct experience of policy and provision from the receiving end. Social work and social care is being transformed by this idea of 'user involvement'. Since the implementation of the Children Act 1989 and the National Health Service and Community Care Act 1990, service users and carers have become involved in a growing range of social services and health activities, including service planning and commissioning, service evaluation and research, professional education and training and monitoring complaints procedures.

3.5.2 The involvement of service users and carers in social work education has been a central element in social work education and training for the last fifteen years, and in particular since the introduction of the full degree programme for social work. It is a requirement for all social work degrees that service users are involved in both the provision of teaching as well as in the recruitment of students onto the course. Universities and other higher education institutions, which deliver the degree programme, are given funding by the Department of Health to facilitate this form of involvement. The Care Standards Act 2000 also made provision for lay people to have a role in inspecting social work degree courses.

Academic social work research has had increased involvement of service users and carers dramatically in recent years. Service users have also been actively involved in developing their own research approaches, and working as research consultants or

as active researchers (see for example ‘<http://www.invo.org.uk>’ and ‘<http://www.shapingourlives.org.uk>’)

3.5.3 Involvement of service users in quality definition and measurement such as in the setting and maintenance of standards has also been a feature of the last two decades (see later this report). The General Social Care Council (GSCC), which regulated the social work profession and social work education in England from 2001-2012, and the Commission for Social Care Inspection (CSCI) were keen to involve people who use services and carers in the development of their regulatory frameworks for social care professionals. The GSCC established a series of focus groups with a range of different groups of people to do this, and a network of different service user organisations was also used to distribute the draft code and provide input into the GSCC’s consultation. In 2003 the GSCC established and chaired a group of national organisations concerned with promoting and sharing best practice in user and carer participation in social care and health. The group became known as the Joint Participation Steering Group (JPSG) and consisted of: the GSCC; the Commission for Social Care Inspection (CSCI); Social Services Inspectorate (SSI); Social Care Institute for Excellence (SCIE); Topss (now known as Skills for Care (SfC)); the Healthcare Commission; the Department of Health; and Shaping Our Lives (service user led organisation). The Department for Education and Skills (DfES) and the Better Regulation Task Force had monitoring roles on the group. The group met regularly and shared best practice as well as the concerns, dilemmas and challenges they faced.

3.5.4 Children are also of course an important sector of the service user population with experience of the social work profession. An increasing awareness of the importance of listening to the voice of the child led to the establishment of the children’s rights director in 2001, employed to ‘champion’ the views of children and young people living away from home, or in care, asking them about social care, and how they are looked after in children’s homes, boarding schools, residential special

schools, further education colleges or residential family centres. Over 150 children's views reports were published from speaking with around 20,000 children and young people and provided feedback directly to government, policy-makers, and professionals who work with young people. In April 2014 the responsibilities of Children's Rights Director were handed over to the office of the Children's Commissioner. Organisations controlled by children and young people have also developed, for example, the National Association of Young People in Care (NAYPIC). Children and young people are also now very active in research and supported to undertake their own research (e.g. Ward, 1997; West, 1997; Kirby, 1999).

### **3.6 Media and public perceptions of social workers**

3.6.1 Child protection tragedies such as Victoria Climbié and Peter Connolly, newspaper front page headlines (that often appear to be distortions of situations) and follow up enquiries, in addition to an increasing number of concerns about safeguarding adults and care provision for adult service users, have all lead to particular and seemingly widespread perceptions about the profession of social work and professional social workers. Despite attempts to shift this, there is still a pervasive negative stereotype of social workers as child removers. There seem to be deeply held concerns and fears about social work held by many people, which can lead to worries about accessing social work altogether even outside of the child and family sector.

Social work may be something that the public has strong, often negative attitudes about without actually having a clear understanding of what social work actually is and what social workers do. The roles and tasks of social work are not very well known to the public or to service users as various studies of public and service user understandings have shown (e.g. Beresford, Adshead and Croft, 2007, see also later in this report).

3.6.2 The provision of social work and contact with social workers is often seen as being for others – not for individuals themselves. For many people, even, arguably, the public as a whole, social work appears to be associated with deprivation, disadvantage and the de-valued in society, perhaps following early/enduring associations with workhouses and charitable provision for the ‘deserving’ poor and needy. Social work is not generally seen to be a universal service, (theoretically) available to all who might be in need. In addition, a key characteristic of social work is the enormous range of activities it includes, as well as the wide variety of approaches and ways of working with people that it encompasses. And, as a ‘human’ service that is fundamentally about communication between people – its essential nature may be difficult to grasp in a concrete way. While this may be one of its strengths, it makes understanding the essence of social work much more difficult both for individuals who may be in need of social work support and assistance, and the wider public (Beresford 2007).

The result of many decades of public negative perceptions, interspersed with condemnation of individual social workers as a result of tragedies (particularly in relation to child protection) is undoubtedly a key factor leading to problems in recruiting and retaining good quality social work staff within social work services in local councils. Added to this are the effects of inadequate funding, resource constraints and over-bureaucratisation, which are also seen as playing an important part in employment related issues. However such aspects may also affect both the experience(s) of individuals who receive such support and assistance, and may further impact the views of the public about both the provision of social work and care services and the profession itself, with little apparent distinction made at times between these different elements.

## 4. Service user views on the setting and maintenance of professional standards

### Key points

- The bodies involved in the regulation and standards of conduct and practice for social care staff have invested in some specific strategies to gain the views of service users.
- People do consider that standards are important. However prior to taking part in consultations few people had any awareness of the current regulatory bodies, regulation procedures or standards of conduct. Clear, accessible information on the codes must be published in order for people to be clear what the standards are and aware when they are not receiving their entitlements.
- Most people feel that there should be a unified approach to standards across national health and social services and throughout the UK and that standards should be enforceable, monitored and improved.
- People have stressed that service users and carers should be involved at different stages of the process; this includes developing, implementing and monitoring of standards, training and assessment, recruitment, commissioning and the monitoring and evaluation of services. Good practice in relation to service user involvement must be set out in the standards.
- Factors felt to be important in social work practice include personal qualities of courtesy, integrity, honesty, trustworthiness, openness, respect, compassion, reliability, reassurance, empathy and warmth, as well as the maintenance of confidentiality and privacy, equity and fairness, awareness of cultural and religious differences and clear communication in English. People desire relationships that inspire confidence, are empowering, enable choice and control, are non-discriminatory and non-judgemental and offer informality and flexibility. Continuity in relationships and the provision of clear, up-to-date,

factual and comprehensive information and expert, targeted, holistic and efficient help was also listed as important.

- A key theme voiced throughout many different consultations was of ‘putting the person first’ – providing person-centred support that enables people to be fully involved in decision making and fulfil their own agendas.
- A strong emphasis on human rights, the United Nations Convention on the Rights of the Child (UNCRC) and challenging discrimination within the standards was also suggested as important for inclusion in any standards.
- Specification of conduct which is unacceptable in terms of abuse, breaches of trust and neglect of duty should also be included, as well as clear, protective procedures around ‘whistleblowing’. The general public have shown mixed views regarding the specific types of actions, behaviours or practices the public should always be protected from, or that might cause concern about the quality of health or social care. This is particularly the case with regard to off duty behaviour; there tends to be no overall agreement about what behaviours, actions or situations would always bring a health or care professional’s fitness to practise into question. However consistently poor performance of professionals or actions which shed doubt on the professional’s general character traits of ‘trustworthiness’, ‘judgement’ or ‘responsibility’ should be challenged.
- There is concern as to whether the ideals presented in standards can actually be delivered within the constraints of time, resources and budgets.
- Although there has been some research looking at service user views on the setting and maintenance of professional standards for professional in general sample sizes have often been small and there has been very little research on conduct expected specifically from social workers. This is an area which needs to be addressed, with inclusion of a wide range of participants.

#### 4.1 Research on service user views of professional standards

4.1.1 Over the last 20 years the bodies involved in the regulation and standards of conduct and practice for social care staff have invested in specific strategies to gain the views of service users. The aim has been to ensure that the regulators work is relevant to and meets the needs of not just the practitioners but also those who are the everyday recipients of their services and actions. Targeted consultations have ensured that service user's particular needs and (often) more limited resources are taken into account. Initial consultations with service users began even in the early stages of code development. A key study of service user views included as part of wider research on standards took place in the mid 1990's. Commissioned by the Department of Health, it aimed to identify the quality and standards that people wanted from their social care workers in their day-to-day, face to face practice (Harding and Beresford, 1996). The consultations involved a wide range of service users and carers' organisations across the country with a broad experience of different types of social work and social care services. Despite this, researchers noted that the views expressed were highly consistent.

4.1.2 A few years later when the General Social Care Council in England was established, it was tasked with the development of codes of conduct and practice for social care workers and employers, Shaping Our Lives (SOL) were commissioned to undertake focus group research with care user groups; specifically users living in residential homes, older people using domiciliary care services, people with learning difficulties and mental health users/survivors (Shaping Our Lives, 2001). The respondents were asked to reflect on the proposed codes as well as consider the general qualities and standards that they wanted from social care workers. Meetings were run using a semi-structured interview topic guide which allowed people to discuss a range of relevant issues: the content of the codes, the benefits of having them and how they would work. Grounded theory analysis helped to ensure that what people actually said formed the results presented in their report.

The Health and Care Professions Council (HCPC), which replaced the GSCC in 2012 as the regulator and keeper of the register of social work professionals (see above), commissioned studies to inform this addition to their work and role shortly after commencing this work. 'Shaping Our Lives' was again commissioned to help review the Standards of Conduct, performance and ethics for Health and Social care professionals (Matthews and Meakin, 2013). Service users (including disabled people) and carers took part in interviews and a focus group was also conducted. All had used at least one or more of the professions required to register with the HCPC and 40% of all their participants had used social workers.

4.1.3 A further consultation with service users on the HCPC's Standards was undertaken by 'Connect', a charity for people living with aphasia, a communication disability which results from damage to the communication centres of the brain (Connect, 2013). People with moderate to severe aphasia were included, taking part in either interviews or focus groups. Although there was not a specific focus on social workers, participants reflected on the experience of receiving a service from a variety of professionals that were involved in their care, which included some social workers. Participants were asked to first think about their own experience about of receiving care and consider their expectations of relevant professionals. They were then asked to consider whether they felt that the HCPC standards corresponded to these expectations. Finally they were asked whether the standards were accessible to service users with aphasia and their carers, and to suggest any necessary changes to the standards.

'The Focus Group', an independent research and evaluation agency also explored registrants and service users' views on the context and accessibility of the HCPC's Standards (Focus Group, 2013). Over eighty service users were recruited to take part in focus groups. Slightly over 20% of these had experience of social workers and/or social care.

4.1.4 The Picker Institute Europe was also commissioned by HCPC as part of the 'Fitness to Practice work plan' in 2012. This research aimed to explore both public and professional views and understandings around the areas of public protection and fitness to practise in the health and social care field (Moore *et al.*, 2013).

Members of the public, service-users and carers took part in focus groups and there was also an online survey with both professionals and the public. Just under half the survey respondents (48%) identified themselves as members of the public, patients, service-users and carers (all the survey respondents, regardless of their role are presented together in the report's findings). The study included a particular focus on particular behaviour or actions that people might feel should be taken into account when determining fitness to practise through the use of fictional scenarios.

Also of relevance to this area, around the same time in 2013, the Care Council for Wales conducted a 12 week consultation on their document *The Social Worker: Draft Practice Guidance for Social Workers registered with the Care Council for Wales*. The consultation was promoted among service user and carer groups. Around 90 % of responses were from social workers themselves, so the service user input was minimal, and the service user comments are not separated out in the summary report. However some of the points made by service users or their representatives can be seen in the full report of all consultations received.

Although not all of these consultations had a single focus on social workers, social work professionals were included in the remit of the consultations, and are therefore worthy of note in relation to this review. The findings of these different consultations have been collected together and summarised under the thematic headings presented below.

## 4.2 Having and using standards

4.2.1 Harding and Beresford's (1996) consultations showed that people do consider that standards are important. However, in order for the standards to be truly effective

and make a difference to service user experience the consultants expressed that it was necessary to ensure that service users and carers are clear what the standards are so that they know when they are not receiving the service they are entitled to. They also wanted the standards to be enforceable with people able to be called to account if they do not meet appropriate standards, with fair appeals procedures. They felt standards should be monitored and improved.

The Shaping Our Lives focus groups (2001) had similarly favourable reactions to the prospect of having codes of conduct and practice in place but expressed doubts as to how effective the codes would be in practice. Many participants highlighted the importance of publishing clear information on the codes and encouraging people to make use of them. The recent consultation for the HCPC (Matthews and Meakin, 2013) uncovered concern about the ideals presented in the standards and whether these could actually be delivered within the constraints of time, resources and budgets. The Connect group of participants felt it was important that healthcare professionals 'signed up' to the agreed set of guidelines at the point of qualifying in their respective profession.

### **4.3 A universal code of conduct**

Harding and Beresford's consultees stressed that there should be a unified approach to standards across national health and social services, and between children's services (including education) and adult services. This corresponds to the emphasis given to the importance of partnerships and links between these services.

Participants also felt that the regulations should apply to all sectors that provide practitioners and services whether these are voluntary, statutory, private or user-controlled organisations. The Shaping Our Lives focus groups stressed that consistency throughout the UK was important, and that codes should be the same despite the fact that there were separate care councils in England, Scotland, Wales and Northern Ireland. This would be necessary to avoid confusion and help to

ensure no variation in the practice would be received if people move between countries within the UK.

The more recent Shaping our Lives consultation for the HCPC (Matthews and Meakin 2013) found that most interviewees (70%) also thought that all the sixteen different types of professionals on their register could be covered by one set of standards. There were suggestions that some specific additional standards for individual professions might also be needed, and comments were also made that not all standards would apply to all professions. However contrastingly only 2 out of the 8 focus group participants however felt that one set of standards would work for all, with one respondent specifically stating they thought social workers were an exception and should have a different set of standards.

#### **4.4 The involvement of service users in the setting and monitoring of standards**

Both Harding and Beresford's consultees and the Shaping Our Lives focus group participants were clear that service users and carers should be involved at different stages of the process. This was not just in developing, implementing and monitoring of standards and quality criteria but also in areas such as staff training and assessment, designing job specifications and recruitment (such as being involved in interviewing), the commissioning of independent service providers and the monitoring and evaluation of services. Matthews and Meakin's (2013) interviewees noted that they had experienced a lack of disability awareness and some discrimination from service providers, showing the importance of service user involvement in standard setting.

#### **4.5 What do people expect to be in a code of conduct for professionals?**

Standards should hopefully reflect what service users themselves consider to be the quality of service expected from professionals. In many consultations with service users around standards, prior to looking at the draft or current versions that have

been created by the registrant, people have been asked to consider how they expect professionals to work with them, and what they would like to see in any standards produced.

Harding and Beresford (1996)'s early research into standards aimed to uncover the qualities wanted and expected of social workers and social care workers by a wide range of service users and carers' organisations. The results were categorised according to desired relationships, skills and services.

#### **4.6 In relation to the quality of relationships with social workers people valued:**

- Relationships that contain basic human qualities of courtesy, honesty, reliability and empathy. Examples given included: using names; letting people know what is going on; answering queries and letters promptly. Also thinking about how it may feel to get unwanted or unexpected communication or changes in services and workers.
- Relationships that are **empowering**. They wanted to be treated as 'real people' and engaged with as equals rather than as dependent clients. Various people or groups referred to negative experiences of workers who 'talked down' to them, were patronising and unhelpful, or even gossiped about.
- Relationships that **inspire confidence** in service users and carers. Having skills, maturity and professionalism was seen as relevant here, but also a professional having relevant experience themselves of the issues they are helping with (e.g. being a parent, or having been in care).
- Relationships that demonstrate **respect** for service users and carers. This was defined as taking people's views seriously, acknowledging what is important to people and recognising their right to be heard. People also wanted acknowledgement of the expertise they have gained from their lives as a user. People expressed their right to know and understand what they are entitled to, so they can make their own choices and take control of their own

lives. Service users also valued workers who were flexible and responsive to their individual circumstances rather than followed set structures and models.

- Relationships which maintaining **confidentiality** and **privacy**, including for children. Participants stressed this must be particularly adhered to residential settings and for children in care. People must have opportunities to speak to their worker without being overheard. Without this it is difficult for people to raise private matters, and also to voice worries, concerns or complaints:
- **Continuity** in relationships was also very important to people. Service users and carers made very clear that it takes time for relationships to grow and trust to develop. To start all over again with someone new can be detrimental to his or her experience of their worker.

#### 4.6.1 In relation to the quality of skills people valued:

- **Listening and communicating.** Participants expressed that few workers truly listen well and take notice of what is said. For real listening, workers need to give people their full attention. They also need to be aware of cultural and religious differences and deal with any communication barriers appropriately and promptly.
- **Counselling and understanding.** People valued the broader experience and insights that professionals can bring. This can mean for example understanding and knowing about the prognosis for a condition and its physical effects, but also having a full understanding of emotional and psychological needs that may accompany it.
- **Knowledge about service and resources.** Up-to-date knowledge about both local services (including self-advocacy organisations) and national resources like the Independent Living Fund and social security entitlements was seen as absolutely essential.
- **Enabling** whilst at the same time judging appropriate levels of risk. There were different views among service users about whether or not social services staff tend to be too overprotective or frightened of 'allowing' service users to

do what they wanted to do. The Independent Living movement had campaigned for moving away from what was felt to be controlling and restrictive professional power. But some people felt there were occasions when social workers had not been protective enough. The researchers felt that everyone's sense of acceptable and unacceptable risk is likely to be different and that each individual service user needs to be considered on their own merit. They point out that regulations applied routinely to all or avoidance of risk for fear of criticism are unhelpful and will serve to undermine people's autonomy and right to choose.

#### 4.6.2 In relation to the quality of services given people valued:

- Equal access to services, and ensuring equity and fairness in their delivery
- Taking into account cultural needs in relation to services such as dietary needs
- Clear, comprehensive information about services and rights to services. Presenting information in ways appropriate to that individual (taking into account communication barriers and accessibility for example). Being proactive about information giving. Also clear information about the standards that should be expected.
- Access to advocacy.
- Choice and control over their lives with flexibility in the service offered to enable this.
- Having enough time to talk over and consider options, being able to make decisions in an informed and considered way, with enough time for the services themselves to be delivered with thought, care and respect.
- Avoidance of negative effects such as harm or trauma.

#### 4.6.3 The researcher summed up what service users value in their contacts with social care workers with the following quote:

*‘They value courtesy and respect, being treated as equals, as individuals, and as people who make their own decisions; they value workers who are experienced, well informed and reliable, able to explain things clearly and without condescension, and who ‘really listen’; and they value workers who are able to act effectively and make practical things happen... The way workers behave, and what they do or not do, makes a big difference to how people feel about themselves and the quality of their lives...’* (Harding and Beresford, 1996, p1)

The Shaping Our Lives (2001) focus group members, when considering how they thought social care staff should work, voiced many comments which the researchers saw as all elements of *‘putting the person first’*; showing respect for users as people. This included comments made such as: respecting individuals’ views and be supportive; not judging people or making assumptions about what people need; keeping to time; giving holistic support; providing clear and accurate information; ensuring users are treated equally, ensuring treatment is accessible, ensuring users have control (although with adequate support); and ensuring privacy and confidentiality.

4.6.4 A later literature informed discussion paper Beresford (2007) completed for *Shaping Our Lives*, looking at what people found helpful in the contact they had with a social workers, refers to the *‘remarkable consistency’* (p42) across the literature in what service users say about social work practice, despite a wide range of service users and the whole spectrum of social work interventions being considered (including work with adults, mental health service users, young people, families and children, in criminal justice, residential, day services and field work). Positive responses again refer to the social work *relationship* and the positive *personal qualities* of the social worker.

4.6.5 Beresford (2007) noted that service users see the *relationship* with the social worker as the key element of the valuable social work practice. They referred to the strengths of the informality, flexibility, and warmth of this relationship. Having a continued and trusting relationship is seen as able to build confidence and support people's self-empowerment. Positive personal qualities commonly seen as important by those consulted with were warmth, respect, being non-judgemental, listening, treating people with equality, being trustworthy, openness and honesty, reliability and communicating well. They also value social work practitioners who:

- Support people to work out their own agendas and give them time to sort things out
- Are available, accessible, reliable and responsive and deliver
- Provide continuity of support
- Have a good level of knowledge and expertise
- Value the expertise of the service user

Beresford's (2007) report summarises that the type of social work practice prioritised by service users: is participatory, promotes and supports independence rather than dependence, offers continuity, is flexible, offers holistic and person-centred support that addresses personal, social, emotional and practical issues and needs, takes into account rights, risks and their complex interrelations and finally provides inclusive understanding and knowledge taking into account the service users own personal and experiential knowledge (Beresford, 2007).

4.6.6 The Connect (2013) participants, before considering the HCPC standards, were asked to consider their key expectations of professionals. Themes touched on by all or most participants were

Professionals caring about their work and the people they work with

- Valuing others and treating people as individuals and with respect and dignity
- Having appropriate up to date knowledge
- Communicating effectively
- Taking time to listen and find out a person's needs and wishes

- Being positive and reassuring
- Being mindful of people's emotional state
- Being flexible and adapting to changing needs
- Not abusing power
- Being accurate, honest, and reliable and doing what they say they will
- Working safely
- Respecting privacy and confidentiality

*“Treat patients the way you would have liked to have been treated”* (Connect, 2013 p7)

*“Good at modifying their communication. Taking time, face to face to listen”*  
(Connect, 2013 p8)

Some of Connect participants also referred to dressing appropriately, being organised and being on time, working as a team. However the group agreed that this was of differing importance depending on the professional role.

Reflecting on their negative experiences of professionals, participants gave examples of those who did not explain or collaborate sufficiently with the individual, or gave negative information in a blunt manner. This included such aspects as incorrect information being provided, not explaining a course of action or why this was needed or failing to turn up for an appointment with no explanation provided.

4.6.7 The Focus Group (2013) participants were also asked to describe the attributes they would expect to be in a code of conduct for individual professionals. Included in their generated list were:

- Caring attributes – being compassionate, humane, understanding, reassuring and empathetic. This was seen as important to take into account that people are often seeing professionals at a time when they feel very vulnerable. Being

treated with dignity was also considered very important and a fundamental basis of care

- Attributes concerned with integrity – being honest, trustworthy and reliable. Service users felt that professionals should work within a high moral framework, and have the correct criminal record /police checks and data protection procedures are in place. They also need to be accountable when things go wrong.
- Attributes concerned with the treatment of people as individuals – for example showing respect (not being treated as a ‘number’). Also being non-discriminatory and non-judgemental in both attitude and practice.
- Attributes concerned with giving communication, information and involvement - keeping service users informed about what is happening to them, why certain treatments or services are being used and what other help or services that would benefit them. Ensuring service users are involved in the decision-making about their treatment or care and are kept informed about what is happening was seen as essential. Also mentioned was the importance of professionals having a good command of the English language
- Confidentiality – however sharing information with other professionals when necessary to ensure effective teamwork and to avoid service users repeating their story multiple times
- Continuity of care, either by seeing the same person each time or ensuring that the care team are all aware of their individual circumstances on each visit or appointment.
- Timeliness/efficiency – both turning up on time and getting things done in a timely manner
- Being competent and qualified – not just having a basic qualification to practice but also keeping up-to-date with current practice and legislation

#### **4.7 Service user input into code of conduct development**

The Shaping Our Lives focus groups recommended that a code of conduct for social workers should:

1. Have at its core the key principle of putting the person first (as outlined above) and the particular concerns of users in terms of timing and time keeping; holistic support; information provision; accessibility; equal treatment; control; and privacy and confidentiality.
2. Specify the conduct which is *unacceptable* in terms of abuse, breaches of trust and neglect of duty
3. Set out good practice in relation to service user involvement, including access to files and meetings; basic training for all staff; the maintenance of care plans and meeting of needs identified at assessment, with particular attention to people with multiple needs; response times; and providing information to users, particularly on issues relating to consistency of the service

4.7.1 The GSCC explained that key changes were made as a result of the input of service users throughout the period of their code development (GSCC 2012). There is a particular note that service users expressed concerns that the codes as originally drafted emphasised the protection of people and their rights without recognising the importance of service users having the right to manage their own lives. The final text of the codes were changed to reflect the fact that social workers should support the autonomy and independence of service users as a paramount function.

#### **4.8 Service users' views on the content of the HCPC standards**

When presented with the fourteen standards put together by the HCPC (see Appendix 1 for full list), Matthews and Meakin's (2013) interviewees generally agreed with them and felt that most were relevant to service users. No new or additional standards were suggested by respondents, however there were several

recommendations about how several of the current standards could be improved, either by increasing clarity or adding to the content.

4.8.1 The Connect (2013) focus group participants were asked to compare their previously generated expectations of professionals (as noted above) alongside the HCPC standards, and to consider whether they felt the HCPC standards reflected their expectations. There was considerable overlap of themes generated by the focus group and the HCPC standards, however the participants did suggest alternative wording/emphasis for many of the standards. Key changes suggested were that there should be more emphasis on the **personal qualities** required by health care professionals, and the importance of **accessible explanation** and **information provision**.

Two guidelines included in the HCPC standards had not been previously generated by the group in their initial consideration of expectations: '*You should keep accurate records*' and '*You should deal fairly and safely with the risks of infection*'. The group still felt they were important in good care and expressed that they should continue to be part of the HCPC standards.

A summary of the comments made on the specific standards by the participants involved in both the above HCPC consultations can be seen in Appendix 1 of this report.

The majority of The Focus Group (2013) participants felt the HCPC list of standards were a very comprehensive list. Most felt there was nothing missing, however The Focus Group researchers do comment that there was no direct reference in the current Standards to some of the qualities raised by participants as things they would expect to see in a code of conduct for professionals. These were: showing caring qualities; maintaining continuity of care for service users; the importance of time keeping; and the importance of clear communications in English. There was also a

feeling that the importance of workers showing respect and being non-discriminatory and non-judgemental should be given more emphasis. In addition, several people in The Focus Group sessions felt that 'whistleblowing' should be included within this list as this appeared to be missing from the standards.

#### **4.9 Awareness of standards and regulations**

The Focus Group research found that none of the service users they spoke to had any awareness of the HCPC and little was known about either regulation or standards of conduct. Most did however have confidence that if there was a problem they would find out where to go. They stated that they usually put trust in the organisation that the individual professions work within (for example the local authority) and they assumed that the organisation would be protecting their safety and ensuring staff were competent and professional.

The consultations held by Matthews and Meakin (2013) focussing on the role and standards of the HCPC found that most people (60%) were not aware of the HCPC or the standards prior to the research. Only 30 per cent of respondents said they would know where to find them, although most assumed they would be accessible via a website. Many respondents assumed that professional practitioners did have some sort of regulatory body, but did not know the name of it. Most interviewees (83%) did not know that the HCPC had a Register of practitioners, although a couple remembered seeing the HCPC referred to on individual therapist's business documents.

#### **4.10 Accessibility of standards and regulations**

The GSCC, reflecting on the experience of engaging with service users in the development of standards, had underlined the importance of any standards or codes being fully accessible to a wide range of people. The GSCC ended up producing them in 30 different languages and a variety of formats including sign language, video, Makaton, large print and pictorial versions.

4.10.1 With regard to the HCPC code, Matthews and Meakin's (2013) report notes a large number of comments about the 'challenging' language of the standards and a feeling that they should be more user friendly. As part of their study, a Word and Picture team at CHANGE ([www.changepeople.org](http://www.changepeople.org)) was asked to comment on each of the standards in terms of their accessibility to people with learning difficulties. It was concluded that long words such as 'confidentiality' 'practitioner' 'supervision' and 'competence' should be avoided, as well as terms that do not tend to be used in everyday language (such as: 'best interests', 'personal conduct', 'professional knowledge' and 'relevant regulators'). The Connect (2013) report also notes that their consultees thought the HCPC standards could be written more clearly in simple language without the use of jargon and acronyms. It was felt that this would improve accessibility generally, not just for people with disabilities. Additionally, respondents wanted to change some terminology to reflect an equal partnership with workers (e.g. using 'person' instead 'service user').

Several people were reported by Matthews and Meakin's (2013) to want the HCPC to ensure that all documents produced for the public (and practitioners who have access needs) are available in a variety of formats, including video, at the point of service as well as online. Several people who had viewed the HCPC website online as part of their interview reported finding it difficult to locate the standards on the website.

4.10.2 In addition a number of Matthews and Meakin's (2013) respondents felt the order of the standards was muddled. The code was seen to contain some standards relevant to members of the public or service users and others more relevant to the practitioner or the organisation they work for. These were seen as being integrated together in no particular order. The researchers suggest that two sets of standards could be more appropriate; one setting out the required standards of conduct, performance and ethics for professionals registered with the HCPC. A second set of

standards, linked to the first, could be targeted at people using services, which would more clearly outline what individuals should expect from a professional service.

4.10.3 Changes to the ordering of the themes, in order to group them together in a more logical order was also suggested by participants in the Change (2013) study. A suggested order was proposed: firstly standards relating to how the healthcare professional should treat the individual, secondly standards relating to knowledge; thirdly standards relating to appearance; and finally a code of practice for reporting concerns if the standards are not followed. The group rewrote the standards to be more concrete and specific rather than abstract and general. Eight revised standards were agreed on, which they felt accurately reflected all their discussions and were expressed in the appropriate language. See Box 2 below.

## Box 2

### 1. Partnership and mutual respect:

- You should treat the people you work with, with respect and dignity.
- You should always be aware of their emotional state and be positive and reassuring.
- You should treat the person not the symptoms, be friendly and value people.
- You should ask the person if there is anyone else they would like to be involved in their healthcare.

### 2. Providing information, communication and getting consent:

- You need to listen to people and find out their needs and wishes.
- You should give information and explanations in a way the person can understand.
- You should give information at every stage of care to the person and, where appropriate the family.
- Explain things in a straight-forward way.
- You should not use jargon or acronyms.
- You should communicate well with other professionals and work as a team.

- After giving information you should ask the person for their agreement for treatment.

### **3. Honesty, confidentiality and trust:**

- You should not abuse your position of power.
- You should be honest and respect people's confidentiality and privacy.
- You should be reliable and do what you say you will.
- You should be organised and on time.

### **4. Knowledge and skills:**

- You should have the appropriate skills, knowledge and training to do your job.
- You should know your boundaries and check if you don't know something.
- You should make sure your knowledge is up to date or seek support.

### **5. Appearance and presentation:**

- You should appropriately for your job and have good personal hygiene.
- You should not come to work under the influence of drugs or alcohol.

### **6. Reporting concerns:**

- You should report any concerns about those you work with.

### **7. You should keep accurate records**

### **8. You should deal safely with the risks of infection**

#### **4.11 Issues relevant to children**

The Office of the Children's Commissioner for Wales (CCFW) submitted a detailed response to the Care Council for Wales's consultation on its practice guidance for social workers (2013). They stated this had been informed by evidence gathered from children and young people who contributed to reviews undertaken by the office ('Telling Concerns (2003)', 'Lost After Care (2011)' and 'Missing Voices (2012)' available at: <http://www.childcom.org.uk/> Children's Commissioner for Wales). The key points made were:

- There should be a stronger emphasis on the The United Nations Convention on the Rights of the Child (UNCRC) within the guidance. This should ensure that social workers fully apply the convention to their practice.
- Greater prominence should be given to the duty the social worker has to challenge discrimination, at both the personal and organisational levels, using their knowledge of legislation. Social workers should expect to support the children and young people they are working with to enjoy the levels of wellbeing experienced by their peers. (The National Deaf Children’s Society (NDCS) Cymru also echoed this point).
- Children and young people have the right to be heard in decisions that affect them and they should be involved in the care planning process (Article 12 of the UNCRC). There must therefore be clear direction on the need to explain care management decisions to children and young people and to ensure that they understand what is going to happen, why and when. When changes are made to the care plan children and young people should be involved in decisions about these changes and provided with an explanation of why the changes are happening.
- Age specific guidance, as well as guidance focused on the varying needs of service users, such as physical and learning disabilities would be useful.
- The clear focus on citizen centred care and support, with practice that enables service users to have a strong voice and control over their care, support and services was welcomed. To strengthen this further the guidance should outline practice that is child centred and relate to the rights of each child and young person in a clear and unambiguous manner.
- The importance of independent professional advocacy services for children and young people should be stressed further. CCFW reviews had stressed the difference advocacy made to children and how children’s understanding of advocacy can be low prior to accessing a service. Social work professionals working with children and young people have a crucial role in promoting and explaining advocacy to children and young people, and should do this

routinely and ensuring support is given to enable access. Guidance for social workers and support staff should therefore convey the need for a clear working understanding of independent advocacy and how it compliments their own role as an advocate for the children they work with.

#### **4.12 Service user views interpretations of public protection and fitness to practise**

Professional regulation is not just about aiming for the ideal, as set out in the standards of conduct and practice, but involves taking action to remove unsuitable workers in rare cases when things go wrong in the interest of public protection. HCPC's literature states: "*the purpose of our fitness to practise process is to protect the public from those who are not fit to practise.*" In other words they have a role in determining whether or not a health or social care professional is fit to continue practising as they have before. This is clearly a serious decision, which involves balancing the potentially great harm this could cause to the worker and their family with protection of the public and service user and the maintenance of public confidence in the profession.

4.12.1 Service user views about this area were the focus of a research study carried out by the Picker Institute Europe (Moore *et al.*, 2013). Their participants were able to provide specific examples of 'poor' experiences of their own care from health or social care professionals. These included instances when an individual's concerns or feelings had been disregarded or downplayed, personal information had been lost, confusing or contradictory information and advice had been given, or a breakdown in communications caused fear that inappropriate treatment may be given. When asked for their concerns about wider public protection, members of the public, patients and services users again readily described *specific* instances, which had been widely reported in the media, indicating major failures in the care system.

*The place was eventually shut down, but the machinery of managing it and the Care Quality Commission had just patently failed to do anything about it. And that is really frightening because we trust our ... daughters to somebody else. (Moore et al., 2013, p14)*

However participants generally found it difficult to suggest the *types* of actions, behaviours or practices the public should always be protected from, or that might cause concern about the quality of health or social care. When presented with fictional scenarios showing professional's potentially compromising behaviour, people usually responded with mixed judgments; there was no agreement as to what behaviours, actions or situations would always bring a health or care professional's fitness to practise into question. For example when considering the situation of personal notes being left on public view in a hospital, some judged it to be clearly wrong (either because of a breach of privacy or because the notes could be misplaced), some felt it was only wrong only if personal contact details present, and others deemed it not to be wrong as they felt that within a health or care setting there was a natural respect of confidentiality or privacy, as everyone present is in a similar situation. Similar mixed views were generated around the topic of a health or care professional sharing personal information with a patient, service-user or carer; most participants recommended that either no action should be taken in this case, or that an informal reprimand from an employer would be appropriate.

Importantly members of the public were keen to take into account any extenuating circumstances as to why the action may have happened, in order to understand why it might have happened and react proportionately. For example it was expressed that in an acute health setting normal standards might slip when one has to respond to a crisis situation. In addition a worker's personal circumstances and possible mitigating factors must be considered. Many people showed empathy to the professional's situation and felt they should be helped to improve in their work.

4.12.2 Focus group participants were clear that they would like to be protected from *consistently* poor performance of professionals. People generally did not support escalating ‘one-off’ issues or mistakes to the regulator. However for health professionals and services who are ‘repeat offenders’, and show a pattern of poor behaviour or professional practice, this was another matter. This was especially so if it had been brought up with a professional, and/or previously included within a professional development plan. Participants emphasised the importance of employers formally documenting instances of poor work and the remedial support or training provided. Recurrent and ongoing problems could then be identified quickly and escalation could take place if necessary.

4.12.3 When considering *off duty* behaviour scenarios, the blurred boundary between ‘upholding the profession’ and the right to a private life while off duty was raised. Off duty behaviour was generally considered less serious than on-duty breach of professional practice. When considering behaviour such as shoplifting, drink driving and possessing cannabis, it was not always regarded as a serious problem just because it was a ‘crime’ or ‘illegal’, particularly if it was something individuals had done or could imagine doing themselves. The intention of the practitioner was a crucial part of their judgements; knowingly doing something wrong was seen as a more serious situation.

4.12.4 A key factor seeming to influence participant’s judgement of all the scenarios was whether the actions shed doubt on the professional’s general character traits of ‘trustworthiness’, ‘judgement’ or ‘responsibility – all of which participants felt to be crucial character traits of health and care professionals, impacting on competence. Therefore a professional carrying out shoplifting raised higher levels of concern as it could indicate a more general dishonesty. A situation of unreadable record keeping also generated fairly consistent views – people tended to view this action negatively as the problem could be related to laziness and/or a lack of care and concern as opposed to an ‘honest mistake’. Many participants were also concerned about the

possession of illegal drugs (cannabis) as this could be an indicator of impaired judgement and poor decision-making. Also possession of illegal drugs could lead to concern about the potential for individuals abusing legal drugs within the health care setting that they worked due to their 'accessibility and so a greater cause for concern. Participants also were more likely to believe that escalation to the regulator would be appropriate if the professional worked in the community or in people's homes – where personal character seems more relevant.

4.12.5 Participants, in both the focus groups and the online survey, were likely to view things more seriously and consider that a health professional's fitness to practise should be investigated if they were led to believe that the action had caused *actual harm*. Members of the public found it more difficult to separate the consequences from the act. For example, some participants were more likely to prescribe serious responses if a negative outcome were to result from the decision to drink-drive.

#### **4.13 Consequences of poor fitness to practice**

The focus groups were asked whether a formal health assessment might be an appropriate response to any of the concerns described in the scenarios, to uncover any underlying addiction or mental health issues of which the behaviour was a symptom. Participants were very unlikely to recommend that a formal health assessment should be conducted for a 'one-off' act. However in the case of shoplifting, nearly all members of the public felt a formal health assessment was appropriate. Participants generally felt that it was also not necessary in the case of drink-driving, and slightly less so for possessing cannabis. However there could be a need to develop a historic record to see whether a *history* of alcohol or drug misuse was present order to identify potentially problematic patterns of behaviour. The researchers of this study emphasise that participants were keen for any consequences following from the 'unprofessional' action to be supportive and rehabilitative rather than punitive. They wanted to understand the circumstances that

might help to explain what had occurred, and to find ways to support the health professional to be fully fit to practise.

4.13.1 Participants disagreed on the point at which the regulator might need to be informed about an act of alleged criminality by one of their registrants. For some, an arrest was, on its own, enough to warrant notification to the regulator. Others did not feel that the regulator should be involved until a health or care professional was actually convicted of a criminal offence; and even then, they were not certain that notifying the regulator should necessarily initiate a fitness to practise investigation. Focus group participants additionally emphasised that all people would be dealt with by the justice system for criminal acts such as, using illegal drugs and drunk-driving and so professionals should not face ‘double jeopardy’ through HCPC processes and be punished twice for the same criminal offence, or indeed being punished more harshly than other members of society. The results of the online survey seem to show a slightly more lenient viewpoint on some of the scenarios, in that the threshold for notifying the regulator seemed higher than in the public focus groups. Researchers felt that this might be because they had less information presented in the scenarios to make a fair decision.

4.13.2 Overall the Picker Institute Europe (2013) study uncovered little consensus from the public on what specifically they would want to be protected from, or what behaviours or actions should always trigger investigation of fitness to practise. Key concerns about health professionals shared by members of the public were professionals who were consistently performing below standard, dangerously, or without consideration of patient and service-user needs. There was also concern that professionals should be honest and trustworthy, both on and off duty. Some criminal actions such as shoplifting would shed doubt on this and should be taken seriously. People tended to have a relatively relaxed attitude, towards off-duty use of alcohol, including ‘one-off’ drink-driving but showed greater concern about possession/use of illegal drugs. This seemed to be attributable to the intent behind the action and the

choice to knowingly do something illegal. It was emphasised however by most people that fitness to practise and impairment should be considered on a case-by-case basis, taking all relevant factors and individual circumstances into account. Blanket recommendations and fixed responses were not wanted or felt to be appropriate.

## 5. Making complaints about professionals and services

### Key points

- People feel that isolated issues with a workers practice are seen as best resolved with an employer; however a significant number of people would want a regulator to have been notified of any warnings or incidents.
- When people have problems in relation to their interactions with professionals and receipt of services they do not always complain or report these issues. Information about complaints procedures can be difficult to obtain, there is also a lack of knowledge of the rights to services that people have, and the standards of care that they should expect.
- Power imbalances between individuals and service providers can also be barrier to complaining. There can be scepticism that a complaint will be responded to appropriately, as opposed to defending the authority or professional against liability.
- People also tend to be fearful of retribution, loss of service, negative scrutiny or media interest. People are often unwilling to appear ungrateful for services or do not wish to be seen as awkward or to be 'moaners'. People in residential care are particularly vulnerable and unlikely to speak up about their rights or concerns for fear of retribution or making matters worse.
- One review suggested that people can be intimidated by having to make complaints in writing and that people prefer to be able to make complaints by telephone. However, research suggests that there is also scepticism about whether or not telephone calls will be acted on and therefore some prefer the formality of letters, which also allows copies to be kept. Young people may also have a preference for using phone or text messages, rather than writing letters.

- It is recommended that: all organisations foster a supportive environment for its care professionals and a protective environment for the public; advocacy services should always be available to help with any issues or complaints that individuals make; care councils should clearly present themselves as independent; using the code of conduct in practice should be seen as ‘normal’ so that individuals feel able to do so; different mechanisms should be available for complaining, both formal and informal.
- This review encountered a dearth of studies specifically looking at complaints about social work and social care. In our view this is an area which should be addressed, together with further research focussing on public perceptions of the standards and competence of social workers.

5.1 According to the SCIE review of prevention in adult safeguarding (Faulkner and Sweeney, 2011), if people are to protect themselves from abuse, they need to be aware of what abuse is, to be informed about their rights and to have the skills and resources to be able to deal with it. They need to have the information, knowledge and confidence to take action if/as necessary.

5.1.1 When people have problems in relation to their interactions with professionals and receipt of services they do not always complain or report the issues. For example Preston-Shoot’s (2001) analysis of the findings from four research projects looking at service users’ experiences of community care provision found in one project that users were twice as likely to *want* to complain than actually did so. A similar trend emerged in the other three projects. Those who did not complain still had serious concerns about the help received or staff attitudes. The low level of complaints did not necessarily indicate general satisfaction with services. Many concerns were reported by respondents, that were not always referred to as ‘*complaints*’ or reported.

5.1.2 In Preston-Shoot's (2001) research, the main areas people complained about were issues such as unmet needs/insufficient provision and poor-quality provision/care. The latter, for example in one project, included concerns about staff attitudes, levels, experience and training, and about care home facilities, atmosphere, company and food. Rogers and Pilgrim (1995) found that mentally distressed people were dissatisfied with the frequency, length and content of contact with professionals, and with the range of services offered. Wilson (1995) researching older people's experiences of health services, found complaints about ageism, the quality and environment of services, and staff attitudes. As this research was undertaken before the introduction of the National Service Framework for Older People (2001) it is likely that such comments would also have been relevant for social work and care services more generally. Abbey and colleagues noted complaints about the physical discomfort of buildings, the lack of activities, inadequate food, and the impact of cost savings in care homes Abbey *et al.*, 1999)

5.1.3 A scoping report looking at research on nature and extent of complaints against HPC-registered professions from the complainants' perspective was commissioned by the Health Professions Council (HPC) in 2009. It looked specifically at what levels of awareness about complaints mechanisms existed in different user populations. Most of the literature was found to relate to complaints about health services (hospitals, GPs and other health services). However, although the report does not have a particular focus on social workers it does focus on general themes relating to complaints, which are likely to also apply to the social work professions.

5.1.4 One key barrier to complaining identified in the HPC scoping review was that information about complaints procedures can be difficult to obtain. This was partly due to the complexity of organisations providing care. Research on the overlap between health and social care shows that people are generally not knowledgeable about who provides what or who is responsible for dealing with problems. A lack of

knowledge of the redress mechanisms can also exist, but there is also a lack of knowledge of the rights to services that people have, and the standards of care that they should expect. People can also be less likely to complain if they have low expectations about the service and relevant standards in the first place. Additionally power imbalances between patients and service providers can be barrier to complaining.

5.1.5 Matthews and Meakin (2013) recent consultation for the HCPC (see previous section) explored the action participants thought they would take if they were concerned about the conduct of a practitioner or service provider. Some people in the focus groups stated that contacting the HCPC in such situations was a very serious course of action that could lead to someone being struck-off or suspended from practise. Because of this, and a need to consider individual circumstances of professionals, several people said they would rather raise the problem with the worker or provider at the time or try to contact the practitioner's or provider's manager. The interviewees came up with the option of putting forward a formal written complaint. One person mentioned contacting PALS, and two the HCPC (although three other people said they would report it 'to the appropriate [professional] body'). One person suggested that the client should be told clearly how to complain at the first visit/meeting with the professional. (Matthews and Meakin 2013)

5.1.6 Eighty-five per cent of members of the public in the Picker Institute Europe (2013) consultation (see previous section) also felt that isolated issues with a workers practice are best resolved with an employer; but just over a third of people would want the regulator to have been notified that the health or care professional had received a warning. Many people suggested that the HCPC could have a role in monitoring incidents that would not, in themselves, cause concern about fitness to practise but that might indicate a problem if repeated and/or if viewed as part of a pattern. If they were unhappy with a service people generally said they would

complain directly to the health or care setting concerned, or to the local council – however, if they had done this it was usually without a positive response or changes.

5.1.7 Various research studies referred to in the HPC (2009) scoping review evidenced that people are often unwilling to seem ungrateful for services or do not wish to be seen as awkward or to be ‘moaners’. Fear of retribution was also often cited as a barrier to complaining, especially if people are reliant on the service provided for ongoing care. Some participants in the Picker Institute Europe (Moore et al., 2013) consultation and the Shaping Our Lives (2001) focus groups, particularly those with long-term health needs, reported a fear of retribution or loss of service if they were to complain about the services they relied upon, particularly in situations where perhaps only one practitioner was available in an area.

People in residential care may be particularly vulnerable to the consequences of complaining. Faulkner’s (2012) consultees (a group of service user activists or members of user-led groups) shared a concern that many people in residential care are often afraid to speak up about their rights or concerns. The fear of retribution for service users in residential and mental health services is powerful, particularly if they continue to need or live in that service. Such people are consequently not receiving the care that is their right. A member of the Independent Living User Reference Group said:

*‘I can’t tell you how many times people have phoned me up saying they are in a residential home or their relative is and I will get the whole sob story. And when I said ‘why are you not doing something about it?’ She said because it might make it worse for my relation. People are afraid to assert their rights, they know what they should and shouldn’t get. It’s the same in hospital.*  
(Faulkner, 2012, p17)

5.1.8 Faulkner notes how many of her conversations with service users *demonstrated just how difficult it is for people to assert their rights when in situations*

*of powerlessness, which raises the question of how we as a society raise the profile of everyone's right to equal rights. The challenge is how to enable people to assert their rights without necessarily entering into situations of conflict; to make the language of rights more commonplace* (Faulkner, 2012, p32). She recommends that mental health and residential care services should raise awareness about people's human rights. In such situations a collective approach to solving problems may be more appropriate than individualistic approaches such as following a complaints procedure. As Barnes (1999) states; *"power imbalances also mean that users who speak out put themselves at risk, and need the support of peers if they are not to suffer as a result"* (Barnes, 1999, p82).

5.1.9 In Penhale et al.'s (2007) research, communication between statutory agencies and family members about allegations of abuse within formal care settings was consistently reported to have been problematic. It was not uncommon to hear respondents saying that these agencies *'didn't care'* or *'we weren't listened to'* by professionals. As one respondent stated: *Carers just get platitudes and are not really listened to.*

Scepticism was identified as a major barrier to complaining in the HPC (2009) scoping review. People will not complain or take action if they believe it will not make any difference. Satisfaction with a particular redress procedure will depend in part on what people want from it in the first place. Most studies of complainants found that people were dissatisfied with the procedure. Studies have also noted that attempting to resolve problems can be stressful and can lead to 'unintended consequences' such as health problems. A lack of common understanding of its purpose can also be a source of dissatisfaction amongst users of a procedure. Communication with complainants and potential complainants about what can and cannot be dealt with is vital.

5.1.10 Unfortunately the general public group members in the Picker Institute Europe study, particularly those who were patients or carers, perceived that both NHS management's and professional bodies' default response to a complaint was to protect the hospital or professional from liability, an unfortunate result of the litigious nature of society. As part of this, there was a view that the experience of the complainant was most likely to be discredited or down played. Some participants perceived health and care professions in a more negative light because of it. There was also a concern shared by most of the public participants that making a complaint could expose the patient to negative scrutiny or media interest.

5.1.11 Complainants are often unhappy with a system which requires them to make their initial complaint to the person (or part of the organisation) they perceive to be the problem; The HPC review questions the assumption that local and informal is best, particularly for complaints involving 'issues of competence and conduct'. Wallace and Mulcahy (1999) argue that, at these 'higher' levels of health complaints, people seek formal, rather than informal mechanisms. However, other research suggests that people seek an informal opportunity to air their grievances (Adler and Gulland 2003).

5.1.12 It was suggested by the Shaping Our Lives (2001) focus groups that independent support such as an advocacy service should always be available to help with any issues or complaints that individuals make against the more powerful body of the social care. They also noted that care councils should clearly present themselves as independent, and that using the code of conduct in practice should be seen as 'normal' so that individuals could be encouraged to do so.

5.1.13 The Connect (2013) participants also discussed the issue of reporting concerns and whistle blowing. They felt it was the responsibility of all organisations to foster a supportive environment for its care professionals and a protective environment for the public. Additionally, the Picker institute Europe (2013)

highlighted what appears to be a commonly held perception, possibly influenced by media reports of gross failures in health and care, that there is a small group of health professionals who consistently escape disciplinary procedures or fitness to practise proceedings through a lack of reporting, or moving to other roles and organisations. This was one area where members of the public felt there might be a role for the HCPC in mitigating.

5.1.14 The Office of the Children’s Commissioner for Wales (CCFW) response to The Care Council for Wales’s consultation on its practice guidance for social workers (2013) pointed out that professionals should be helped, perhaps through the guidance, to understand complaints procedures and how service users could escalate their complaints and concerns. A detailed explanation of the roles of the Older Person’s Commissioner and the Children’s Commissioner for Wales, as well as the Public Service Ombudsman should be included in the guidance. These bodies can and should provide assistance to service users, parents, carers and professionals working with service users. This point is also applicable to codes of conduct in England, as similar roles exist.

5.1.15 Factors such as gender, ethnicity, age, education, income and accessibility of advice services and information all affect the likelihood of people actually taking action in relation to the services. A higher proportion of complaints made on behalf of patients are made by women than by men, possibly reflecting women’s ‘caring’ role. Complaints about community care services are also more likely to be made by relatives than by service users directly. The consequence of this is that it may be more difficult for people to complain if they do not have a family member who is able to take up an issue for them. Having support from advocacy or patient support organisations has been found to be crucial for many complainants, both in the field of health and in other areas of citizen redress. This is particularly the case for groups who might have more difficulty in representing themselves.

5.1.16 Some studies suggest that ‘older people’ are less likely to make complaints. Those who have higher educational qualifications and those who are better off are more likely to take action about problems while those on lower incomes are more likely to take no action. People in low paid work are the least likely to take action to deal with problems. The lowest social groups can find it more difficult to put complaints in writing. Unemployed people were found to have little knowledge about how to complain about health services. Pleasence *et al.* (2004) also suggest that people from minority ethnic communities may be more likely to be fearful of the possible consequences of taking action. People are often unable or unwilling to complain if they are very ill or if carers are taken up with the day-to-day business of looking after a disabled person. People with mental health problems or difficulties relating to drug or alcohol misuse may be deterred from complaining because of the fear of stigma associated with their condition.

5.1.17 Many studies referred to in the HPC review suggest that people can be intimidated by having to make complaints in writing and that people prefer to be able to make complaints by telephone. However, research suggests that there is also scepticism over whether or not telephone calls will be acted on and therefore some prefer the formality of letters, or possibly emails (although some are doubtful of how well these are dealt with) which allow copies to be kept. Pleasence *et al.* (2004) also stress the value of face-to-face advice in helping people to resolve problems. Although they suggest that new technology may come to replace face-to-face advice for many people, it is likely to be those who are already most socially and economically excluded who will be unable to make use of such technology. Young people may also have a preference for using phone or text messages, over writing letters.

## 6. Regulation of services

### Key points

- The clearer and more specific the regulations are governing a service, the easier they are for a service user to make sense of and to challenge when necessary
- There is a danger that as regulatory bodies take on a wider range of services, standards become more universal and simultaneously become vaguer, and more open to interpretation.
- Centralisation of regulatory bodies can also be a disadvantage. Having local inspectors with whom to threaten local service providers, mean that people can more easily be contacted and involved at local level.
- Service users should be routinely involved in inspection visits and the monitoring of safeguarding processes
- There is a danger that regulation or an overriding concern to enforce safety can impact on the quality of care and rights. Safeguarding may be experienced as 'safety at the expense of other qualities of life, such as self-determination and the right to family life'

6.1 Some of the comments made by people on the regulation of services can also be seen as relevant to service users' perceptions of a professional relationship, as similar principles may apply. The service user consultants spoken to by Faulkner (2012) saw regulation to only be useful if it is specific. It was noted how the clearer and more specific the regulations are governing a service, the easier they are for a service user to make sense of and to challenge when necessary. Several consultees explained that the danger with regulatory bodies taking on a wider range of services means that standards, as they become more universal, simultaneously become

vaguer, and more open to interpretation. Standards should be more specifically relevant to social care and there should be more frequent inspections. Another consultee raised an issue about the centralisation of regulatory bodies. There was seen to be an advantage of having local inspectors with whom to threaten local service providers, people who can easily be contacted and involved at local level. It was also seen to be important that service users were involved in inspection visits and the monitoring of safeguarding. One service summed up their wishes for regulation:

*'The regulation we need is the one that's lacking, the one that ensures good quality standards of treatment, support, enablement - that also protects the rights of the individual, that they are not going to get abused - that takes it beyond social care to the police etc when you're talking about hate crime.'*  
(Faulkner, 2012, p29)

6.1.2 Faulkner's (2012) service user consultees also pointed out the danger of regulation having a negative impact on the balance between risks and rights. An overriding concern to enforce safety can impact on the quality of care and rights. For example, Faulkner quoted an example of the removal of ligature points in a non-acute mental health unit which led to curtains being removed and windows fixed shut, which compromised dignity and made the unit unbearably hot in summer. The consultation report of the review of No Secrets (DH, 2009) also found that people are concerned about the balance between safeguarding and personalisation, between choice and risk. The consultation found that safeguarding can be experienced as *'safety at the expense of other qualities of life, such as self-determination and the right to family life'*.

This review encountered a dearth of studies specifically looking at complaints about social work and social care. In our view this is an area which should be addressed, perhaps together with research focussing on public perceptions of the standards and competence of social workers.

## 7. Service user views relating to social work with adults, carers, and older people and related to palliative care

### Key Points

- For adults and carers there can be considerable confusion about what constitutes 'social work' and what social workers do. Older people generally have overwhelmingly negative views of social work and social workers prior to direct experiences with social workers themselves.
- Unequal access to social work seems to be an issue. Many people experience barriers to accessing social work services, or feel there is discriminatory practice against older people. People do not always know what they are entitled to or how to access this information.
- The attitudes of individual workers can make a real difference to a service user's experience. Good social workers are seen as those who are helpful, caring, trustworthy, responsive, reliable, accessible, supportive, sympathetic, kind, warm, compassionate, sensitive, empathic, thoughtful, non-judgemental, friendly, committed, good communicators, service user/carer-centred and prepared to listen.
- Many service users do not see some of the positive personal qualities of the social worker as things that could be acquired or learned through training but view these as very much of the person. Many feel that managers should be recruited from front-line staff. The employment and involvement of service users at all levels of working was also recommended as a way of ensuring the existence of right attitudes amongst staff.
- A consistently strong message from service users is a wish to be treated with respect, have their experience valued and be viewed as the expert in their

care. Relationships wanted with staff are those that promoted equality and maximised choice and control – collaborative relationships.

- The importance of social workers' efficiency was noted. This is both in terms of giving advice and information, and in being able to truly take on board the difficulties that individuals and families face and providing clear and effective solutions. People also value recognition of their wide ranging needs and a worker's ability to holistically offer a wide range of social work approaches to suit different needs.
- Another key aspect that people find most helpful about their social worker is the relationship that they have with them. People valued a social worker relationship that was 'on their side', or even was as a 'friend' (characterised by perceptions of shared power and equality, trust and support, ordinariness' or informality, reciprocity, firmness and an ability to 'talk straight').
- People show a concern for more openness within and coherence around the profession. Empowerment to challenge their own social workers should be promoted in service users. Systems of adult protection/adult safeguarding could be improved and service providers should take what vulnerable adults report seriously. Confidential whistle-blower schemes are important but could be improved.
- Service users usually feel very strongly that they should be able to take decisions for themselves on matters which impact upon their own lives and wellbeing. They have highlighted the importance of an ability to understand not just risks but also the rights of the individual. Dignity and quality of life can be significantly affected by universal, generalised approaches towards risk.

## 7.1 Introduction

The spectrum of service users of social work is incredibly vast. Different groups of users will have different priorities and views depending on their situations and the

nature of their contact with social workers. To highlight one contrast; some seek the help and support from a social worker yet others will strongly resist it. Social worker roles and tasks can also differ markedly from situation to situation. Both these factors – role and context – are likely to have a significant bearing on the nature of the relationship between service user and worker and what the service user expects and wants. However despite this, there do seem to be core elements common to different users shown in the literature on service user views.

This section presents a sample of research that focusses on adults and carers. The studies presented here sometimes but do not always distinguish between different types of service users. Even when they do focus on a particular category of service user – for example ‘people with disabilities’ or ‘carers’- the differences between people within this ‘type’ will be immense and many within the category will have greater similarities with other types of service user than their own ‘type’. Some adult service users will have involvement with social workers because they are experiencing mental distress or have disabilities or physical health needs that may cause extra challenges in life. Adults of all ages and backgrounds may at some point become involved with a social worker. Older people may become more likely to need support due to physical frailty, chronic conditions and/or multiple impairments (including dementia). The prevalence of most health conditions increases dramatically amongst the oldest age groups but people can develop high support needs at any time due to health problems (either acute or chronic) or they may enter adulthood with a pre-existing disability. Usually people approaching the end of their life, and who are in need of care and support, receive palliative care – not just older people but also younger people experiencing terminal illnesses. Palliative care refers to the physical, psychological, social and spiritual support given to individuals to enable them to live as well as possible until they die. Palliative care social work is an established social work specialism with a focus on people with life-limiting illnesses and conditions or facing bereavement.

Social work, whether in palliative care, mental health, disability or in other settings, tends to take a holistic approach accepting that the needs of people are complex and that care should focus on physical, psychological, personal spiritual, familial and social needs. Social workers, by the nature of their role, can be involved in a wide range of matters surrounding the service user incorporating issues connected to their families, carers and dependents, including child protection, adult safeguarding, and emotional wellbeing.

7.1.1 A crisis in the funding of public sector services, particularly in social care, is causing a withdrawal of services and the tightening of eligibility criteria in many areas. For example Age UK (2015) report how despite rising demand from growing numbers of people in need of support, the amount spent on social care services for older people has fallen nationally by a total of £1.4 billion (17.7%) since 2005/6. In 2005/6, 15.3% of all people aged 65 and over (some 1,230,625 individuals) received social care. In January 2015 just 9.1% of older people (849,280) receive any support. In total this represents a reduction of over 40% over that period whilst at the same time the number of people aged 65 and over has increased by 15.6% or 1,254,879.

7.1.2 As compared to social work in relation to children and families there have been fewer research studies with adult users of social work, particularly in social work with older people and palliative care. This lack may not just be because of disinterest. Older people's first contact with social workers is often at a time of crisis and often when they are experiencing acute or major illness, high levels of disability or developing cognitive difficulties such as dementia (Godfrey *et al.* 2004). Involving people with dementia or other types of cognitive impairment and at a very vulnerable time in their lives in research presents different challenges with regard to ethical issues (for example informed consent ) and reliability of interview data, as well as funding constraints for research.

7.1.3 Other challenges can arise with regard to research in this area. Ware *et al.* (2003) found that many older people appeared to be cautious of appearing critical of services or the staff who provide them when interviewed. And expectations of social services and/or social workers may not be made explicit by, or clarified with individuals. Bauld *et al.* (2000) also presented evidence that older people might not find it easy or feasible to raise concerns about care services, so could be reluctant to voice criticism. Beresford *et al.*'s (2007, 2008) researchers in their large-scale UK qualitative research study looking at over a hundred service users' views and experiences of specialist palliative care social work attempted to balance potential biases arising from '*grateful patient syndrome*' (where service users have a tendency to be overly positive about the support they received) by including questions in their interview schedule which encouraged participants to express any concerns or reservations that they might have had.

7.1.4 There can also be some confusion over what is a 'social worker' or 'social services' when responding to researcher's questions; older people often have many different professionals involved in their lives. Manthorpe *et al.*'s (2007) study on the experiences and expectations of a diverse population of older people (aged from 50s-90s) and their carers in a range of localities included those who had not been considered as eligible for social care services or who had ruled themselves out in the face of means testing and other thresholds. Overall their data suggested that older people found social workers' roles unclear and variable, even within the same locality. As one research interviewee stated in a large scale study looking at older people's perceptions of social work stated: '*Social services—a big umbrella term—what do they do?*' (Manthorpe *et al.*, 2007, p1139). Stanley *et al.* (1999) found older people were confused about the role of care managers. Middleton (1998) interviewed the parents caring for disabled children who were in contact with a social worker and found considerable confusion about both what both constituted social work and which agency was providing the service. Innovations in Dementia's (2010) participants with dementia and carers recommended in their interviews that more

help is required nationally to people to understand what social workers do. They felt there should also be action taken to make sure that social work is talked about fairly in newspapers and on television to avoid misconceptions.

## 7.2 The context of engagement with a social worker

As mentioned above, many adults and elderly people will usually only encounter social workers at a time of crisis and manifest health or cognitive difficulties (Godfrey *et al.* 2004). People will often have had very limited or no experience or understanding of social work before their diagnosis or issues which require social work and social care support especially if in later life. For many people therefore, the way that social work is portrayed in the media is extremely important in forming their views on what social workers actually do, and what it means for them. Some studies (Beresford *et al.*, 2008; Innovations in Dementia, 2010) have revealed that older people generally have overwhelmingly negative views of social work and social workers prior to direct experiences with social workers themselves. These perceptions were influenced mostly by media accounts of social workers but also in some cases direct experience or the experience of others in their social circle. Beresford *et al.* (2007) reported participants to view social workers as intrusive, bossy, controlling, ineffectual and '*for other people*'. There was generally a low rate of self-referral to specialist palliative care social work. The Innovations in Dementia (2010) research found one person with dementia who had not had any contact with social workers due to feeling that social workers were not for them but for a '*crisis situation only*'. Social work was also seen to be associated with child protection and the removal of children into care or loss of independence of older people.

However when older people and those with life limiting degenerative diseases experience social work directly it is usually highly valued and seen as having a valuable and often life changing contribution. (Beresford *et al.*, 2007; Innovations in Dementia, 2010). Beresford *et al.*'s (2008) participants were able to identify a range of positive outcomes, including improvements in their own capacity to deal with the

difficult situations they might be facing and support with material problems they might face. Unfortunately, as Beresford notes, pre-existing negative expectations of social work may cause some people to turn down and miss out on good professional input. Proactive approaches from social workers with clear publicity and explanations may be required; service users appreciated the informal way in which most had been approached by the social worker in Beresford *et al.*'s (2007) study. This seemed to make them feel safe and cared for and worked well when people might have rejected more formal approaches.

Beresford *et al.* (2008) also showed in their research that access to and the organisation of specialist palliative care social work support could be negatively impacted upon by limited availability, limited status, poor self-image and the dominance of medical approaches in palliative care. Service users repeatedly mentioned late referral by other professionals. Few service users seemed to be referred to palliative care services specifically to access social work support. Some service users in the study said they would have liked to receive it earlier.

### **7.3 Key themes from studies focussed upon adults, carers, and older people's views of social workers and their care**

#### **7.3.1 A need for anti-discriminatory practice, accessible and proactive social work**

Many of the 'hard to reach' service users who were consulted by The Social Care Institute for Excellence (SCIE, 2005) were preoccupied with simply fulfilling their basic needs, fearful of societal discrimination and were generally suspicious of statutory services. All these factors, together with language issues and concerns regarding their safety and legal status set up barriers to accessing services in the first instance. Issues such as financial management, knowledge of possible services, language barriers and literacy were additionally perceived as barriers to the take up

of direct payments. Generally the people consulted tended to prefer services provided by voluntary organisations.

Manthorpe *et al.*'s (2007)' participants were usually aware of the restrictive resource context within which the social workers worked, and believed that the neediest people should be targeted for allocation of (increasingly) scarce resources. However there was some feeling that social workers did not attempt to reach out to older people or publicise their services. Moreover some participants reported a perception that social workers could be discriminatory against older people and that they chose to spend money on younger people instead. And, another area of discrimination was felt by some older people and carers who thought that they were being denied services because they lived with their families or had a carer:

*Social services expect a lot from carers—if there is an able-bodied person in the house social services don't consider you need help (Manthorpe et al., 2007, p1141).*

A commitment to anti-discriminatory practices was seen as vital for a 'good' social worker.

Gott *et al.*'s (2007) study extracted patient views of social service provision for older people with advanced heart failure in England. The majority of participants reported no receipt of social services support, including 60% of people with advanced heart failure. For some there were issues with access to and information about help available; several participants stated that they did not know what they were entitled to in terms of social service provision, nor did they know how to access this information. For example, when one participant was asked whether she could benefit from extra help from social services she replied, '*I think I possibly could, but I don't know anything about it, you see*' (female patient, aged 88 years). Similarly, the following comment from a 76-year-old female patient regarding receipt of information about Social Services provision was typical:

*Participant: I think they [social services] don't give information out really, you know.*

*Interviewer: So you don't know what you're entitled to?*

*Participant: No. (Gott et al., 2007, p337)*

This finding echoes the argument that '*Information [about available social services] is not always clearly presented, available in different formats, or well-distributed*'

(Commission for Social Care Inspection 2005, p. 23). In addition, some participants reported unsuccessful attempts to make contact with social services:

*My sister phoned 'em up twice, but I've never seen social services. (Gott et al., 2007, p337)*

Most people in Innovations in Dementia (2010) study were not currently actively using social work services, but many felt a real need to have a link to the service so that they could quickly access support if they needed it in the future. A single reliable point of contact was wanted:

*"I feel quite vulnerable – I'm OK at the moment, but if things did suddenly get worse it would be lovely if I just had a single number I could call to get help"*  
(Person with dementia, Innovations in Dementia, 2010, p7)

There was also a strong feeling that social work needed to be proactive in the support it offered, ensuring that people knew what was available and how to access assistance rather than just responding at times of crises. This was particularly important at the early stages of dementia, a time when people did not know what to do and how to cope; this is also of relevance to other life-changing or life-limiting health conditions.

### **7.3.2 Social worker personal qualities, attitudes and approach**

It can often be that in the same localities with identical services, where there are people who voice negative experiences of social work there are also those who

express positive experiences. Manthorpe's team of researchers (2007) point out how this shows that the attitudes of individual workers can make a difference to a service user's experience despite a context of financial constraints and staff shortages. Positive stories were shared about social workers who were '*helpful, caring, trustworthy and responsive*' (Manthorpe *et al.* 2007 p1142). Good social workers were also seen as reliable, accessible, supportive, sympathetic, and prepared to listen. One participant commented how '*first class treatment*' involved always getting a reply from a social worker after she left a message. Additionally advocacy for service users, promotion of empowerment, personal support and empathy were all highlighted as valued this research.

Beresford *et al.*'s (2008) research in the palliative care field also highlights that many of their participants felt that successful social work was due to the personal qualities of their social worker, or simply the 'kind of person' they were. A typical comment was:

*I can't speak any [more] highly of her because she's just fantastic really, probably the person but also the role, mainly the person.* (Beresford *et al.*, 2008, p1395)

The qualities which they valued and saw as relating to the 'kind of person' the specialist palliative care social worker was were what Beresford *et al.* refers to as *human* qualities - kindness, warmth, compassion, caring, sensitivity, empathy and thoughtfulness. These were all frequently mentioned as vital qualities apparently demonstrated by the social workers that had worked with them:

*It's her caring and understanding. That's what most people need. And her kindness and putting herself out to help* (Beresford *et al.*, 2008, p1396)  
*. . . and when I was in hospital and had a big operation [the social worker] turns up when I was feeling low with me bunch of flowers and visited me* (Beresford *et al.*, 2008, p1396)

According to the researchers, many of the service users stated that they did not see these personal qualities of the social worker as things that could be acquired or learned through training. In contrast they thought that these valued social worker qualities were part of the person, in other words that '*the person had a nature and personality that suited the work they were doing*'. (Beresford *et al.*, 2008, p1396)

Service users who were considered 'hard to reach' were consulted by the Social Care Institute for Excellence (SCIE) on the proposals laid out in the green paper *Independence, well-being and choice: Our vision for the future of social care for adults in England* (SCIE, 2005). The groups consulted included homeless people and people with chaotic lifestyles (including people with multiple substance abuse and mental health problems), Black and minority ethnic people, refugees and asylum seekers and people with severe learning disabilities and/or communication impairments. Additionally, a small-scale piece of work with a group of people with severe learning disabilities and/or communication impairments was undertaken. Participants readily articulated the qualities of their ideal social care staff. These included being non-judgemental, friendly, able to listen, committed, good communicators and service user-centred and carer-centred. It was widely felt that managers should be recruited from front-line staff, giving them a direct experience of the issues that are influencing. The employment and involvement of service users, at all levels of working, was also recommended as a way of ensuring the right attitudes amongst staff.

### **7.3.3 Treating people with respect**

A key message that comes across time and time again in the literature is that service users want to be treated with respect, have their experience valued and be viewed as the expert in their care. Wolf *et al* (2000) looked at service user experiences of the broad range of mental health professionals, including social workers. Priorities for participants in this study were for professionals to treat users with respect, to involve them in planning their own care and not to dismiss or trivialise users' own

experience. Mulhall's (2000) focus group members commented on the work of a team of mental health professionals, including social workers, at a support centre for people with mental health problems living in the community. Having respect from professionals and being able to trust them was very important to these participants. They expressed that *'the attitude of the staff was crucial...they seem to want one that actually listens, treats them with respect and if possible someone who has always known them'* (Mulhall 2000, p33).

Vernon and Qureshi (2000), who carried out focus groups and in-depth interviews with people with disabilities, concluded *'...the single most important factor identified by service users in determining good quality services was the attitude of those providing the service...respect, dignity, being treated equally, trust and reliability were all identified as critical factors in how service users felt about the service they received. At their best, relationships with staff maximised choice and control, reinforcing self-esteem and dignity and made service users feel genuinely valued and cared for; at worst they could enforce dependency and passivity, erode self-esteem and be intrusive'* (Vernon and Qureshi (2000 p272-3)

Marrable, *et al's.* (2010) national consultation of carers for the College of Social Work involving over one hundred service users, carers and other stakeholders and a mixture of methods included strategies to ensure participation of hard to access groups such as Romany and gypsy communities, rural and isolated carers, those from immigrant and Black and minority ethnicity communities and carers of people with substance misuse difficulties. The participants cared for others for a variety of reasons. Similar values to those mentioned above were stated by carers as important for the College to promote to social workers: respect; honesty; the ability to listen and to treat people as individuals, empathy and dignity. The theme of respect was particularly strong throughout Marrable *et al.'s* (2010) consultation, and included recognising the expertise that many carers have about those they are caring for:

*“Listen to people and respect where they are coming from, especially if their views, lifestyle and background etc is different to your own experience – ‘the book’ is just that – a book and nothing beats the lived experience” (p20)*

The importance of being treated with respect also came across in Penhale *et al.*'s (2007) report. A contrasting attitude of ‘distancing’ by professionals was shown in the account of a respondent who exemplified how her aunt who had memory problems and took a long time to ‘get to the point’, something that her niece felt was not dealt with well by this health professional:

*‘[My aunt was] very fond of talking about how she used to be a professional woman and when you lose that standing in society you don’t feel valued anymore, so you feel that when you talk to people you have to let them know that you were once part of a valuable network within society and it is part of your identity’ (Penhale et al. 2007, p149).*

This respondent continued to describe the care for her aunt as: ‘*ineffective, unsympathetic [and] uncaring*’ (p149). Another respondent reported a similar experience of nursing staff in a hospital:

*‘They might as well be in a factory making bread because they have no emotional interest in the job that they are doing as one would expect...people are on a production line making a component and that’s what worries me, is that the wrong people are doing the jobs’ (Penhale et al. 2007, p150).*

Although these comments above relate to healthcare professionals, the points about being caring, sympathetic and empathic, together with the need for emotional interest in the work undertaken also have currency for social work professionals. Moreover, from Penhale *et al.*'s (2007) findings from service users, carers and family members, there was a sense of disappointment arising from contact with both individual professionals and adult protection processes. Reports of incidents of poor communication, marginalisation, negative attitudes and bad practice were given by

respondents that reduced the impact of other findings in the study relating to improvements in inter-agency working in this area.

Some of the participants in the Innovations in Dementia (2010) consultation who had had negative experiences of social work professionals were frustrated by the social workers focusing on and communicating with the carer rather than the person with dementia:

*“The social worker refuses to see my husband - because of his condition he says what he thinks – despite the fact that her speciality was (older) people with dementia... I find it very offensive – that she looks at me while she is asking a question about my husband – they just don’t seem to understand that he can speak for himself...and although she was his social worker she always wrote to me despite the fact that he can read and we kept on telling her to talk to him not me”* (Carer, Innovations in Dementia, 2010, p5)

Beresford’s team noted how relationships with health and welfare services in palliative care could often be disempowering for users of services. Being treated with respect was one of the strengths service users reported in their contact with specialist palliative care social workers. For example:

*Well, esteem, pure esteem that’s the feeling we had, that she cared about us you know* (Beresford *et al.*, 2007, p1397).

### **7.3.4 Collaboration and working in partnership with the individual**

Some service users may be very resistant to health and social care professional input. ‘Hard to reach’ consultees in The Social Care Institute for Excellence (SCIE, 2005) report were positive about the possibility of being able to develop a package of care in genuine *partnership* with someone knowledgeable about local services. Innovations in Dementia’s recent consultation with 25 people with dementia and carers reported that one of the key things that could be done to improve social work

for people with dementia was to *listen to what people who use services want* (Innovations in Dementia 2010)

Similarly, for Katz's team from the Open University (Katz *et al.*, 2011), when asking older people with high support needs to consider what they valued in their lives, it was clear that people valued having input into decisions about their lives.

Beresford's (2008) research has also stressed that being able to work in partnership with their social worker and having a sense of control over the whole process was very important to many service users. Service users generally felt they did have a real say in the process:

*. . . she always said it's what you want, I'm only guiding you, but it's what you want . . . it's what we think, or what pleases us, or what we feel we should have* (Beresford *et al.*, 2008, p1397).

Gault *et al.*'s (2013) qualitative study looked at treatment adherence in people who had experienced compulsory drug treatment after partial or complete non-adherence to drug treatment. Although focused on healthcare professionals similar dynamics no doubt apply to social care professionals working with resistant service users. It was clear in Gault *et al.*'s study that healthcare professionals who had a collaborative attitude to working with the individual, such as trying different medication to avoid side effects, were appreciated by service users and felt to enable adherence. Conversely, a non-collaborative attitude towards care from healthcare professionals was likely to result in poor adherence. Non-collaborative care included not giving adequate information, reluctance to listen to service users' genuine concerns about side effects or over-medication, or treating service users like a nuisance or problem. These results suggest that having a collaborative relationship with professionals may lead to improved attitudes towards future adherence to treatment or services. However it is important to note that it may be necessary for the professional to take a lead role in demonstrating and establishing relationships that are collaborative in nature and based on principles of (equal) partnership.

### 7.3.5 Good communication, empathic listening and non-judgmental attitudes

Carers stressed the importance of good communication skills as well as forward planning in Marrable et al.'s (2010) national consultation:

*There should be more communication between social work teams. When our social worker is on holiday, it's not acceptable that we are not informed and then have to wait to get the support from another team member (Marrable et al., 2010, p24).*

Honesty and clear communication was seen as important by Manthorpe's interviewees. Making false promises was raised as a criticism. Some people gave examples of missed visits, or lack of continuity when visits seemed to peter out with no explanation. These latter issues were often seen to be the result of shortages of workers, not necessarily something that individual workers could necessarily help, however it could have been handled differently by professionals who communicated the constraints and changes, for example.

Marrable et al.'s (2010) carers also highlighted empathic listening skills as a key value to be promoted in social workers by. Beresford *et al.*, 2007's book also notes that having a social worker who truly listened to them was crucial for many service users. Equally it was important for them that their social worker took on board and *acted* on what they said:

*She was just prepared to listen, she listened basically and where she felt that she needed to give some counselling, advice, whatever, she would offer it to me but she wouldn't force it on me (Beresford et al., 2007, p1397).*

Service users have shared how they positively gain from being able to express their feelings to their social worker and for these to be accepted, without judgment:

*... she made it okay for me to have the feelings that I was having. When I felt frustrated she made it acceptable that I was frustrated; when I was*

*disappointed or upset or tearful, she made it acceptable* (Beresford *et al.*, 2007, p1397).

Both appropriate listening skills and non-directive, non-judgmental approaches to people are core interpersonal skills that individuals may develop, if the person did not already have such skills, through the course of their social work training and continue to be honed during professional practice. They may thus be seen as contributing to competence and proficiency within the profession.

### **7.3.6 Trust in professional relationships**

Factors which enhanced or undermined trust in professional relationships was investigated by Laugharne *et al.* (2012). They conducted a qualitative study in the UK of the experiences and attitudes towards mental health care in people who had received compulsory inpatient treatment for psychosis. Although the interviews focused on how service users built trusting relationships with *clinicians*, the results could also apply to a wide range of professionals working with this service user group including social workers. Factors that enhanced trust, which were related to the clinician included the clinicians' professional expertise, but also the clinician's caring or kind attitude. Continuity of care was another important theme, which included having a regular or reliable clinician who delivered on promises. Trust was additionally enhanced when clinicians listened to the service user, were honest and positive about the future, or related to the service user by disclosing small details of personal information. Trust was undermined by a history or perception of coercion and clinicians relying only on scientific knowledge. The nature of the illness itself in service users could also affect whether a trusting relationship developed - something that may need to be taken into account by workers.

### **7.3.7 Giving time and being available and accessible**

Another positive factor frequently referred to by service users in the Beresford (2007) study was the sense that social workers conveyed to them that they had time for

them. According to the researchers, being given time stood out as being ‘absolutely central’ to service users’ perception about what was most valuable in specialist palliative care social work:

*I can’t emphasize the time scale of things, there’s no rush, you don’t feel as though you are being a burden or that you know you are wasting their time somehow. You know she’s always got the time that you need (Beresford, 2007).*

Associated with the feeling of ‘having time’ was the idea that the social worker was generally available and accessible to the service user. Service users repeatedly stated how they valued this feeling that they could see or contact the social worker if they needed to:

*We knew she would be here if we wanted her about anything, you know, and we had access to that and if she wasn’t here they would bleep her for me . . . in fact I think I could say I saw her every day I was here even if it was only ‘Hello, how are you?’ . . . she was certainly very much hands on, she wasn’t one for sitting in her office (Beresford, 2007).*

The researchers were interested in exploring the possibility that being generally accessible was unmanageable for social workers and left them overwhelmed with calls for help. However they considered that the interview data inferred that service users found the idea of being able to access support sustaining and that this was a key part of their coping strategy but they did not necessarily call on it. Just simply knowing that it was there if ever needed was the important thing for individuals.

### **7.3.8 Targeted action**

Looking at the examples of valued and effective action that are detailed in their report, Manthorpe’s participants seem to illustrate social workers sympathetically and intuitively taking on board the difficulties that individuals and families faced and providing clear solutions which positively impacted on their issues (Manthorpe *et al.*

2007). One person spoke of how a social worker helped a daughter move her mother from a care home that did not fully meet her needs to one that was much more suitable. Another example was voiced by a carer, who felt the social worker fully understood the impact of a family member's dementia on the family, and so facilitated her attendance at a day centre and 'persuaded' the family to consider a care home. In both examples the social workers took action that was 'enabling' and helped the Individuals to lead more fulfilled lives. Other social workers that were '*trouble shooters*' sorted out difficult situations with clear practical solutions and showed persistence and commitment to the individual.

In relation to the general helpfulness of social workers, complaints from Manthorpe's participants seemed to centre upon social workers being too slow to respond to help, not responding at all, being too guarded about the money available and rationing, or refusing services that had been requested by nurses or general practitioners. There was a feeling that social workers took a more guarded or negative stance than other professionals:

*My doctor told me that I needed a surgical stocking and that if I phoned social services someone would come and put it on for me. But they wouldn't send anyone as they said I didn't need personal care so didn't qualify (Manthorpe et al. 2007 p1140).*

### **7.3.9 Having specialist skills and an expert knowledge base**

The ability to provide knowledge and information were additional values raised in Marrable *et al.*'s (2010) national consultation of carers. There was a request for social workers to give clear advice and information about different services that are available, as well as more guidance on benefits etc. Efficiency was also seen as a key value that should be promoted.

Participants also stressed the importance of social workers' efficiency in terms of giving advice and information in Manthorpe *et al.*'s (2007) study. People thought that

social workers should be more 'professional' in terms of having a broader range of specialist skills and an expert knowledge base; for example about particular disabilities and the relevant services available to support. Social workers were appreciated when they gave appropriate advice, provided information about and had an in-depth knowledge about relevant specialist services available. However there were complaints about social workers not having proper information or knowledge about services or just being generally '*not good on advice*'. There seemed to be inconsistencies concerning the quality of information and advice giving, as even within the same locality individuals described mixed experiences. For example, one elderly carer had been told about a day centre for people with dementia for her husband by one social worker, but not by another.

But one group of older people with multiple sclerosis in this study were critical about professionals' lack of knowledge and information about their conditions and the equipment they used. Innovations in Dementia (2010)'s participants sometimes referred to the lack of awareness social workers had about dementia and the impact of this on the individual. Advice and training for social workers in this area was seen as vital. In fact, having specialist social workers for people with dementia was an idea that many supported:

*"When she first came out she offered respite – and meals on wheels – I don't want respite and I can cook – they only know about older people and I am not the same – it breaks their circle and they don't know how to come back into it"*

(Person with dementia, Innovations in Dementia, 2010, p5)

*"if they had understood how dementia affects people that would have made a big difference – or at least have read up on what that dementia is - to turn up on someone's door and not have an idea about what it entails is not on"* (Carer, Innovations in Dementia, 2010, p9)

It was also important to service users in Beresford's (2008) research that social workers had specialist knowledge of the difficulties and conditions that they were

experiencing. Much of their work involved liaison with external agencies, and the social workers had extensive knowledge of other resources and groups. This was commonly valued by service users as summed up in one couple's interview:

*She not only understands the patient, and the partner of the patient, she understands the systems as well . . . . It's obvious to us that she knows her job inside out. And just by the way she comes back at you with an answer and what she's saying, you know she knows what she's talking about and that she knows her job and what is available. And if she's not sure, she'll tell you, but she will find out (Beresford, 2008).*

There was also a strong feeling in the Innovations in Dementia (2010) project that social workers needed to remain professional, knowledgeable, skilled, assertive and objective. Specialist knowledge about dementia as well as knowledge about appropriate local services was also seen as crucial:

*"This is not something that the family or friends can do – and there will be times when we need help from someone with a professional knowledge – of services and of, especially things like benefits and all the rules and regulations of getting the right help" (Carer, Innovations in Dementia, 2010, p10)*

### **7.3.10 A holistic approach**

The skills and approaches of the social workers in Beresford *et al.*'s (2008) research were varied; counselling and advice, practical help, advocacy, individual and group work, were all evident in their work and tailored to match the individual needs and preferences of people worked with. Service users valued the social worker's recognition of their wide ranging needs and their ability to offer a wide range of social work approaches to suit different needs. They reported taking a widespread range of issues to their social worker and felt that social workers were willing to respond to these varied concerns. Most people wanted help with emotional and practical or financial matters; these aspects could be closely interlinked and service users valued

social workers' willingness to respond to all areas. Participants valued support for not only their own needs, but also the needs of the whole family or group of people linked with them:

*My mum up till then had been my family carer, and basically my body carer. I was quite a lot of pressure on my mum, so she didn't have time for my brother and sister and other things. So when [the social worker] realised that, she managed to get funding to employ a carer (Beresford et al., 2008, p1399).*

In contrast, Gott *et al.*'s (2007) study found that the *inflexibility* of social services in their responses to adapting to the needs of the individual was one of the key complaints voiced by participants and their carers who had received services. For example, two participants reported that, whilst they had been provided with wheelchairs to aid their mobility, they could not use these because of access problems from their house that social services would not pay to rectify. In another case:

*Someone offered to cook my meals, but some days I'm not really hungry ... so it's no good having anybody coming in if you don't feel like eating at dinner time, and I went to the doctor's, and she said, 'small amounts often', you know? Because I couldn't eat a big meal. (Gott et al., 2007, p339)*

Middleton (1998) consulted with parents of disabled children who expressed how social workers were good at arranging practical help, which was helpful. However they generally felt that social workers did not want to listen to them or offer advice; both things that they really wanted. However, respondents did not want counselling as this implied they had more problems than just caring for their children and was seen as stigmatising.

This findings neatly illustrate a key difference between individuals (social workers) and organisations (social services), particularly in terms of the ability to respond flexibly and in person-centred ways to address individual needs.

### 7.3.11 Relationship building

Manthorpe *et al.* (2007) note that a valued social worker for older service users was not just someone who could solve problems but also one who showed a person-centred approach - a relationship that is 'on their side' which may for example be shown in commitment to try to help people remain independent and in their own homes regardless of age. This relational approach was also valued in the case study undertaken by Philips and Waterson (2002). Their older people and carers valued social workers who negotiated effectively between themselves and care homes but also recognised their feelings and worries and gave emotional support. Unfortunately as Philips and Waterson note, the NHS and Community Care Act (1990) stresses the role of social workers as managers of resources rather than '*recognising and dealing with people's feelings*' (p. 182).

Innovations in Dementia's (2010) consultation found that positive contact with social workers was the experience of the majority of participants in the group. Participants were asked to reflect upon the attributes that they considered social workers need for positive support for people with dementia and their carers. The ability to build a relationship with the person they are working with, so that they can find out what the individual themselves perceives as important for good living, was again a key attribute stressed as important:

*"I need someone to work with me to find out how to help me to live well – and they can't do that unless they find out who I am"* (Person with dementia, Innovations in Dementia, 2010, p9)

There was considerable mention of the caring qualities needed by social work professionals. Words such as the following were frequently used: humanity, respect, good listener, sympathy, empathy with patient, not cold or uncaring, a friend, and a good heart.

Participants in Beresford et al.'s (2008) study also frequently said that one of the things that they found most helpful about the specialist palliative care social worker was the *relationship* that they had with them. Service users repeatedly spoke of how they valued this relationship:

*They may have the skill but they have to bond as well, there has to be that trust and that relationship.* (Beresford et al., 2008, p1394)

Relationship-based work is often seen as representative of 'traditional' style or 'old-school' social work, but evidently is of prime importance within successful work with individuals experiencing life (and death) transitions. The type of relationship individuals had with their specialist palliative care social worker was at times contrasted with what was seen as a more negative experience of contact with non-specialist social workers:

*Just fill that form—you should be all right—bye-bye—signed and finished, back in the file.* (Beresford et al., 2008, p1394)

### **7.3.12 Social worker as a 'friend'**

When describing their palliative care social worker in Beresford et al.'s (2008) research service users repeatedly used the word 'friend':

*. . . looking back now I don't class her as a social worker, I class her as a friend to be honest with you . . . . Because like I say, she's been absolutely brilliant for us, honestly I mean it* (Beresford et al., 2008, p1394).

*We are talking about a friend. We don't see her as a social worker* (Beresford et al., 2008, p1394).

According to the researchers, the service users were not just referring to the social worker as someone who was 'friendly', but rather that they saw their social worker as having the attributes of a 'real' friend. The researchers outlined some of the aspects that they felt were shared by 'friends' in the traditional sense and the 'friendship' quality of the professional social worker relationship. One aspect was that service

users seem to refer to the relationship as ‘ordinary’ or informal. Another was that there was an expectation of trust and support:

*I was looking forward to her coming as a friend, I felt I could talk to her about anything, I wouldn't need to watch my tongue . . . I had complete confidence in her, complete confidence (Beresford et al., 2008, p1394)*

Another core aspect of the relationship being as a ‘friendship’ was a feeling of shared *power*, and equality between the service user and the professional. Service users felt enabled to say and do what *they* felt to be important. A few contrasted this with other professional relationships such as their medical consultant. Being a ‘friend’ could also mean reciprocity in the relationship. Knowing a little about the social worker’s life allowed people to show interest, concern and kindness—in other words, to engage in an ordinary, balanced, two-way human relationship. The researchers explained how service users frequently spoke of how they wanted the relationship with the social worker and the hospice to be two-way:

*. . . it seemed unfair to tell [the specialist palliative care social worker] everything about me. I wanted to say well how are you today? . . . and you know I wanted to, she was much more of a friend, than . . . as time went on but also she was still my counsellor, you know she still kept the professional situation, yeah (white, UK, woman patient, age group twenty-six to thirty five years).*

Firmness and an ability to ‘talk straight’ were also mentioned as positive aspects of the relationship; service users felt the social worker could, like a good friend, be honest with them and tell them if they thought they might be wrong about something.

Having flexibility in the relationship that went beyond expected professional boundaries also seemed to be part of the concept of friendship in the social work relationship. Service users made reference to how their specialist palliative care social worker seemed to have made special efforts for them in order to meet their

specific needs. According to the researchers, interviewees sometimes seemed to be saying that the social worker had gone beyond their expectations of a paid worker and that this had been greatly appreciated:

*. . . and [the social worker] came and you know talked to the kids about it that evening . . . and when my dad died, and my older son was in a terrible state, she came that night as well, at nine o'clock. So pretty impressive support really. And I'm sure she would do that for everyone . . . that's the person she is (white, UK, bereaved man, age group forty-six to fifty-five years).*

Several service users reported acts of kindness and caring from their social workers and many times told the researchers that the social worker '*went beyond the call of duty*' (p1401). The researchers note that they are not able to determine whether or not the social workers themselves saw their actions as simply part of their professional repertoire, but they were clearly interpreted by the interviewees as more than this. Many people referred to the social worker as '*genuine*' and not just '*doing a job*'. There seemed to be a feeling of a genuine 'bond of affection' —another core element of friendship— apparent in service users' comments.

The researchers noted that what service users were describing as 'friendship' suggested elements of a person-centred relationship - built around empathy, genuineness and unconditional positive regard, all core elements of person-centred approaches (Rogers, 1961; Egan, 2002). However according to the researchers the interviewees also seemed to perceive that the social worker was 'a friend' in terms of being someone they could communicate and feel comfortable with and who was not restricted by '*professional trappings*' (p1402). Service users, in this study, viewed this positively. Interviewees were frequently told that the social worker was seen as an '*ordinary and approachable person- not like a professional*' (p1402) but at the same time not over-friendly or too informal.

The researchers were aware of concerns that might surround the idea that a social work professional could be a friend, particularly in relation to professional boundaries being put at risk. Whilst exploring this issue with one of their project's service user steering groups, service users all said very clearly that they *did* see their social worker as a friend and that this was very valuable to them, but they also clearly understood that it was a friendship that had limits. They knew where these limits lay and they did not feel any need to overstep them. There is no mention as to whether they ever felt the professionals were unclear around or over-stepped these boundaries – certainly it was not raised as an issue.

### 7.3.13 Providing continuity of support

Middleton's (1998) consultation with parents of disabled children mentioned that a key barrier was lack of continuity in social work personnel, which mitigated against the formation of a working relationship. Marrable, et al.'s (2010) consultation also highlighted continuity and consistency and the importance of having one assigned social worker - It is important to have some regularity and routine (p24). Continuity of worker was also referred to as important in Laugharne et al.'s (2012) study of trust in professionals' relationships and in the Penhale et al (2007) study. In this study, it was a repeated observation in interviews and focus groups that 'you never get the same person'. One respondent even reported that some individuals and agencies 'won't speak to you'.

Most of the service users spoken with in Beresford's (2008) research had experienced the continuity of one specific specialist palliative care social worker throughout their care. This was often raised as a positive aspect of the relationship with them and sometimes contrasted to the type of relationship they had with medical personnel:

*I felt that because she knew me right more or less from the beginning, that it was very easy to talk to her about it all . . . you build up quite a bond*  
(Beresford *et al.*, 2008, p1398)

This may contrast markedly with the experiences of service users accessing social workers from non-specialist services, where long-term work is not the norm and the chances of seeing the same social worker at the point of re-assessment or further referral may be very low/restricted.

### **7.3.14 Openness, coherence, accountability and safeguarding**

Additionally, Marrable, *et al.*'s (2010) consultation showed a concern for more openness within and coherence around the profession. This included not offering services that cannot be provided, making the social worker role more transparent, and not being '*a law unto themselves*' (Marrable *et al.*'s 2010, p20). There was a feeling that social workers should be willing to challenge when necessary, and also to stand up and challenge people in authority.

Marrable *et al.*'s (2010) consultants also felt that empowerment to challenge their own social workers should be promoted in service users. An atmosphere that accepts challenges and was ready to quickly respond to complaints was shown to be important in an early study, which sought service users' views on adult safeguarding (Penhale, 2007). It was strongly felt that workers and organisations should be committed to take what is reported by vulnerable adults seriously:

*'I hope that the person will be listened to and will also be believed and that people in a professional role will particularly listen and believe and equally hear the person. It doesn't have to be someone in a professional role but they should have an attitude that acknowledges that the person is equal in value as they are and should be heard' (p143).*

Some respondents in Penhale's (2007) report were very disillusioned by the way they were treated when taking action to ensure relatives were protected from abuse. Penhale's (2007) study also noted disillusionment of service users with regard to

Criminal Records Bureau (CRB) checks (which has now changed to the Disclosure and Barring Service) in identifying perpetrators of abuse:

*‘Everything is ‘oh, got to have a CRB’. Yet look at the POVA check; that is much more for me, it is just as important, or even more so in cases in social care, yet they don’t have, there are very few who are signing up to it yet’* (p149).

Respondents in Penhales *et al.*’s (2007) study were asked to suggest how systems of adult protection could be improved. There was a mixed response with some people indicating little faith that anything could be changed. However some positive suggestions were also made. One respondent pointed out that the *‘starting point has to be more openness and to promote awareness’* (p152). It was also raised that professionals should take more responsibility for ensuring vulnerable adults were protected:

*‘Much of it is so hidden, that’s the whole point really. People in care homes are victims of the system and it’s also the system that has the power to address the problem and resolve it. No one else can really do this’* (p153).

A confidential whistle-blower scheme was suggested as a positive move in Penhales *et al.*’s (2007) study. Additionally it was felt that there should be much greater accountability than is currently given to incidents where adult protection fails. The general feeling amongst respondents was that ‘people must be brought to public account if they don’t do things properly’. A number of respondents also spoke voiced a need for specific legislation in adult protection.

### **7.3.15 Safeguarding, rights and risks**

Support for adults with disabilities and other difficulties often involves professionals and service users weighing up what can seem as contrasting rights to both *take risk* but also be *protected from risks*. The Innovations in Dementia (2010) participants

also highlighted the importance of an ability to understand not just the risks but also the *rights* of the individual:

*“I don’t need to be covered in cotton wool – and I need someone who will understand that I need to stay connected with that part of me”* (Person with dementia, Innovations in Dementia, 2010, p9)

Adults, regardless of the difficulties they experience, usually feel very strongly that they should be able to take decisions for themselves on matters which impact upon their own lives and wellbeing. Faulkner (2012) held discussions with seventeen service users, many of whom were activists or working in user led organisations, to gain some insight into their views of risk and decision making. She highlighted that a significant fear for many service users with mental health issues and disabilities is the fear of losing their independence. This was found to be of greater concern than many of the potential dangers perceived or apparent in their lives. However, for many people, the potential risks to independence and quality of life did not appear to be considered by social care services, and was not given the same priority as, for example, the health and safety risks of doing an activity. For Faulkner’s consultees the consequences to the individual of *not* taking a risk were seen as not just the risk of reduced independence, but also of increased institutionalisation and even the undermining of a person’s sense of self and self-worth.

Faulkner’s consultations raise an important issue of how quality of life can be significantly affected as a result of services imposing an institutional approach towards risk upon everyone, without much thought for the individual consequences or differences. The inappropriateness of some sweeping decisions could have a considerable impact on an individual, yet could often be resolved with basic common sense or simple adjustments. One example given by a member of the Independent Living User Reference Group was in relation to her mother who had smoked since she was 11. She strongly wanted to continue but was refused an opportunity to go outside to smoke by her day centre which caused great frustration. Faulkner

suggests that if a relationship of trust existed between a person and their supporter, worker or carer, reasonable risks could be taken that would promote or preserve an individual's independence. Having someone genuinely listen and take on board what the person has to say can build a relationship of trust and enable a more tailored approach to risk and safeguarding.

Most of the people that Faulkner spoke with were people keen to retain their independence in a variety of different ways; however she acknowledges the potential bias of her sample (mainly activists or working in user led organisations) and does importantly stress that: *we should also respect the choices of people who opt for less independence and less risk taking...It may be a question of finding the right balance for the individual between independence and isolation, risk and safety, as long as there is real choice involved (p17)*

Faulkner's consultees explained how there would often be a 'weighing up' the risks and benefits involved in a particular decision or action. However some people were unhappy that their experience of this weighing-up process was that they were often not allowed to participate in it; instead, this was done by others, on their behalf. For example when assessing the health and safety risks involved in going on an outing this would often take place without the individuals concerned and by people who are not directly affected by the risk. However professionals can be more concerned with protection of themselves from possible recriminations and accountability than concern for the service user wellbeing.

The consultation report of the review of No Secrets (Department of Health, 2009) also stated how people would like help to deal with potentially and actually abusive situations in their own way. Respondents to the consultation did not want decisions made for them but felt that it was their own responsibility to keep themselves safe. They wanted to '*do their own safeguarding, they wanted help with information, options, alternatives, suggestions, mediation, "talking to" and so on*' (Department of

Health, 2009, p18). Other studies with people using mental health services, also reported similar concerns, whether they represented a risk to themselves or to other people (Langan and Lindow, 2004). Faulkner (2012) points out how excluding people from decisions about their own risks has implications, not just for the accuracy of the assessment, but also for individual's dignity and human rights. However one key issue emerging from her consultation was how perceptions of risk and rights seem to be significantly different for mental health service users. In this situation, people are often perceived first as a source of risk rather than being considered potentially at risk in vulnerable situations. Individuals can be overlooked by adult safeguarding practices, and their individual rights compromised by the Mental Health Act 1983

There will always be complexity within the area of risk and rights; it must be remembered that the choices of one person can impact upon the life choices of another and it will be difficult to set an easy guideline to follow. Faulkner (2012) concludes:

*There is often no ideal solution to a complex situation, but rather a series of compromises to find the best fit (p32). She expressed a concern however that the culture and ethos surrounding risk and rights, both in wider society and within individual services, is risk-averse, with a tendency to blame individuals when something goes wrong... Regulation should be centred on the views and experiences of the people using the service being inspected, reflecting their quality of life. It should not be risk-averse; ensuring safety should not adversely impact on quality of care. (Faulkner, 2012, p32-33)*

## 7.4 Conclusion

Manthorpe's *et al.*'s (2007) research concludes by presenting a list of 'desired social work competences and qualities' (p1143) that were identified through the course of the study. The older participants in their study wanted their social workers to be:

- knowledgeable about their condition and its effects;
- able to listen and respond appropriately;

- skilled in enabling a person to speak out without taking umbrage;
- sympathetic and not intimidating;
- able to make a thorough and informed assessment; and
- committed to anti-discriminatory practice

Beresford *et al.* (2008) note in conclusion to their research that what service users seemed to value highly was the way in which the specialist palliative care social worker was someone who was prepared to stay alongside them in their journey through their illness or bereavement, wherever it might take them, like a 'friend', yet at the same time having the skills and knowledge of an effective professional. The researchers comment how '*It was as if they recognised and appreciated the expertise of the social worker without seeing him/her as an expert remote from them and their lives*' (p1402). Individuals also appreciated the unique blend the role offered:

*What service users seemed to value from social work practice was that it was truly psycho-social; that is to say, it addressed both individual personal and psychological needs and the broader social circumstances and worlds people lived in and faced. These two were seen as inextricable. The combination of practical help and support, with a relationship and 'friendship', were what so often were seen as valuable and unique (Beresford et al., 2008, p1405)*

Unfortunately, as Beresford *et al.* (2008) note, the characteristics, which service users seem to see as the strengths of specialist palliative care social work in their study – its flexibility, informality and 'ordinariness' – generally do not attract professional value or recognition. Nor are these attributes necessarily available in many other settings in which social workers are currently based and work, perhaps due to the overriding pressures of workloads and constraints of resources, including time.

The evidence from these studies suggests strongly that the distinctions between personal qualities and professional competence may not be as great as might be thought at first glance. Although service user participants spoke freely (and eloquently) about their experiences of social workers and clearly referred a great deal to their personal qualities and relationship-based care, they also included much detail about professional skills, attributes and competence in their discussions with researchers. In seeking to know more about essential standards and competence needed by professional social workers, we also need to understand the holistic and composite nature of both the evidence and individual (social workers) as both people and professionals.

## 8. The experience of social workers by parents in troubled and resistant families

### Key points

- Being involved in a child protection investigation causes immense stress for families at all stages. Many parents feel stigmatised by social workers, although parents can view involvement with child protection services positively and understand that social workers have to be diligent and persistent to protect children and prevent tragedies such as affected Baby Peter (Connelly).
- Many parents in child protection cases – even those who experience an unwanted outcome - can feel helped or supported by their social worker and many can identify positive qualities in the professionals who supported them.
- Service users sometimes reported struggling to understand what was happening to them and why. Clear information and explanation is essential but absorbing information at the start of the investigation process is difficult for many parents, due to stress and anxiety which can impact on an individual's ability to retain information. Time to absorb difficult communication and repeated giving of information may be needed.
- There were some complaints that child protection processes over-emphasise problems, and that good factors were ignored. Having strengths recognised by professionals can increase morale and motivation.
- As in other fields of social work considered in this review people stress the importance of the social work relationship. Personal qualities valued in social workers include being reliable, supportive, listening carefully, promoting co-operation, being matter of fact and being 'human', promoting trust,

communicating openly and clearly and providing mutual understanding and support.

- Feeling listened to and consulted and being shown empathy and respect can particularly lead to a more positive experience of social worker involvement. In addition being open, clear, honest and ‘upfront’ could help to build a positive relationship and establish trust, even where service users did not like what they were being told. Providing a written copy of all that was discussed between them could help.
- Some people have expressed concern about the balance of power in child protection systems and a sense of not being treated as innocent until proven guilty. It is very important that all people feel they are being treated ‘fairly’ and with courtesy. A perceived lack of fairness is compounded by a lack of understanding of their rights within the social work system. Social workers should always remain very aware of power imbalances and their impact on individuals.
- Being recognised as a parent even if no longer able to physically care for the child was hugely important to parents of children who are in care or adopted.

8.1 Social workers typically become involved with families when the family is struggling to cope with needs and issues that are beyond those of the ‘normal’ family, or because the child is in need of protection due to issues with or behaviour of the parents. In many cases the family may not want or be highly anxious about the involvement of a social worker. The social worker’s presence can feel an intrusion in the normally private and intimate dynamics of family life. It can cause stigma, stress and worry, especially in cases of child protection investigations. Ghaffar (2012) found stress to be experienced by families at all stages of child protection investigations. Davies, a social science lecturer at an English university, found her own experience as a mother involved in a child protection investigation ‘*devastating*’

despite her innocence and eventual case closure (Davies, 2010, p201). Platt (2001) found that *'for many parents, a wariness (at best) about social workers visiting them was evident in the initial stages of most of the interventions . . . for some families, a social worker knocking at your door was bad enough, irrespective of whether they were investigating alleged abuse or offering an assessment'* (Platt, 2001, p144–5). Families however became generally more appreciative of the intervention as it proceeded, with Platt concluding that there was a real difference for families in being the subject of an assessment as opposed to an investigation as it was less invasive and more conducive to the development of partnership working arrangements. The involvement of a social worker can be embraced and appreciated, especially if the family and children are supported and given access to services and opportunities that radically improve their lives.

8.1.1 For a social worker it can be difficult to balance apparently contradictory tasks of both supporting parents whilst protecting vulnerable children, in a context of large and difficult caseloads and angry, wary or resistant clients. Social workers may often have distressing information to acknowledge and are required to raise concerns appropriately with parents. Despite this it is interesting that parents in a range of different research projects, including those who have experienced the removal of a child into care, have often been able to identify positive qualities in at least some of their social workers or are appreciative of their conduct and professionalism. The studies show that families do not have a consistent service from social workers but acknowledge differences between them, and appreciate particular standards of practice.

8.1.2 Thoburn, Lewis and Shemmings (1995), in their extensive study of social work practice, found that half the parents in child protection cases thought that they were helped or supported by their social worker. Similarly Ghaffar (2012), when exploring the experiences of forty-two families with children subject to Child Protection Plans in three English local authorities, found three quarters of families were able to identify

positive qualities in the professionals who supported them. One former drug using mother in this research said; *'People think (Social Services) just come and take your children...and it's not the case...They...give you a chance to sort yourself out'*. A couple who disagreed with the involvement of child protection agencies still acknowledged that *'they had (baby)'s best interest at heart...they did do their job properly'* (p900). Whilst their study excluded those families who were *currently* referred because of child protection issues, Tunstill and Aldgate noted that 86 per cent of the parents they spoke to found Social Services *'sympathetic and helpful'* (Tunstill and Aldgate, 2000, p137).

## 8.2 Personal qualities valued in social workers

In this field of social work, as in the others considered in this review, there are particular personal qualities of workers that stand out consistently in the research as being valued and appreciated by the service users. For example in Dale's study of child protection services, families valued social workers *'being supportive, listening carefully, promoting co-operation, being matter of fact and being human'* (Dale, 2004, p149).

## 8.3 The social work relationship

Spratt and Callan (2004) found that parents rated the attitude of the social worker and their ability to make and sustain relationships with both parents and children as key factors in positive social work. Smith *et al.*'s (2012) twelve-month research and knowledge exchange project on engaging with involuntary service users in social work also highlighted the importance of the social work relationship for effective engagement with service users:

*Our findings also strongly suggest that worthwhile user engagement only becomes realisable through effective personal–professional relationships. Relationships built around trust, communication, mutual understanding and support are all pre-requisites of meaningful participatory practice (Smith et al., 2012, p1474)*

Buckley et al. (2010) equally found *'the factor that was most likely to neutralise service user negativity was the development of a quality relationship between families and workers'* (Buckley et al., 2010, p105). This is consistent with Munro's (2011) emphasis on relationship-based social work practice. One of the key principles for an effective child protection system, highlighted by Munro (paragraph 2.24), is engagement with parents and carers, with respect, challenge, support and appropriate use of authority. The research on families' experience of social workers adds further detail to this concept of an effective personal–professional relationship, indicating that the various factors detailed below help lead to the formation of positive relationships with social workers.

#### **8.4 Being reliable**

Ghaffar's (2012) parent participants valued social workers and other professionals who were reliable, consistent and organised, with clear plans being followed through; *'I came here and everything made sense; it was just so much more organised and planned, and it worked'* (Ghaffar, 2012, p900).

#### **8.5 Giving time to people**

Ghaffar's parents particularly appreciated social workers who spent time with them and their children. Giving time for practical support was also welcomed. One mother who had been abused herself as a child appreciated the time her social worker spent with her to address issues from her own childhood: *'She'd actually come to see me on my own so I could tell her about my family history. It had always been in my mind.'* (Ghaffar, 2012, p900)

#### **8.6 Openness and honesty**

Smith *et al.*'s (2012) research showed how trust was usually built up gradually through simple, everyday, small-scale actions. Being honest and 'upfront' could help to build a positive relationship and establish trust, even where service users did not

like what they were being told. The participants expressed wanting to be properly informed about interventions, particularly where the consequences were likely to be significant. Clarity and honesty from the social worker was also appreciated in other studies:

*'Being open and honest, I think works a lot better. You know where you stand. You know what you've got to do. You know what will happen if you don't.'*

(Ghaffar, 2012, p900).

*He's honest, he tells me straight, he's direct with me, and I'm straight with him*  
(McCann, 2006, p10)

Similarly in Neil *et al.*'s (2010) research with birth parents who had experienced the compulsory loss of their child to adoption, even in this difficult, sometimes adversarial context a trusting relationship could be established with social workers who were open and honest about difficult information and provided a written copy of all that was discussed between them.

### **8.7 Clear information and explanation**

Smith *et al.*'s (2012) service users repeatedly emphasised the importance of clear communication and appropriate information. Service users sometimes reported struggling to understand what was happening to them and why. Explanation was therefore crucial:

*They didnae sit doon and say, 'right these are the complaints or the worries that we have got. Now we are gonnae dae this'. They said 'right we are taking your son off you' and I thought 'Whit?' [what?]* (Smith *et al.*, 2012, p1470).

Ghaffar (2012) similarly heard from parents who felt that the limited information received had led to confusion and misunderstanding about the seriousness and purpose of the child protection process:

*'They didn't really make it clear what was actually happening.' The agencies needed 'to be more frank with people, not brushing it off as if it's a little speck*

*of dust, and it's not really. It's like a big rolling ball. I'd no idea what I was in for.* (Ghaffar, 2012, p897)

Ghaffar (2012) points out how absorbing information at the start of the investigation process was difficult for many parents, due to stress and anxiety which can impact on an individual's ability to retain information. Ghaffar noted how mothers with disabilities or serious health problems, or with disabled children, seemed particularly vulnerable. Stress can stop parents taking in information or processing it, and, therefore, how much has been understood by parents needs to be checked regularly. One parent in Neil et al.'s study noted that *'they do explain it to me, but it's like it goes in one ear and out the other cause I can't keep hold of the thoughts inside. I keep forgetting'* (Neil et al., 2010, p92).

8.7.1 Time to absorb difficult communication, whenever it is given can also be important. Ghaffar (2012) noted how several parents commented on the lack of time they were given to read and reflect on assessment reports written about them that had been prepared for case conferences. They felt that they needed time and help to understand what had been written. Of course preparation and advance warning is not always possible at every stage; there are situations in which urgent action on the part of social workers may be justified, but individuals evidently need as much time as possible to read, understand and at times respond to information that they have been given, particularly when the effects are likely to be significant for them.

## **8.8 Being consulted and involved in decision-making**

Feeling listened to and consulted also could lead to a more positive experience of social worker involvement. Ghaffar's (2012) parent participants particularly valued social workers and other professionals who listened to their point of view and who were respectful. Some parents also appreciated that their ideas were always given due consideration. A father described how decisions about his daughters were agreed through a process of negotiation. One mother described being *'involved in*

*every decision on what was going to happen next'* (Ghaffar, 2012 p899). . McCann's (2006) interviews with parents of children in foster care also found choice important:

*She gives me choices and not so much tells me what to do but sort of guides me what to do* (McCann, 2006, p9)

Six parents in Ghaffar (2012)'s study felt they had limited influence on decision making, but still felt respected and listened to. Some felt that their influence on decisions was quite restricted: *'I was consulted, I was involved, but obviously some decisions I couldn't be involved with.'* Another parent reported: *'I wasn't involved in any decisions, but they explained (things) very well, and they listened'* (Ghaffar, 2012, p899).

In Ghaffar (2012)'s study a more negative experience resulted when people felt decisions were made before meetings had even started. One couple felt they could not contribute to decisions being made. They said: *'from her being born until her coming home . . . we were kept in the dark about a lot of things'* (Ghaffar, 2012, p899). Several families said that the level of consultation was heavily dependent on which social worker was working with them at the time. Families where mothers had serious disabilities or health problems were critical of consultation that paid too little regard to these factors.

### **8.9 Acknowledging the positive**

Some service users in Smith et al (2012)'s research complained that there was an over-emphasis on their problems, and that good factors were ignored:

*[Our previous social worker] didn't know how to deal with positive things. She was all happy to jump on us when we done stuff wrong but when we done stuff right she never commented on it, she never said nothing* (Smith et al.' 2012, p1470).

Similarly, several parents in Ghaffar's study complained about what they perceived as a *deficit* and *disempowering* model of assessment. A couple of mothers spoke about an assessment report or agencies only referring to negative things about their parenting:

*'There was nothing positive, it was all bad. When you're in a room full of professionals it's not very nice.'* (Ghaffar, 2012, p897)

By contrast, when parents' strengths were recognised by professionals, their morale and motivation improved. One mother, who had previously had a negative experience of professionals, spoke of how social workers' belief in her ability to change motivated her to seek help and focus on the needs of her children: *'They told me...I've got the potential to do it. I've just got to get my mind in the right place.'* (Ghaffar, 2012, p898).

### 8.10 Empathy and respect

Twelve parents in Ghaffar's study experienced professionals as lacking empathy. One mother whose partner had allegedly sexually abused her daughter had said to social workers *'When he finds out what's been said, he'll just want to kill himself. They said, "Well, that's not our problem"'*. (p900). Showing empathy could mean taking account of individuals' needs, such as around timescales - for example where a service user had agreed to leave an abusive partner or stop using drugs

*I have minor learning difficulties and I said that I will get there, you just need to give me time and work slowly with me . . . be patient with me instead of saying to me you need to do this by a certain date. Ever since then me and my social worker got closer and worked together* (Smith *et al.*, 2012, p1469).

Several studies have involved birth parents who, after social work intervention and often against their wishes, experienced the removal and placement of their child into care or for adoption. Parents of children not able to live with them are at risk of stigma and lack of sympathy from society; their right to grieve the loss of their

children may be compromised by what Doka (1989) has described as 'disenfranchised grief'—grief that is not culturally acknowledged or supported. Their identity as a parent is threatened by the care status of their children (Schofield *et al.*, 2011) and the associated perceptions that they have failed in this role.

A non-judgmental, non-patronising attitude was important for parents in McCann's study; parents valued those who treated them like a parent and responded to their need for information about their child. Similarly Schofield *et al.* (2011) who interviewed parents (mothers or fathers) who had children who had been in foster care for at least a year, also highlighted their need to be treated by social workers with respect and empathy; to receive information about their children; and to be involved, where possible, in the children's lives.

*If they can remember what the person is going through, losing their kids and the pain that causes. We are not made of stone. None of us are made of stone. (Schofield et al., 2011 p85)*

9.10.1 Some parents in these studies felt that professionals spoke to them as if the child had never been theirs. Some described feeling stripped of their identity as parents and a lack of sympathy or empathy from professionals. There could be a lack of recognition that they had loved the child, in spite of their difficulties as parents. When this was encountered in the social worker's approach parents felt that their anxiety and fears about the child's wellbeing could not be shared with social workers. Schofield notes that there seemed to be a link, according to the parents, between a lack of respect and recognition for them as parents, a lack of information available from social workers about the child and a lack of involvement in the child's life in a way that they thought was reasonable:

*I think social workers need to change the way they do things, because feeling entirely out of touch with your children is the worst thing possible. (Schofield et al., 2011, p86)*

Neil et al (2010) found that around a third of birth parents in their interview study referred to a period of several months - or even up to several years – following placement and prior to the adoption of their child where they had no information about their progress or welfare, even though they may have been desperate for acknowledgement that their child was well. Although it is possible that some parents avoided or lost touch with social workers, others were insistent that they had not been kept informed.

8.10.2 Although negative feelings were more common, there were parents in these studies who did feel completely involved and in some way still a ‘parent’, indicating that their social workers were not only respectful, but also helpful and empathic about their role and feelings as parents:

*I can talk to my social worker and if anything ever happens she is straight on the phone to me. If the children were ill or something had happened, she says, ‘I will always let you know’ (Schofield et al., 2011, p86).*

*She gets back to us with a telephone call after she has been there, that his behaviour is the same, or better or whatever. She rings every time she sees him, it’s brilliant. (McCann, 2006, p13)*

One of Neil et al.’s Birth mother participants, who had just experienced a court decision for her child to be adopted, noted that her social worker rang her up a few days after the final hearing. She thought that was ‘*nice in one respect because they were thinking about me and, you know, realising that it is traumatic: I didn’t find them cold or anything like that. They were very sympathetic*’ (Neil et al. 2010, p91).

Another birth mother explained how her social worker called once a month to provide information on events and the child’s wellbeing, and promised to do so until six months after the adoption. Others birth parents (and grandparents) were encouraged to and fully supported by their social workers to meet their child’s adoptive parents and remain in contact through letters. This was not just to meet their own needs for information; some social workers emphasised the ongoing value

to the child of knowing about their birth family, promoting the birth families ongoing and important role in the child's life.

Of course where parents may put a child's placement or well-being at risk, there can be good reasons for limiting the amount of information or involvement available. But, in most cases, Schofield *et al's* (2011) interviews inferred there were more subtle difficulties, not based on direct risk to the child or the placement, which got in the way of good communication between social workers and parents. For example some parents in Schofield's study felt they were not seen and respected as human beings reacting to a crisis, but only as 'drug addicts' or problem parents.

### **8.11 Continuity of the social work relationship**

Related to the idea of trust, Smith et al (2012)'s research emphasises the importance of continuity in social work relationships, reinforcing messages from previous research (Munro, 2001; Cashmore, 2002; McLeod, 2007; Franklin and Sloper, 2009). Many families in Ghaffar's (2012) study commented critically on the numbers of social workers involved with them, and they highlighted the discomfort they experienced in being expected to share detailed personal information with different people. The parents of children in foster care interviewed in McCann's (2006) study found it difficult when social workers moved on and a new one took over. People struggled with having to 'explain yourself all over again' (p14). This raises particular challenges in contexts of high staff turnover; however how transitions are done can make a difference – in McCann's study it helped if people were informed of the change and had a '*good good-bye*' (McCann, 2006, p15)

### **8.12 Being treated 'fairly' and with courtesy**

Participants in Ghaffar's (2012) study were clear about the roles and duties of social workers. Some said that the 'Baby Peter (Connelly)' case had made them realise that social workers had to be diligent and persistent. Although there were examples of parents feeling stigmatised by social workers, other parents saw involvement with

child protection services positively. Numbers of parents who agreed (N = 19) and who disagreed (N = 17) with decisions for their children to be made subject to Child Protection Plans were fairly evenly split. Those who agreed did so because they felt it gave them support or reassurance about their child's safety. They felt that the structure and focus of a Child Protection Plan put them in a position where they had to confront the risks faced by their children. Eighteen parents felt the Child Protection Plan had made a positive difference to their family. And even of those who did not agree with the decision, five families indicated that they did have an understanding of the safeguarding responsibilities of professionals working with children, and they were able to empathise with their role. One parent stated: *'Well...they were only doing their job...they just thought I wasn't looking after my children properly.'* (Ghaffar, 2012, p898)

Bell (2003)'s research found that fair and clear treatment could make a difference to the parents experience; most family members experiencing case conferences felt they had not influenced conference decisions, but three-quarters felt that they had been fairly treated. Neil *et al.* heard from a birth parent who had lost her child to adoption at the time of the interview who explained how fair treatment and persistence had a positive impact on her relationship with her social worker:

*At first I didn't get on with the social worker...it did change because she was always good with keeping us up to date with everything and going to meetings...she was easy to talk to...if we wanted to know anything about the children and she would get straight back to us...she was really nice'* (Neil *et al.*, 2010, p91)

McCann (2006) interviewed twenty-six parents of a child in foster care, the majority of whom had not wanted their child to be taken into care. Despite their loss, many parents praised social workers who appeared to be supporting them and promoting their participation, and being on their side as well as their child's:

*[He is] best social worker because he is on both sides, he has given me a chance and I've not let him down, I've not let the children down (McCann, 2006, p9)*

Conversely McCann's parents felt betrayed and let down if they had felt left out or avoided. The most frequent complaint about social workers was not returning telephone calls:

*You phone up again. 'Oh yes I will come and see you'. Nothing happens. (McCann, 2006, p11)*

### **8.13 Judicious use of power**

Of course sometimes child protection investigations eventually do result in '*no further action*'. Very occasionally even caring parents find themselves caught up in child protection systems for example in cases where injuries deemed to be non-accidental are found to have an innocent cause. As one newspaper headline stated families can be '*torn apart*' through the '*nightmare*' experience of unfounded allegations (Savill, 2006). The role of a social worker is extremely difficult in ambiguous cases with a fine line between being accused of failing to intervene or intervening too zealously. The importance of social workers taking account of the negative impact a child protection investigation can have on a family is drawn attention to in Davies (2011) account, a paper written based on her own experience of being in the system. She recalls feeling '*victimised*', (p202). Others interviewed by researchers have also shared how professional investigations can leave parents feeling vulnerable, fragile, and frightened and completely powerless (Richardson, 2003; Dumbrill, 2006; de Boer and Cody, 2007).

Most family members in Wiffin's (2010) interviews felt that they experienced the social work system as unfair and they felt that they were not given a chance. "*In law you're innocent until proven guilty, in social work it's the other way around.*" (Wiffin, 2010, p12) This perceived lack of fairness was compounded by a lack of

understanding of their rights within the social work system. One parent said: “*Are you allowed to see all the documents written about you?*” (p12). Family members said they did not know who they could ask for help and felt it would be inappropriate to ask their social worker, as they assumed they would not help them, either because they wanted to withhold this information or because they were not allowed to discuss it. Either way this led to feelings of suspicion and a lack of control for the family.

9.13.1 Davies (2011) expresses concern about the balance of power in child protection systems. Davies felt from the beginning of her investigation there was an assumption that she was guilty and that anything she said would be interpreted negatively. A hierarchical status of knowledge seemed to exist and her own ‘*evidence*’ was discounted in favour of paediatricians. She felt that key knowledge on her son could be obtained from his paediatrician in the neighbouring hospital yet the professionals did not respond to her request that they communicate together. She also felt that ‘*heavy handed regulatory practice*’ and rigid ‘*bureaucratic processes*’ took over when individual flexibility and courageous autonomous judgment could have allowed the process to be exited quickly in her case, without a case conference. Davies also felt let down by the fact that, despite the case conference concluding with no further action, there was no letter of reassurance afterwards, no acknowledgement of innocence and, despite requests, no minutes provided. All this contributed to a lack of exoneration and total closure that prolonged the agonies of her experience.

Davies feels that the professionals she interacted with acted competently, and much of her negative experience was system related rather than factors related to individuals. However she does put forward recommendations that apply to social workers themselves. Rather than treating parents as suspects from the start, she states that social workers should consider the parental role as ‘partners with professionals’. Social workers should think about their significant painful and intrusive impact on family members and ‘*be more consciously reflexive about*

*balancing power with compassion*' (p208). Dumbrill's (2006) Canadian parents similarly spoke of the absolute power agencies had over them even when the abuse or neglect allegations were unfounded. Dumbrill argues that social workers must acknowledge the fear parents have in the face of this power and work sensitively with the unequal power relations. Respect and support and interpersonal styles of working, along with prudent use of power are also recommended in other research with parents (Dale 2004; Palmer *et al.*, 2006; de Boer and Cody, 2007).

### **8.14 Recommendations for social workers**

Although not a researcher, Hazel Davies who has co-ordinated a Parents' Aid group Parents' a voluntary organization for families who either were or were likely to become involved in local Social Services Department, has insight into the situations where parents most often take objection to Social Services' approach. Her 2009 paper lists five key points for social workers which she states are 'guaranteed' to improve working relations with parents in child protection and court situations:

1. Write reports that are both factually accurate and objective. There's nothing more infuriating than hearing your parenting style criticized by professionals who can't be bothered to get your children's names and birth dates right.
2. Take as much time to build a relationship with the parents as you do with the children. It's necessary to be child-centred but you won't get a full picture if you assume a conflict of interests between their position and the parents'.
3. Remember to treat gossip with extreme caution. Social workers traditionally take referrals and gather information from every potential witness, but the neighbours of a 'problem' family who are stigmatized locally, estranged partners and many in-laws are not reliable sources of evidence.
4. Don't back off from parents just because they seem hostile. You would appear hostile too if you thought people might be coming to take your

children away. Listen to them instead: as their anxiety levels come down, so will the defences.

5. Try to be as honest and reliable as possible. Always keep your word: keep the appointments that you have made and return telephone calls promptly. Admit mistakes when you make them: it's much better to retain the family's trust than to try to appear flawless

(Davis, 2009, p325)

## 9. Children's views of social workers

### Key points

- Children and young people often strongly fear the consequences of confiding in their social workers. They want information and help from friendly, non-judgemental professionals, who encourage them to ask questions, listen without prejudice, convey trust, treat information with confidence and act with competence. Great sensitivity and reassurance from a social worker is needed to reduce their fears around whether they will be believed and understood and what will happen with any information given.
- Communication skills involving empathic listening and questioning are particularly valued by children and young people. They appreciate social workers who listen and communicate with them at an appropriate level about everything that is going on for them – especially around child protection procedures, moving into looked after settings and other transitions.
- Children and young people frequently make clear that they want to be treated as individuals. Social workers need to provide flexibility around children's unique and individual need for support.
- The child's own wishes regarding their situation must be respected and fully taken into account even if the social worker is not able to go along with those wishes. The evident inequality of power should be respected, acknowledged and not abused.
- Children and young people generally want more opportunities to understand and have an influence on what is happening to them. Children repeatedly state that they want to be given more information about what decisions are being made and why. They want a key say in discussions and decision making especially around placement moves, schools and contact. Particular effort needs to be made with disabled children, privately fostered children,

children in kinship care and children in youth custody, as these groups feel even less involved in decision making. Training and skills in communication with children with disabilities is important.

- Social workers should aim to empower children - not just to allow them to voice their opinions more but also to generally take more control of their lives.
- Children and young people frequently complain about social workers being difficult to get in touch with. How much contact and how close a relationship children want with their social worker can vary depending on their needs at particular times and situations. Children would like social workers to give them more time and attention around key events and changes. To meet children's varied and fluctuating needs social workers should be flexible about visits, and attune to children's wishes without following a prescriptive pattern or continuing with a routine that is no longer appropriate. Social workers also need to be easily available and respond to particular needs. They need to be sensitive to a meeting context and ensure it does not single a child out from their peers.
- When holding meetings that children and young people are able to attend there should greater flexibility to allow children to participate in their own way. This includes attending for part rather than all of the meeting, or going through reports and plans beforehand so that they can have their views passed on indirectly.
- Children and young people want good communication between professionals and support for moving between professionals and services without having to tell their story several times.

9.1 Children tend to experience the involvement of a social worker because they have needs that lead to extra demands upon parents above the 'normal' family (for example because they are sick or disabled or show emotional and behavioural

difficulties), because they may be at risk of harm or neglect or because they are living apart from their birth families in local authority care. Research which includes the perspectives of children living in their families as well as those in foster and residential care and care leavers is included here. Stein (2009) noted that many children who have contact with children's services perceive their social worker as the most important person in their lives, and recognise the potentially powerful position that the social worker holds in relation to them.

## **9.2 The context of a child's experience of a social worker**

The beginning of a child's a relationship with a social worker is usually initiated by others and often following concerns regarding their care or behaviour. It may be difficult for the child to understand why this unusual professional is suddenly interested in intimate details of their life, asking difficult/intrusive questions or making life-altering changes. They may pick up resentment and opposition from their own carers. It is likely therefore that the child may feel anxious, powerless, and possibly stigmatised; they may treat social workers with caution and may be worried about the consequences of talking to them about what is happening in their lives.

Young children involved in child protection processes may be particularly confused and distressed (Cossar and Long, 2008). Children who have had to be removed from their families and taken into care may perceive their social worker as the cause of this huge, disruptive and life changing event. It may have been traumatic and abrupt, and with little or no time for careful explanation or choice. The child will no doubt have a complex mix of feelings and emotions – which may include relief (Ward et al 2005) but also many negative feelings such as guilt, anxiety, sadness, uncertainty and loss (Timms and Thoburn 2003).

## **9.3 What do children want from social workers?**

### **9.3.1 Being available for and trusted by children in need**

Young children cite teachers as the first person outside the family that they would turn to if in trouble and older children and young people would usually turn to friends for help (Featherstone, 2004). However sometimes children who have access to a social worker fail to confide in them even when in desperate need of help. Research has begun to explore reasons why children do not always disclose abuse or turn to professionals when in need of help, and can shed light on whether there is anything related to the conduct of the social worker that may be a factor.

Some of the barriers to help seeking referred to are not concerned with the social worker or other professional attitude and stance towards the help seeker, but more about the child's own feelings about and awareness of the abuse, loyalty towards their birth family and fear of stigma or not being believed (see for example Action for children, 2010). Mainey *et al.*'s (2009) review of children's views of services (not just social work services) found that many research studies showed children simply lack clarity about where to go for help in different areas of their lives and lacked information on what sources of help they were or what responses to seeking help would be. Even when children have identified an appropriate service their ability to access these services can be limited by factors such as opening times, inaccessible or inconvenient locations and waiting times or waiting lists for appointments. However barriers relating to the social worker or other professional attitude and stance towards the help seeker have also been referred to. Mainey *et al.*'s (2009) review indicated that staff skills and behaviours are relevant. Their review concluded with regard to help seeking that:

*'Young people want information from friendly, non-judgemental professionals, who encourage them to ask questions, preferably from staff they know and trust, and to have a choice of carer or staff they can approach for different problems'* (Mainey *et al.*, 2009, p7).

9.3.2 Other barriers to help seeking referred to include a fear of loss of control, fear of people taking over and concerns about whether the person told about the abuse

would be able to treat the information with confidence and act with competence. Aldridge and Becker's (2003) research with young carers also showed that children are often afraid to discuss their caring responsibilities because they are anxious about the consequences of asking for help. Children's fear of the consequences of confiding in their social workers represents a common theme in children's accounts of child protection processes: *'I was too scared of my mum and she was really poorly. ...I had been looking after her for about 9 or 10 years...she was really bad then but I couldn't (speak to the social worker) because of how ill she was. I knew that if she got arrested she wouldn't be able to cope'*. (Cossar and Long, 2008, p9).

The central importance of a trusting relationship when seeking and receiving help was identified by Bell (2002) in her study of 27 children and young people who were involved in a child protection investigation in England. She concluded that a trusting relationship was the best way to promote children's rights and interests and that children and their families valued a combination of practical and emotional support from their social worker.

9.3.3 Tucker (2011) specifically investigated why children felt they were not believed when they reported abuse and/or neglect to a professionals. Factors identified included; negative attitudes by professionals treating them as problematic or troublesome; professionals holding similar negative attitudes towards their own families; a feeling that some professionals were weighing up their probability of their story being true and had the power to dismiss it; feeling judged by professionals as to how they acted and what they wore such as 'revealing' clothes; and a reluctance for professionals to believe them if the abuser was in a respected position or well known in the community.

Altogether this research implies that social workers' skill at being able to listen without prejudice and to convey trust and provide reassurance is very important. Yet at the same time they need to be honest and realistic (Shaw, 2006) Great sensitivity is needed when in contact with children in order to reduce their fears around whether

they will be believed and understood and what will happen with any information given. The social worker needs to provide flexibility around their need for support. The child's own wishes regarding their situation must be respected and fully taken into account even if the social worker is not able to go along with those wishes. The inequality of power should be respected and not abused.

#### **9.4 Being honest, building trust and ensuring fairness in investigations**

Cossar and Long (2008) research showed the importance of honesty – the children they spoke to valued openness, and appreciated, for example, social workers going through reports with them prior to a case conference. Being able to trust their social worker is vitally important; without this children are less likely to discuss issues, views and feelings openly with them (Graham et al 2007; White et al, 2008):

*'Social workers are sometimes very judgemental and do not realise how scared, vulnerable and nervous it feels to be in care. Why should I let someone else know my feelings and thoughts? And subsequently the reaction comes out the wrong way – anger, bad behaviour...'* (Allen, 2003, p26).

Research shows that children are more likely to confer trust when their confidentiality is respected (Mainey *et al.*, 2009) and that children tend to confer trust to individual practitioners, and not to particular services or approaches (Sandbaek, 1999 cited in Hill, 1999; Hart, 2006). It therefore may be the case that children can have a good relationship with their social worker, but remain mistrustful of social services in general (Farnfield, 1998 cited in Hill, 1999).

Children worry that their views will be misrepresented, distorted or only partially accepted (Davidson et al, 2006; Cossar and Long, 2008). Other studies of young people's views of child protection services in the UK have further highlighted feelings of intrusion, being interrogated and seen solely as a source of evidence (for example Wiffin, 2010). The young people in these studies also often felt powerless to affect what happened to them next, and would have appreciated more opportunities to

have an influence on the process, and to make decisions themselves (Bell, 2002, Woolfson *et al.*, 2009, Cossar *et al.*, 2011, Buckley *et al.*, 2011).

### 9.5 Clear and effective communication

Good information and clear communication that is child friendly and appropriate frequently appears in the literature as wanted by children and young people (Bell, 2002, Houghton, 2008, Woolfson, 2009, Gallagher *et al.*, 2011, Jago *et al.*, 2011). Communication skills involving empathic listening and questioning are particularly valued (Cossar and Long, 2008). Children tend to like social workers who listen and communicate with them at an appropriate level (Ward *et al.*, 2005).

*'I really didn't like her... 'cos every time I tried talking to her, she always butted in. Wouldn't let me talk'.* (Ward *et al.*, 2005, p14)

*'Not too adult, and not using street talk which just sounds stupid.'* (OFSTED 2009b)

Perhaps not surprisingly children dislike social workers who make unjustified assumptions about them, are patronising, talk down to them, 'nag' them or are just 'boring'. (Triseliotis *et al.* 1995a; Baldry and Kemmis 1996; Farnfield 1998 all cited in Hill, 1999; Bell, 2002). A common criticism from Bell's interviewees was of questioning experienced as invasive and threatening: *'The lady who came asked me lots of questions. She put me under pressure'*. (Bell, 2002, p5)

Social work systems and procedures can be complicated. Wiffin's (2010) interviews with a very small group of young people in 'resistant' families notes that the young people she interviewed expressed not having enough information about or understanding the child protection system they were drawn into. Social workers need to be effective at communicating the process in a manner appropriate to the child's understanding and needs. The Blueprint report (2005) stated that children would like clear communication throughout assessment and admission into care. They would like information to be given to them in writing as well as verbally. They are also keen

to have more information about and to have a choice of placement (which of course may not be possible depending on timing and availability).

9.5.1 It has been a long-standing issue that social workers' personal communication skills could be better (Ward *et al.*, 2005). Social workers may need to take more time to develop a relationship with children, to really get to know young people and discover their concerns prior to meetings, and also to develop strategies to enable children's concerns and agendas to be explored during the meeting itself (Thomas, 2002, Del Busso, 2004 cited in Golding *et al.*, 2006). Children also need to be communicated with in an environment in which they feel comfortable. Social workers may need to pay attention to the context in which they engage with children which may encourage particular power dynamics, (Golding *et al.*, 2006; Thomas, 2005). Sensitivity to children's previous experiences, the place of the interview, and the attitude of the interviewer have also been identified as key elements in facilitating good communication (Golding *et al.*, 2006).

Good communication is not just a one-off interaction; it has argued that good social work practice should involve ongoing promotion of children's skills and confidence in decision making (Thomas, 2002). Having opportunities to listen, negotiate and participate in decisions can empower children not just to voice their opinions more but also to generally take more control of their lives:

*'The social worker I have now is good, she helps me help myself, helps me learn to do things myself'*. (Blueprint Project, 2005, p10)

MacLeod (2006) showed that while social workers reported making extensive efforts to listen to children and to enable their participation, very few young people reported a sense that their views had been heard and taken into account. She suggests that the young people understood listening in an active sense, meaning *'listening and taking action in response to what has been heard'*. The social workers in her study, however, tended to understand listening more passively.

## 9.6 Giving regard to issues for children with disabilities

A child's ability to communicate will be influenced by physical, cognitive or communication disabilities (Broad *et al.*, 2001; Morris, 2005, Knight *et al.*, 2006). An exploration of the individual capacity of each child and the particular support they may need to communicate more effectively will be essential for effective communication. (Thomas, 2005). Morris (2005) found that in general insufficient attention is given to the views and feelings of disabled children in residential care. They can often be physically and socially isolated, receive their care from large numbers of people and have communication or cognitive impairments which make disclosure or feelings difficult to express. Children and young people with disabilities have reported that they want professionals to identify their needs by interviewing and observing them (Beresford *et al.*, 2007). Training in skills in communication with children with disabilities is important and there has been much development in this area; in recent years, a number of studies and pilot projects have investigated alternative and augmentative methods for communicating with children with communication impairments, including symbols (Scott and Larcher, 2002) and Talking Mats (Brewster, 2004).

In two studies involving children with disabilities - Children's Society/NSPCC (2001) and Knight *et al.*, (2006) the children developed some recommendations for social workers and other professionals:

- *'we're just like other children'*;
- *'take your time and make sure you understand'*;
- *'talk directly to us, not just our parents, or our carers'*;
- *'don't be scared to ask questions'*

## 9.7 Accessibility

Children frequently complain about social workers being difficult to get in touch with. The OFSTED (2009b) survey of looked after children reported difficulties in gaining

access to their social worker. Common complaints were social workers not being available on the telephone, failing to return calls and even not turning up for scheduled meetings. Such problems echoed previous findings in Timms and Thoburn's (2003) research. In contrast, some comments made in the OFSTED survey indicated that when social workers sought contact with the child it happened very quickly! Hill (1999) noted that children like to feel reassured that their social worker is 'there for them'. Some social workers do pass their mobile phone number onto children, and in the OFSTED (2009b) survey children had found this helpful.

### **9.8 Social worker visiting flexibly and according to individual needs**

Children vary regarding the frequency and nature of the contact they would like to have with their social worker. This was made clear in the OFSTED (2009b) survey where some indicated they would like more regular contact than they received, or have social workers to spend more time with them when they visit whereas others had found visits from their social worker overly intrusive. In another study one child's advice for her social worker was:

*'...not to come too often and NOT to keep asking if I am happy where I am. If I were not happy, I could phone them at any time. My foster parents love me and I love it here'* (Sinclair *et al.*, 2001, p22)

The young people involved in Shaw's (2006) consultations wanted an approachable worker who would be there for them to talk to when things are going well for them as well as when they are in need. Only a couple of young people shared that they only wanted their workers' input when they had problems. The majority wanted to have continuity of support through good and bad times; a worker who took an interest in their everyday lives. They also wanted their worker to take into account their holistic setting for example having their social workers see them their placement so they know what life is like for them instead of making assumptions.

However how much contact and how close a relationship children want with their social worker varies not just according to individual wishes but can depend on their needs at particular times and situations (e.g. OFSTED 2009c) Sinclair *et al.*, (2001) noted how children would like social workers to give them more time and attention around key events and changes. In particular they would like social workers to spend more time with them after taking them to a placement. The Blueprint (2005) project also found more time with social workers was wanted during a child's transition into care. Similarly leaving care, or particularly stressful times are highlighted as times when children would like more contact with their social worker. Children may also need extra visits if there are problems, or a change in plan, or if the child is unhappy, in danger or misbehaving (OFSTED, 2009c).

To meet children's varied and fluctuating needs, simply following a prescriptive time plan for visits will not be adequate. There should be flexibility with regards to both frequency and type of contact with respect for a child's individual wishes at a particular point in time. Also children should be able to contact their social worker more easily outside of regular visits to accommodate changing or unexpected needs (OFSTED, 2009c).

Another major issue stressed by children in relation to contact with their social worker is that visiting in school can highlight their need for a social worker or simply cause them to stand out from their peers. Dissatisfaction was expressed in Sinclair *et al.*'s study (2001) with social workers who organised meetings in school break time or during lessons and activities which carried the risk of exposing the child's looked after status and stigmatising behaviour from peers. Children generally prefer social workers to organise reviews and other meetings outside of school where they do not need an explanation to their peers or other pupils are around (OFSTED 2009c; Morgan 2007b).

Overall the message from research is that social workers need to be flexible about visits, and attune to children's wishes without following a prescriptive pattern or continuing with routine that is no longer appropriate. They need to be easily available and respond to particular needs. They need to be sensitive to a meeting context and ensure it does not single a child out from their peers.

### 9.9 Providing privacy

Being able to speak in private, without being overheard is clearly important for valid checks on a child's wellbeing and treatment. Children make clear that it is difficult to disclose problems or ill treatment if the people involved such as their carers are listening to their conversation (Children's care monitor 2013/14, 2014). They may also find it difficult to challenge foster accounts of their behaviour (Sinclair et al, 2001). Simply expecting a child to be proactive regarding a private conversation or asking a child in front of their carer whether they are happy with their foster carer remaining in the room will not usually be adequate. As one child stated in Timms and Thoburn (2003) research):

*'Social workers usually ask if it's alright for the foster parent to stay while you talk and when you're with them you can't really say you would mind because then you might hurt their feelings mostly when they're like your parents!'*

(Timms and Thoburn, 2003, p17)

In 2001 it became law that a caseworker visiting a child in care must speak to that child in private unless the child doesn't want to or isn't able to understand enough to have a private talk, or it just isn't possible. However latest figures from the Children's care monitor revealed that only 40% of children were able to speak to their case worker in private on every visit. Just over two thirds (69%) shared that their social workers *always* or *usually* spoke with them in private. One in twenty (5%) stated that it never happened. Children in care but placed to live at home with their parents were less likely than other children in care to speak to their social workers in private. Obviously in many cases the child may not want to speak to the SW alone, and in

some cases the child may not yet have a positive and trusted relationship with their case worker. However effort needs to be put in place to ensure a confidential conversation occurs, either with the case holder themselves or with another neutral adult such as a teacher, their Independent reviewing officer, counsellor or advocate.

### **9.10 Treating children as individuals**

Children frequently make clear that they want to be treated as individuals (Blueprint, 2005; OFSTED, 2009a; OFSTED, 2009b). Hill (1999) stressed the importance of understanding that children in contact with social services are '*children with problems, not problem children*' – they want to be treated as whole human beings, not simply in relation to one 'problem' or 'disorder' and may want to talk about many different aspects of their lives including their interests and achievements. Aldgate and Statham's (2001) research confirms that an appreciated social worker is one who views the child or young person as a whole person and talks about things other than problems of family life.

### **9.11 Being reliable, competent and making an impact**

In addition to being heard, children also report that they want tangible results and for social workers to take action on their behalf and do so in a timely way (Ward et al, 2005; OFSTED 2009b). Various studies show that children appreciate a social worker who shows reliability and takes action, be efficient and diligent (Hill, 1999; Morgan, 2006; Curtis, 2006; Sinclair *et al.*, 2001). Children value social workers who take action and are prepared to advocate for them (Golding *et al.*, 2006; Ward et al, 2005).

The young people in McLeod's (2010) study who had the most negative view of social workers saw them as not responding to their practical needs or making promises that were not delivered: '*They just say "Oh yeah, we'll do it", and then two years later they won't have.*' (p775). Many of the young people complained about

lack of reliability: ‘*She said she was going to [get me a passport], but she keeps forgetting.*’ (p776)

Of course social workers have to juggle large caseloads and cannot always be continually available but communication regarding their situation can make a huge difference. Morgan and Lindsay (2006, p. 11) quote one child who had had thirteen social workers complaining they did not even always tell him they were leaving: ‘*They just go on holiday and don’t come back.*’

Shaw’s (2006) consultations with children on the Department for Education and Skills and The Department Of Health ‘Options For Excellence Review’ reported how her young consultees valued adequate training and good practical skills in their workers that would enable them to offer support that was needed and help them to solve their problems. They wanted a service that was able to effectively assess individual cases so their needs were met. They wanted workers who were aware of policies and to change them if necessary to better meet their needs. They also wanted a holistic service (with emotional support, financial and practical support with education and accommodation) so that young people in need could truly be provided with what they were entitled to.

### **9.12 Involving children in planning and decisions:**

Children repeatedly state that they want to be given more information about what decisions are being made and why (eg Golding *et al.*, 2006; McLeod, 2010). This can be so whatever their age:

*The older you get, the more likely they are to take not of what you say.*

*Though actually I think that a five year old knows just as well what they want as a fifteen year old (McLeod, 2010, p778).*

Children say they want a key say in discussions and decision making before they are taken away from their parents (OFSTED, 2009b). Timms and Thoburn’s (2003) study

showed that children want to be better informed so they can participate in court processes and decisions about their care. The Blueprint report (2005) showed that children are keen to have more information about and to have a choice of placement (which of course may not be possible). The children spoken to by Morgan (2007b) made clear that social workers should discuss school moves with them.

Some children have expressed how it would be helpful if all placements could be treated as a trial to begin with so that the carers and children can both feel they have a choice to continue or not (Sinclair *et al.*, 2001, OFSTED 2009b). Children are often frustrated by policy, finance and practice decisions which may get in the way of them remaining in a placement in which they are happy:

*'My old placement, I liked them very much. I wanted to stay there...And the stupid social worker said that because I'm mixed race and the carers were white that I had to go to someone who was black...If I was the social worker, I'd say, 'you can stay wherever you're happy', but she's (the social worker) got to be so stressful'.*(Oliver, 2008, p194)

*'I think it (the move to a new children's home) was because it was cheaper. Because I was in full-time education where I was, and I wasn't involved with any police or anything. And now I don't have any education'.* (Oliver *et al.*, 2006, p9)

9.12.1 Children often have strong wishes with regards to contact. In Timms and Thoburn's (2003) study a majority of the children they spoke with said they did not see enough of close family members. Many also wanted to see more of former foster carers or friends. Research shows children have very individual needs regarding contact in relation not just who with but also the form and frequency with which it takes place. Some children will not want any contact with some or all of their birth family (Sinclair *et al.*, 2001). Social workers need to have broad understanding of 'family' that takes into account connections that are important to each child. They should take children's feelings about particular people in their network seriously and carefully tailor the contact to the child's individual needs and situations. They need to

intervene quickly to prevent contact as well as initiate it and review the contact regularly to ensure it still meets the needs and wishes of the child (Sinclair *et al.*, 2001).

9.12.2 Just under two thirds of children do say they have a say in their care plan and agree contents (OFSTED 2014) although some children more likely than others to be involved in their care plan. Those living with their birth family had less influence on their care plan. The groups of children who generally indicate they are less likely to be asked for their views about, for example placement choice or review venue, are:

- Disabled children (Abbot *et al.*, 2000)
- Privately fostered children (Morris 2005)
- Children in Kinship care (Broad *et al.*, 2001, Hunt *et al.*, 2008)
- Children in youth custody (Hart, 2006)

Of course there will be many occasions when social workers have to take action which goes strongly against the wishes of a young person. Shaw (2006) explored this issue with her young consultees. The participants felt that going against the wishes of a young person for their own safety (which could involve them being locked up or taken into care) could still be conducted in a positive manner if it was communicated effectively to the young person. The reasons should be explained in a way that was understood by the individual and is not intimidating, ensuring that the young person has opportunities to ask questions.

Shaw's (2006) young consultees also wanted to have a voice on the recruitment of social care workers, be offered more effective options to feedback on their social care experiences and have input into developing social care services locally for other children and young people in similar situations to themselves.

### **9.13 Wishes regarding statutory meetings**

Children appreciate opportunities to attend planning meetings and reviews but often feel they are boring, alienating and intimidating, and inhibit their participation (Bell,

2002; McLeod, 2006; Thomas, 2002, 2005) Having greater flexibility to allow children to participate in their own way, such as attending for part rather than all of the meetings, or being able to go through the report and plans beforehand and have their views passed on indirectly is important (e.g. Cossar and Long, 2008). Cossar and Long also felt that social workers may need to be better prepared to inform children on the purpose of meetings, offer support to prepare them and debrief them afterwards.

### 9.14 Being a 'friend'

Some children describe that a positive relationship with their social workers as one that is 'friendly' (e.g. Buckley *et al.*, 2011). Some children even refer to their social worker as a 'friend' or a 'mate':

*'We were friends. She was there for me when I needed her help. She also left me alone to be able to fend for myself and to get on with things. But the main thing was that the support was there when it was needed'* (Ward *et al.*, 2005, p14)

*'S was a nice person – a nice lass, with the right manner to go about it . . . She was concerned about me – it was like I could talk to her about problems if I had them – like a best mate'* (Bell, 2001, p5)

For other children a social work relationship that blurred the boundary with friendliness was a negative one. This suggests that building up a positive relationship with children involves being sensitive to professional boundaries whilst at the same time being appropriately approachable and 'friendly':

*'This is the biggest problem of my life...they're willing to come talk to you, tell you about all their problems. To me that's cool, but then they get the idea we're best buddies. They've got their job to do and I'm trying to live my life...I don't know what their game is. They're not my friends – they have nothing to do with my life'. (Marchant *et al.*, 2007, p28).*

McLeod's (2010) article explores the issue of how a social worker can be 'friendly' at the same time as maintaining a professional role that is *'quite distinct from friendship'* (McLeod, p2010, p776). Through her questionnaires and interviews with seventy-five looked after children in England she was able to identify the desired characteristics of a 'friend' that children also sought in their social workers. Good social workers for these children were those who were honest, trust-worthy, reliable, relaxed and non-threatening and offered emotional support and truly listened. They were happy to just 'socialise' – take time to get to know the child. Good social workers were seen as an 'ally', on their side in a world which may seem against them. Like a close friend they could 'talk straight' and tell you the truth even if it hurt. Some children also appreciated reciprocity – social workers who were prepared to share something of themselves too. A good social worker was additionally seen *'a friend and an equal'* if they treated the young person as a person, *'equally valued as a human being'* (McLeod, p2010, p778). They did this by showing respect, not lecturing or patronising them but supporting the young person's autonomy and agency.

The Blueprint Project (2004) also felt that children benefit from professionals providing some of the qualities that a friendship provides. Their children referred to the lack of warmth they felt from people working or caring for them. They wanted to feel 'cared for', liked and special from at least someone in their network. The project authors note that this may conflict with a culture where emotional distance is seen as an essential part of a professional approach:

*On a very simplistic level, warmth and emotional involvement, certainly physical affection, is frowned upon. The emerging knowledge from past abuse scandals has had an impact on the way we work. This isn't to suggest that we should discard important lessons about professional boundaries. But it must also be recognised that children and young people need warmth and affection to flourish.* (The Blueprint Project, 2004, p46)

## 9.15 Wishes regarding social worker continuity

For children who have experienced loss and change in their secure base and fragmented relationships with their birth family, it seems clear that continuity of key adults in their lives, including social workers will be vitally important. A change of social worker can be experienced as abandonment or betrayal (McLeod, 2010). Many children have reported unhappiness with repeated changes in social worker (Barn et al, 2005; Barnardos 2006; CSCI, 2007; OFSTED 2009a; Mainey et al, 2009). Children have frequently expressed that changes in social worker causes frustration and upset, as they can often have to re-tell their stories, relive difficult histories and explain again their wishes and views (Blueprint project 2004; Jobe and Gorrin, 2012).

The Blueprint Project (2004) found the increased use of short-term agency staff led young people to believe that they had little to gain from forming emotional attachments or relationships. Hill (1999) noted that young people tend to judge a service not according to the agency's characteristics and qualities but rather the qualities of the individual worker they have contact with. Trust therefore will not be transferred automatically to each new worker taking over a child's case but needs to be re-established with each individual worker. A similar conclusion was reached by Gallagher *et al.*, (2012) who conducted a literature review on children's and parent's involvement in social work decision making in the UK, and found that good, long-term relationships with social workers were crucial, and that continuity allowed trust, respect and consistency to develop.

Although the change for the child may not be in the social workers control, they can take action to prepare for and make a transition better for the child:

*“I tell social workers to READ THE FILES! I hate having to retell my story every time I get a new social worker – it upsets me. I’ve had about seven social workers in the last five years.”* (Blueprint Project, 2004, p45).

A strong message from the Blueprint Project (2004) was that children would like to be able to keep in touch with professionals with whom they had made a bond in the past. The project recommended:

*Keeping in touch doesn't have to be unprofessional. Relationships, which have worked well for children, should not be cut off prematurely and in a way which seems punitive to children and young people. The mechanism for allowing people to keep in touch should be open and explicit* (Blueprint Project, 2004, p46).

## 9.16 Leaving care

Care leavers are a vulnerable group less likely than the general population of young people to be involved in education, training or employment. They need a large amount of practical support in different areas such as housing, education, training or employment along with continued emotional support. In Allen's (2003) study many social workers were appreciated for the help they provided in dealing with benefits, finding accommodation and helping to plan paths through education, training and employment. However other studies (Barn *et al.*, 2005; Blueprint Project, 2005; OFSTED 2009b; Lewis *et al.*, 2007) revealed that practical and emotional support was often lacking across all of these issues. Clear information on services, benefits and practical support available was wanted as well as help to access different sources of support. (Allen 200; Chase *et al.*, 2008) Allen's study found that care leavers preferred support to be offered in a more informal and relationship orientated way. Barn *et al.* (2005) stressed the importance of flexibility and choice in relation to services such as accommodation.

9.16.1 Care leavers who are also parents, or soon to be parents have reported a tendency for social workers to scrutinise care leaver's parenting capacities through the lens of child protection, rather than assessing their potential needs for support. Child protection assessments were commonly experienced as confusing, intimidating and disempowering, with some young parents complaining that social workers

tended to appear on the scene just before the birth of their child in an almost predatory manner (Chase *et al.*, 2008).

Findings indicate that more attention could be paid to training social workers to sensitise them to the impact of past care experiences on care leavers' adult relationships and parenting. Training to allow social workers to reflect critically on their attitudes to young parents might also be appropriate (Chase *et al.*, 2008). In particular, evidence indicates that better and more supportive assessments of the support needs of young parents, including young fathers, who are in or leaving care is warranted. Social work practice in relation to pre- and post-birth assessments of looked after young parents should be reviewed to develop a less threatening and more supportive process.

### **9.17 Integrated and multi-agency working**

Smooth integrated working between agencies can be helpful and productive. For example Dobel-Ober (2005) showed that Social workers have played a key role to play in supporting looked after children to obtain access to health services, including access to sexual health clinics. The NCB (2005) report noted good liaison between nurses and social workers in hospital (NCB, 2005). Mainey *et al.*'s (2009) review stated that parents and children who experienced multi-professional approaches valued supportive signposting, referral, fast-tracking, and coordination of multi-professional responses, especially for families with complex needs. Information sharing protocols need to strike a balance between protecting children's safety and respecting their need for privacy. (Oliver, 2010).

9.17.1 Sometimes liaison between agencies does not work as well as it should. Some research indicates that links between school and social services does not always work smoothly (Morris 2005, Blueprint Project 2005, Barnados 2006). Almost all young people in the Barnados consultation felt they had not had good support in education and almost half said no-one had attended school parents evenings or school sports days. Morgan's (2007a) consultations highlighted a number of young

people who were not in education due to waiting for places following placement moves or exclusions. Children in boarding schools raised a need for quicker responses from social workers regarding enquiries for funding or when obtaining consent for school activities and trips (Morgan, 2007b). Young people in custody have also described their frustration at the ‘over to you’ culture between youth justice and social services that tended to result in a pattern of fragmented services, particularly for young people leaving custody (Hart, 2006).

9.17.2 In general, evidence indicates that children want good communication between professionals and support for moving between services and using multiple services without having to tell their story several times (Mainey *et al.*, 2009). Recently there has been a move towards the Integrated Children’s System (ICS) with a primary focus on the use of computerised and standardised formats for assessment. However there is also the caveat that confidentiality should be respected – children have expressed frustration at having too much information shared about them and want information shared on a ‘need to know’ basis only. (Morgan 2007b). Morgan suggested that undertaking a risk assessment to determine the potential benefits or harm before sharing information with other agencies would help to balance the need to keep children safe and provide adequate support.

### **9.18 Training required for social workers**

Very few studies have explored the views of young people in this area, however this was included in Shaw’s (2006) consultations. Young people, when asked to consider what training should be required for social workers, felt there should be:

- Communications based training that allowed social workers to speak and understand young people who found themselves in different and often difficult situations and;
- Psychology based training that would help works social workers to understand the difficulties that some young people are subject to. One young person

explained this as '*hard training, be in our shoes, feel our pain*' (Shaw, 2006, p11)

The young people that Shaw spoke to were also keen for the training to be very practical including topics such as health and safety, assessment skills and anger management training among other things. They also recommended on the job training so that the professionals could experience the work and gain skills before they started their post.

### 9.19 Conclusions – what makes a good social worker?

*'Listen to us, check if we need anything, help us to stay in contact with our family, keep us safe, remember we are people'.* (OFSTED, 2009b)

*"Social workers need to understand more from a child's perspective about any situation.....[they need] understanding of a person's feelings and to understand all children are different...With children in care, they need to always know they have someone they can turn to and talk to...You just want people to listen, understand and be there on a regular basis."* (Morgan, 2006)

One literature review which explored adolescents' views of their interactions with various professionals mainly from a health background, for example doctors, mental health workers but also other professionals including social workers, counsellors and educational psychologists (Freake *et al.*, 2007). Twelve themes emerged repeatedly from the 45 papers considered, regardless of the type of profession being discussed: confidentiality, clear information, explanations and advice, being listened to and kindness, sympathy and caring, trustworthiness; competence/experience; not being patronised; and gender of professional (seen as important in a medical context)

Hill (1999) characterised an appreciated social worker as one who:

- shows empathy and a willingness to listen;

- is reliable (keeping promises, are available, punctual);
- takes action when needed (address practical problems and material needs);
- respects confidences

Shaw's (2006) consultation also gave young people an opportunity to list qualities of a 'good' social worker. The statements that they generated can be seen in the box below:

- Sit there and listen – not just agree with other adults' views - believe the kids more.
- Have formal qualifications like NVQ/degrees: Like working with kids listen to us and taking our feelings into consideration.
- Doing what is asked of them and giving advice.
- Funny and cool.
- Listen and ask questions.
- Helping young people when they need them and care - be there for them.
- Good communication, understanding other people's problems, solving young people's problems.
- Ability to understand someone else's mind, how they are thinking, predicting what will come next, understanding. Someone with emotion.
- Not take the easy way out.
- Reassure young people regularly.
- Have a regular meeting with the young people in order to make sure they are getting help in every case.
- Listen – keep in touch, Care – acknowledges with what's happening.
- Help young people with what they need.
- Treats children and young people with respect and very chilled.
- Being open minded, honest and realistic.
- Politely.
- Approachable and polite.

- Listening and not making assumptions about things.
- Be practical.
- Not to be pushy.
- Nice and be willing to help young person when they need it.
- Accordingly...some of them don't know the job properly.
- They are good listeners and polite.
- They are polite and respectful.
- Take less time off work for illness.
- Carry out his/her job with the utmost of professionalism.
- Having more time with the young person.
- Come on time.
- Stopping saying I can't have contact with mum – saying she (the social worker) knows what is best for me when I don't think this is the case.
- To be allowed friends to stay, to give more freedom.
- Come to visit and call occasionally just to check in. Take time to get to know them and turn up not just for meetings.
- Be understanding and patient.
- Listen and show that you are the same as them.
- She or he can try to avoid mistakes that were made before.
- Listen to what I have to say and keep his or her word, e.g. appointments.
- Care more and be in touch.
- Respect all young people and listen to what they say and do. Also be patient.

(Shaw, 2006, p9-10)

Shaw's (2006) consultation also gave young people an opportunity to list qualities of a 'good' social care service:

- It listens to young people, respects their views and ideas: It makes sure young people feel they are cared for are not just another number in your files.
- One that is supportive.

- One that works!
- Looking after and giving respect to young people.
- When a person is looking forward to receiving a service.
- Where you find happy young people.
- A good team that talks to each other shows us that you care. A support worker and a social worker listening and trying to show each person that they care and help them with their problems.
- A good service looks like one that is helping and caring.
- A good service looks like a “Family,” who cares about each other and takes action on situations that have to be solved.
- Supportive with education, accommodation and health services.
- One where people who listen to me and didn’t just think I should have punishments because I haven’t made a meeting – (giving me) a bit more understanding.
- Have my whole families’ opinion taking into consideration. So individual feelings and thoughts are taken into account rather than just one person’s.
- Be given choices to see family to include what I want and when I want it.

(Shaw, 2006, p9)

A review of recent consultations by the Department for Children, Schools and Families (WCL, 2008) listed the behaviours that children would like to see from workers:

- fairness without favouritism
- a willingness to trust and believe in them
- asking and listening so they understand their specific situation and background
- helpfulness in creating understanding among their peers
- not prejudging their needs or characteristics
- keeping promises, and

- ease of contact

(WCL, 2008, p.4)

9.18.1 Cossar *et al.*'s (2013) literature review of the qualities young people see as important and desirable in professionals and services when seeking help around abuse and neglect identified a comprehensive list of desired characteristics, presented in the box below:

- Professionals listen
- Professionals are warm, easy to talk to, welcoming and friendly
- Professionals are kind, caring, sympathetic, understanding
- Professionals are not dismissive or patronising, and do not trivialise the child's concerns
- Professionals are non-judgemental and respect the young person's views
- Professionals are trusted and have time to build a trusting relationship
- Professionals are competent, experienced and qualified
- Professionals treat the young person as an individual
- The service is confidential
- The young person is seen alone and offered privacy
- The young person is given sufficient time, and does not feel rushed
- The service is reliable and professionals are punctual
- The young person sees the same professional in subsequent appointments/meetings
- The young person is given a choice about who to see
- The professional is able to act on what the young person says
- The professional is able to keep the young person safe
- The young person is given good information and advice
- The young person is offered real choices as to what services are available

- The young person can participate in decision-making, and to some extent be in charge
- The service is culturally sensitive
- The gender of the professionals may be important, and the young person has a choice.

9.18.2 In contrast Morgan's (2006) consultation with young people highlighted the 'other side of the coin' describing the 'poor' social worker as someone who:

- does not listen properly';
- does not speak to children and young people in private;
- speaks to and believes what adults (such as carers) tell them rather than listening to the child;
- does not do what they promised to do;
- turns up late;
- has too much power over children's lives;
- does not share information with new social worker allocated;
- ignores the views of very young children.

Behaviours that children see as negative were also listed in the review of recent consultations by the Department for Children, Schools and Families (WCL, 2008):

- failure to pass on information
- being difficult to contact
- looking after the needs of their career rather than the child
- failure to listen
- imposing arbitrary rules
- moving away

(WCL, 2008, p5)

9.18.3 Oliver's (2010) review of children's views and experiences of their contact with social workers for the Children's Workforce Development Council concluded

that the less positive social worker is one who is ‘discounting of the child – their views, their needs for privacy, their time, their autonomy and their capacities.’

Oliver (2010) concludes that children want social work support that is: flexible, responsive, individualised and personalised, respectful of children’s views and wishes and participative. She argues that to achieve this:

*‘... the quality of the relationship between children and their social workers is of key importance...the distinction between social work tasks and relationships with children is a false dichotomy; children tend to view ‘paperwork’ and other procedural aspects of social work tasks as inhibiting of their wish to be heard and treated as individuals. Conversely, the quality of the relationship between children and social workers is likely to have an impact on the capacity of the social worker to undertake core assessments and other social work tasks in a comprehensive and balanced way. How tensions between social work tasks and relationships might be addressed is therefore of critical importance to children’s experience of, and contact with, social workers’.* (Oliver 2010)

## 10. Black and minority ethnic groups

### Key points

- Social workers should be aware of the greater barriers to accessing services that minority groups can experience, particularly with regard to language differences and potential concerns about services' cultural or religious appropriateness. The importance of equal access for all should always be kept paramount and workers must enable and support access whenever necessary. Competent interpreters may be needed.
- Social workers should be aware of the prejudice and discrimination that many people from Black and minority ethnic cultures experience. Time may be needed to gain trust and extra support offered to individuals as necessary.
- Improved and ongoing training for social workers and care workers on cultural issues relevant to the local population is required, however generalisations should be avoided and differences in people within an ethnic group must be recognised and acknowledged.
- A person-centred approach is needed when providing care to a culturally diverse population. There needs to be an understanding of people's cultural, linguistic and religious background but without making assumptions and resorting to stereotype; people from the same ethnic background will not have the same needs. Life experiences, individual differences, identity and other factors will always have an impact; a social worker needs to be culturally sensitive but also sensitive to all other aspects of the service user's circumstances because the impact of ethnicity on their needs is nuanced. Open and continual discussion with service users and their families about such aspects is important.

10.1 Many of the studies referred to in this review have involved a range of participants with particular attempts to ensure representation of Black and minority ethnic groups. However some studies have focussed specifically on minority ethnic groups aiming to identify any pertinent or unique themes in their perceptions and experience of social workers and other similar professions. It is concerning that both large-scale quantitative survey data and some qualitative research has shown that some minority ethnic groups are less satisfied than white British users with publically funded social care in England (e.g. Health and Social Care Information Centre 2013, Blake *et al.* 2015). Wilkinson's report on social care services for Black and minority ethnic people for the Commission for Social Care Inspection (2009) found that one quarter of their interviewees and focus groups members said they had faced prejudice or discrimination when using services and many felt that services did not meet their needs. However the picture was certainly not negative overall; over two thirds of the people using social care services in Wilkinson's report said that they would recommend the service to another Black or minority ethnic person.

Several studies have shown that people from Black and minority ethnic groups are less likely to access services. For example studies have found that minority ethnic carers are less likely to use formal services than similar white carers (Mir *et al.* 2001, Dilworth-Anderson *et al.* 2002, Dunlop *et al.* 2002). Some barriers to access may of course not be due to social worker behaviour or approach, but rather connected to cultural values, beliefs, norms and attitudes of the service user themselves. For example some cultures may be less willing to engage with formal support. Some people from some minority ethnic groups may not even perceive themselves as 'carers' and hence eligible for carer support (Ahmed and Rees-Jones 2008). For instance, in some languages such as Urdu and Punjabi, there is no term for a 'carer', suggesting that in these groups, the role may not be recognised in the same way as in other countries/cultures (Williams and Johnson 2010).

10.1.2 However as shown in the recent systematic review carried out by Greenwood *et al.* (2015) many studies of minority ethnic carers have identified not just 'attitudinal barriers' (such as not wanting to involve outsiders or not seeing the need for services) but also 'practical barriers' to access of social care services in the community. The review identified factors such as low awareness of services and service availability, language barriers and concerns about the services' cultural or religious appropriateness. Blake *et al.*'s (2015) comparison of Bangladeshi, Pakistani and white British population's experience of social care found minority groups to face a mixture of educational, language and cultural barriers to obtaining information. The minority groups were more likely than white British people to have been unaware of the services offered by local authorities. Bangladeshi and Pakistani service users and relatives did not necessarily expect their social worker or care workers to speak their language, but they did want them to show cultural sensitivity and to use an interpreter or obtain help from a family member if necessary.

10.1.3 It has been shown already in this review how older people in the general population also felt unaware of services and had a need for clear accessible information, but for those with language and cultural differences there is clearly a great/significant issue. Manthorpe (2009) also highlighted problems that older people from minority ethnic communities had with regard to obtaining information about health and social care services. This was partly caused by a lack of translation of relevant materials, but also, the content not was seen as not relevant to different communities. Social workers should clearly be aware of the greater barriers to accessing services that minority groups can experience, particularly with regard to language differences and potential concerns about services' cultural or religious appropriateness. They should equality and work to enable access whenever necessary.

Language barriers and cultural differences may not just cause difficulties in people becoming aware of and informed about services but can also affect assessment.

Interviewees in Wilkinson's report (2009) shared dissatisfaction with assessment, sometimes due to communication and information barriers, but also differences in values between the assessor and assessed, or lack of understanding by the assessor of the impact of racism or disadvantage. Translation and interpretation were seen as important but not enough for good communication and understanding in Bowl's (2007) small qualitative study on South Asian service users' views of mental health services. He showed how some cultural characteristics such as a relative lack of assertiveness of older women, or a resistance to talk openly about feelings in public or with strangers led to incorrect impressions and unmet needs of service users and relatives. Blake *et al.*'s (2015) study noted how relatives from all three ethnic groups of carers inferred that they had to 'fight' for services, but Bangladeshi and Pakistani families who were not fluent in English found it more challenging to defend their case than white families.

Blake *et al.*'s (2015) research also revealed some concern among relatives of Bangladeshi and Pakistani service users that local authorities were reluctant to provide a high level of formal care to people living with their families. This was felt to be unfair for South Asian South Asian families, who were seen as more likely than white British families to be sharing their homes with older and disabled relatives. Hubert's (2006) interviews with families of people with learning difficulties in Black and minority ethnic groups similarly heard from one interviewee that the UK stereotype of close knit Indian/Hindu families might be preventing social workers from visiting her. In fact, most families in this study felt isolated and left without any support.

Around one quarter of Wilkinson's (2009) participants said that they faced prejudice or discrimination when using services, with over half of the people under sixty reporting this. This could be overt verbal abuse or a failure to meet their language and cultural needs. Many people shared that they had low expectations of services,

and were also reluctant to report concern. Social workers may need to give extra time to gain trust and offer extra support in such situations.

10.1.4 Several research studies have pointed to the importance of social workers having an understanding of and sensitivity to the subtleties of the minority groups within ethnic communities. Without a full understanding of the cultural backgrounds of people from minority ethnic communities there can be misinformed insistence of different and possibly inappropriate practices (e.g. Skinner, A. 2001, quoted in Swift, 2002). A Scottish study (Bowes and Dar, 2000) using interviews with older people from Pakistani and South Asian communities showed the importance of social workers acknowledging the importance of family life and culture to these groups. Giuntoli and Cattan's (2012) study of older migrants in the UK found that some interviewees stressed the importance of acknowledging specific practices in their culture such as halal food, same sex care staff and prayer rooms.

Wilkinson's report (2009) interviews showed that although it is important that culture is taken into account, generalisations should be avoided and differences in people within an ethnic group must also be recognised. Giuntoli and Cattan's (2012) investigation into the wishes of older migrants, including older people and their carers, from services found that participants' had common expectations for high standards of good practice, cultural understanding and responsiveness to individual needs, and all ethnic groups were concerned that they should be treated with dignity. However there was not always similarity across/between ethnic groups about *how* these expectations should be met or *how* dignity should be maintained in old age. These differences could not always be explained as an outcome of different cultural backgrounds – life experiences and personal characteristics were also very influential. Blake *et al.*'s (2015) study also highlighted the importance of individual differences in needs for provision within ethnic groups; provision could be culturally adapted but this might be done in such a way that it did not reflect the particular preferences of service users and their families.

This research confirms that a person-centred approach is needed when providing care to a culturally diverse population. There needs to be an understanding of people's cultural, linguistic and religious background but without making assumptions and resorting to stereotype; people from the same ethnic background will not have the same needs. Life experiences, individual differences, identity and other factors will always have an impact; a social worker needs to be culturally sensitive but also sensitive to all other aspects of the service user's circumstances because the impact of ethnicity on their needs is nuanced. Open and continual discussion with service users and their families about such aspects is important.

10.1.5 As shown in much of the other research included in this review with participants from the general population, having a good relationship with the social worker and care worker was an important factor in being happy with the care received in Blake *et al.*'s (2015) study of Bangladeshi, Pakistani and white British populations' experience of social care.

## 11. How the general public perceive social workers

### Key points:

- Public perceptions are generally derived from media representations – which are mostly negative. Much of this relates to views about social workers acting (or failing to act) in relation to child protection and safeguarding issues.
- There is little public understanding of the social work role or what social workers actually do – this tends to change once individuals come into contact with social workers (especially if not related to child protection/control functions). It is seen however that the work done is necessary and ‘worthwhile’
- There has been little work that has considered public perceptions of standards and competence. One study showed a feeling that social workers needed to be better trained and fully equipped to do their jobs. There are concerns around abuse of power and is a strong desire for fairness and accountability.
- More information about public perceptions of what sort of qualities social workers should possess is required. These are generally in the domains of good interpersonal and communication skills, impartiality and fairness, discretion and the ability to attract and maintain trust and respect. There is also a recognition of the need for resilience and emotional strength.

11.1 Very little research seems to have been carried out looking at public views of social workers in England. Some relevant consultations, which were more specifically focussed on standards and regulatory bodies, has been covered in the previous section of this literature review. This section considers the perspectives of the general public more broadly within society on social workers as a profession. People’s views of social workers are developed from a wide range of influences; a blend of their own experiences (if any), the experiences of others in their family and

social circle, and also the picture of social work presented in the media, including within fictional stories and feature articles as well as news reports.

A fairly thorough, but quite small, study looking at attitudes towards and perceptions of social work and social care amongst the general population was carried out over a decade ago (Research Works, 2001). The researchers used focus group discussions with around 45 respondents drawn from different age brackets (18-24 years old, 25-44 years old, 45-65 years old) to reflect different life and work stages. A mix of lifestyles (studying, working full-time, part-time and retired) and different socio-economic groups were included. People were also screened to ensure that none worked or had close friends or family who worked in either social work or social care.

11.1.1 The sample varied according to how much people knew about social work and social care. Those from lower social classes and female respondents were more likely to have had some contact with social carers and social workers, and therefore were the most knowledgeable about these roles. However generally there was extremely limited understanding of the difference between social work and social care; both tended to be grouped together in participants' thoughts as workers employed by social services who 'helped' or 'cared'. Respondents generally had more contact with social carers than social workers and they were viewed primarily as home helps involved in day-to-day care. Social *workers* were seen as different in that they were responsible for overall decision-making and the co-ordination of services in difficult and traumatic cases. Social workers were strongly associated with work around children (as opposed to adults) and "problem" families, in particular investigating allegations of child abuse. Having a social worker was seen a stigmatising – a sign of poor parenting. Social workers were seen as interfering, having a key role to "check up on you" (p9).

11.1.2 Attitudes towards social work and social care were broadly consistent amongst all the group participants. People had had very little contact with social workers themselves, and so the media mainly influenced perceptions of social work. People unanimously recalled this coverage as entirely negative. Recent stories that

came to mind were ones where social workers were reported to have made serious mistakes (for example Victoria Climbié) or unfoundedly and brutally removed children. Respondents felt that the media presented the extreme views of social workers as either too active and heartless or inactive and inept. These reports had caused respondents to question the efficacy and judgement of social workers and social services, although at the same time they recognised that social work was a tough job to do under difficult circumstances. They could also only recall stories about children and abuse – promoting their perceptions of the social worker role as predominantly relating to children.

11.1.3 Participants in the Research Works study lacked clarity about the management and regulation of social workers. They seemed to have a blurred understanding of some overall ‘system’, which provided resources such as benefits. They were unclear of the relationship between social services and the government, and who was responsible for the different services. There was some feeling that social workers were restricted in their work by the ‘system’ (‘red tape’ and political correctness), which got in the way of ‘common sense’.

Social work was mostly viewed as an extremely demanding job - both stressful and (potentially) personally dangerous, undertaken by those keen to ‘do good’. There was also a sense that social workers were overworked with caseloads that were impossible to manage and long hours of work. There was generally a lack of clarity shown around what social workers actually did on a day-to-day basis, except that they would be dealing with problematic and harrowing situations. Participants did show awareness that social workers would need to be accountable for every decision and therefore have a lot of paperwork. The work undertaken by social workers was deemed to be necessary and worthwhile. They also considered social workers to hold a similar status and pay to broadly equivalent professions such as nursing, teaching or the police.

Respondents had very little idea of what qualifications and training were required in order to become a social worker. When probed they felt that at least ‘A’ level

standard and possibly a degree were needed, together with a lot of training, which was thought to be mainly practical (child care and first aid). Rather than focusing on academic qualifications, respondents steered the discussion to cover the personal qualities they felt were required for the social worker role, referring to good communication skills, patience, impartiality, the ability to attract and maintain trust and respect, discretion and inner emotional strength. All this was seen as important to deal with harrowing situations and tricky dynamics including resistant families. They were also keen to emphasise that social workers should be people who have life experience. There were some respondents who felt that the demand for high qualifications prevented people with valuable life experience from lower class backgrounds becoming social workers. There was generally a feeling that the quality of social workers did need to improve to avoid the type of mistakes that had been highlighted in the media.

11.1.4 The stereotypical image of a social worker that consistently emerged in the focus groups was of one who was female, young, “hippyish”, middle class, naïve and idealistic in outlook, not fully in touch with real world problems. This was particularly the case amongst the lower classes:

*“They told us to sit on the floor and have a family meeting every week ... I mean really, anyone who knew my family knows that that is just not going to happen. I couldn’t stop laughing.” (p12)*

*“Politically correct dipsticks with baggy trousers and lumpy jumpers.” (p12)*

Other research in England looking at public views of social workers has tended to include participants who have had contact with social workers working in contexts such as child protection or palliative care. It is clear that their views at the start of the social work involvement were similar to the views presented in the Research Works report. The lack of clarity around social workers’ roles was confirmed in Manthorpe *et al.*’s study (2007). Despite including a population of older people who were likely to have had some input from social workers as well as many other professionals, one

research interviewee stated: *'Social services—a big umbrella term—what do they do?'* (Manthorpe *et al.*, 2007, p1139)

Beresford *et al.* (2007) reported participants to view social workers as intrusive, bossy, controlling, ineffectual and 'for other people', a similar presentation to that seen in the Research Works report. The Innovations in Dementia (2010) research found one person with dementia had not had any contact with social workers, due to feeling that social workers were not for them but for a 'crisis situation only'. Social work was also seen to be associated with child protection and the removal of children into care or loss of independence of older people:

*"you get the impression that having a social worker means that the police are involved – that you are having your kids taken away from you – you wouldn't want the neighbours to know"* (Innovations in Dementia, 2010 p4)

*"Because you only read about what has gone wrong you don't know what social workers do – so when you get older and you might need one – you just forget it - you don't know what they do so you don't ask for help"* (Innovations in Dementia, 2010 p4)

11.1.5 These more recent studies (Beresford *et al.*, 2008; Innovations in Dementia, 2010) have confirmed that people generally still have overwhelmingly negative views of social work and social workers at least prior to direct experiences with social workers themselves. The Innovations in Dementia (2010) study confirmed that still, nearly a decade after the Research Works report finding, people recall only negative portrayals of social work in the media. Their participants, people with dementia and carers felt that they were influenced by these stories:

*"Baby P – that kind of thing is what you hear about"*

*"on tv – they are always guilty of being in the wrong"*

*"the papers only pick up on problems"*

*"you only see the bad stuff – the papers like to say they are all incompetent"*

*"awful"* (Innovations in Dementia, 2010, p4)

Young families also appear to regard the process of approaching social workers with apprehension. Recently the Children's Commissioner also claimed that poor media coverage led young people to feel *stigmatised and fearful at the prospect of having a social worker* (Children's Commissioner, 2010, p4). Wiffin's (2010) study with 'resistant' users of social services heard many family members talk about the shock they felt when they received a letter from a social work department. They tended to assume that such a letter meant *bad news* and interviewees agreed that the media portrayal of social workers was as either taking children into care for no reason, or being incompetent. They felt that case of 17-month-old 'Baby P' (Peter Connolly), who died in 2007 and whose mother and two men were convicted of causing or allowing his death, reinforced these perceptions. For some families their negative views were also influenced by past encounters and for others it linked to previous experiences of authority figures.

11.1.6 However interestingly a different rather more positive picture of public views of social workers (in general) was presented in an independent telephone poll of 1,000 members of the public carried out for Community Care magazine (Revans, 2007). This revealed that ninety-three per cent of people thought the contribution of social workers in the community is very or fairly important and only 5% of the general public thought that the work social workers do in the community is not important (3% not very important, 2% not at all important). Two-thirds of the sample said that they would trust social workers to help them or their families. That still left a significant proportion, albeit a minority (29%), of the general public who said they would *not* trust social workers to help them or their family. However, four out of five of the twenty per cent who *wouldn't* trust them still recognised the importance of what they do.

The authors explained this more positive result as partly due to the changing demographics of our population. As the population ages and the number of people with complex needs is growing, more people have personal experience of social services. It is no longer a 'hidden service' - more people are using social services and seeing the positive service that it can provide. It was also thought that regulatory

bodies are making a difference. However the article does refer to the continued existence of unbalanced media coverage and argues that more needs to be done to further improve the profession's image. It is arguable that this should include attention to competence and standards for the profession, not just image and perceptions of professionals.

A slightly earlier (2005) Scottish study looking at public knowledge and attitudes to social work in Scotland, with a representative survey of just over 1000 adults (age 16+) as well as eight focus groups also found that people's views of social workers were more likely to be positive than negative in the survey; 43% versus 24% respectively (Davidson and King, 2005). Other results echoed many of those found in the Research Works study population. However there were many respondents who did not feel they understood what social workers do (only around half felt that they did, and two in five did not). They felt stigma was attached to the role and would only use them as a 'last resort'. Participants in most of the focus groups who were asked to discuss the future of social work shared a feeling that social workers needed to be better trained and fully equipped to do their jobs. There was also some feeling that specialisms should be available so workers are able to develop expertise.

## **11.2 A closer look at the impact of the media**

Unfortunately social work stories usually only become of interest and high profile when tragic failures occur. Since the 1980s, there have been high-profile cases into deaths of children known to social services. Social workers have been accused of not intervening quickly enough to protect children such as Jasmine Beckford (Beckford Report, 1985) and Kimberley Carlisle (Blom-Cooper, 1987), both of whom were killed by their carers. At the same time they have been accused of being over-cautious and failing to consider the rights of parents (Parton, 1989) when, in a period of five months, social workers removed eighty-five children from their parents in Cleveland (Department of Health and Social Security, 1988) on suspicion that the children were being sexually abused. In some cases genuine mistakes may have been made as a result of professional mistakes or oversight. However concern has often been expressed around what is perceived to be an intrusive and sensationalist

English media with a sole concern to sell newspapers, which can often result in serious distortion and selective reporting of issues (e.g. Department for Constitutional Affairs, 2007).

The media seems to have a greater focus on stories involving children, perhaps because these stories quickly catch the attention and sympathy of the general population. Franklin and Parton's examination of press articles on social work published in a 12-month period between 1997 and 1998 found that 67% of the articles concerned children (Franklin and Parton 2001). However other shocking stories involving adults from time to time take prominence such as the story of abuse of patients in a specialist private hospital near Bristol, Winterbourne View.

11.2.1 A key recent case which has dominated the media in recent years in England has been that of Peter Connelly, a 17 month old little boy - known initially in the media reporting as 'Baby P' – who died following terrible neglect and abuse. Fifteen months later, his mother, her boyfriend and the boyfriend's brother were sent to prison. A variety of professionals were involved with the family, including those from health education and police. But popular media attention narrowly turned on the social workers and their managers who became the focus of the reporting and of the blame. The Sun newspaper held a particularly vehement campaign calling for the sacking of the social work professionals involved, which secured 1.2 million signatures. The Head of Children's Services at London Borough of Haringey, when the tragedy took place, was removed by direction of the government minister. Subsequent academic reports and books on the case have highlighted the drastic misrepresentation of the case and the unjustified negative portrayal of social workers (e.g Jones, 2014). The Head of Children's Services at Haringey, appealed against her dismissal which was eventually successful and she was paid compensation for unfair dismissal and loss of office and salary.

Negative media reporting and its influence on the English public has been an issue for some time. Concerns that media coverage, particularly of child protection, is almost entirely negative has been expressed in many reports and reviews. For

example Galilee's (2006) literature review on media representations of social work and social workers, found that the media was 'hostile' to social workers and that this has been a constant position since the 1970s. Lord Laming in his review of child protection practice after the baby Peter tragedy commented that, '*there has been a long term appetite in the media to portray social workers in ways that are negative and undermining*' (2009, p44). Similarly, Munro in her more recent review of child protection referred to the, '*sustained nature of the negative media images of social work that have been commonplace*' (2011, p122). She cited Edinburgh University research of media responses to the case of abused and murdered 17 month old Peter Connolly in 2008 which found that, '*social workers were viewed as culpable in their failure to protect Baby P*' (Elsley, 2010, p2) and Parton who stated, '*the media response was immediate and very critical of the services . . . The largest selling Tabloid newspaper the Sun ran a campaign aimed at ensuring that the professionals involved in the case were sacked from their jobs*' (Parton, 2011, p. 865). Munro highlighted a need to enhance responsible and sensitive coverage of child protection issues in the media. The College of Social Work was asked to devise a strategy to improve social workers' public image (2011a).

11.2.2 The qualitative studies included at the start of this section all referred to the media as having negatively influenced their perceptions of social workers prior to actual contact. Similarly a Community Care magazine poll of 1,000 UK social workers carried out in 2000, found that 9 out of 10 respondents felt that negative reporting created hostility from the general public, with 8 out of 10 blaming it for increasing mistrust from service users about social work and social workers (Neate, 2000).

A negative representation of social work in the media does not *automatically* translate into the general public having a poor image of social work. Media audiences are active interpreters. A MORI poll quoted in Galilee's (2006) review showed that 47% of respondents felt that they had gained their understanding of social workers through television news and current affairs, with 36% citing national newspapers as their source. However, personal experience or contact was viewed

as the most influential (32%), with only 20% of respondents indicating that television news / current affairs and 10% for the national press was the most influential.

Goddard noted some time ago, '*It is easy to be critical of the media's coverage of child abuse. The media, however, have made it more acceptable to talk about and disclose child abuse* (1996, p. 307). The 'Baby P' effect, which refers to a surge in numbers of referrals to children's services at the end of 2008 when the case came to public attention, could be perceived as increased defensiveness or risk averse behaviour of social workers. However it can also be viewed as *indicative of improved public awareness and more effective protection systems, which promote reporting* (Davies, 2014, p50). Davies points out that some journalists were sympathetic to the social workers in the Peter Connolly case and did not want to scapegoat them. They focused instead on the demise of child protection systems and the abolition in 2008 of the child protection register.

However, surveys completed after the 'Baby P' media outbreak have pointed to at least some increased negative impact on social workers and on public perceptions of social workers. A survey by Community Care readers in 2009 found that 40% of those taking part said that the 'Baby P' case was impacting negatively on their professional practice as they faced renewed scrutiny from the public (Ahmed 2009). The local union branch secretary in the London Borough of Haringey (where the baby Peter case took place) said that the media coverage was resulting in verbal abuse of staff (Ahmed 2009). A local Government Association poll (2009a) found that 42% of people's views of social workers had worsened after the baby P case. The poll also identified that 62% of people thought that the community – friends, family and neighbours) should have more responsibility protecting a child at home.

Concern for what is seen as selective and biased media accounts when reporting child welfare cases have resulted in recent moves to break down the privacy barrier in the court system. The aim has been to enable full and balanced reporting and subsequently improve public understanding and confidence in care proceedings. Media representatives (but not the wider public) are now able to attend certain family

proceedings held in private, with the court retaining the power to exclude and restrict reporting if deemed necessary (Part 27 of *Family Procedure Rules* 2010). The media are still able to report only limited information about the proceedings they are able to attend. A pilot project in five family courts for anonymised publication of all judgments ran from November 2009 to December 2010. Since 2014, the publication of anonymised judgements is now encouraged for all cases. They are published on the BAILII website ([www.bailii.org](http://www.bailii.org)).

11.2.3 The importance of greater transparency in the wider child welfare arena has been highlighted by Sir James Munby, now President of the Family Division, the senior child and family judge in England. In 2013 he gave a controversial judgment involving a young baby who was subject to an Emergency Protection Order and removed from his parents immediately after his birth early 2013 (*Re J (A Child)*, 2013). The father rapidly began commenting on the removal on Facebook (referring to the workers as ‘Nazi paramilitaries’) and posted secret video of footage of the actual removal online. The council applied to court to stop the publication of names, images and video footage of social workers involved in the case. The case was put before the President who stressed the vital role that transparency and public debate has in maintaining public confidence in the family welfare system and made clear that the need for transparency meant that courts should not prevent the freedom of speech. He did make an injunction to prohibit the child's name from being published, but did not prohibit publication of the video stating that the one-day old baby was unlikely be identified in the images; and in any event, the video was posted on a website outside England and Wales and there was little the judge could do to ban it. The President issued a statement declaring that he was determined to improve access to and reporting of family proceedings so that the family court was no longer viewed as a system of secret and unaccountable justice (Munby, 2014).

Some remain very sceptical of the impact of openness on public confidence in the family welfare system. Mansuri, spokesperson for the British Association of Social Workers, reflected on a popular social work website how transparency and freedom of reporting would not help public confidence in the family welfare system due to the

‘malevolent agenda’ of some newspapers when reporting on social work (Community Care website, 10th September 2013). She referred to one popular newspaper’s ‘unbalanced’ reporting of the Munby judgement in the above baby video case, stating how it hugely distorted the issues by choosing to focus on the removal of the child and the harrowing distress experienced by the mother (Daily Mail, 2013).

11.2.4 Unbalanced reporting does seem to continue despite campaigns such the Community Care magazine’s 2009 ‘Stand up Now for Social Work’ campaign which was set up following concerns over news coverage of the ‘Baby P’ case. In 2014 a popular and respected British television programme Panorama screened a feature entitled ‘I Want My Baby Back’, which was advertised as an investigation of the secretive world of the family courts and asking whether some parents might have unfairly lost their children forever. One politician, Liberal Democrat John Hemming, chair of a campaign group known as ‘Justice for Families’ and noted for his highly critical views of social work, was quoted in the programme as saying that parents should flee the country if they feared being denied a fair hearing in the family courts. This view was promoted heavily in news articles (e.g. Independent, 2014) following the programme’s release where Hemming was quoted widely as saying that the legal system was stacked heavily against individuals and in favour of local authorities and that he had been contacted by hundreds of parents who claimed they were being unfairly targeted by social services:

*“All the cards are held by the local authority. It has large resources to fight the cases, it does all the assessments...My advice to people, if they can afford it, is just to go abroad. You can’t get a fair trial here, because you can’t rely on the evidence being fair. It’s best simply to go if you can, at the right time, lawfully.”* (Independent, 2014)

11.2.5 As yet we unfortunately do not have a large-scale study of the perceptions of the wider English public to know the full impact of the recent strategies to improve the media image and current media presentations of social work and social workers. It is likely that views will vary according to preferred media and culture of different social groups within society and any research will need to take this into account.

What we can be clear about is that the topic of safeguarding has been brought to the forefront of people's minds.

## 12. Conclusions and Recommendations

For many people – even those who have had or are experiencing input from a social worker - there is considerable confusion about what constitutes ‘social work’ and what social workers do. People generally have overwhelmingly negative views of social work and social workers prior to direct experiences with social workers themselves. The media unfortunately can present a highly distorted picture and is a considerable influence on peoples’ views. Good news stories about social work in the media are comparatively rare and when asked, people predominantly recall negative portrayals.

People do consider that a code of conduct and accountability are important and necessary. There are clear concerns around lack of fairness and abuse of power. However few people have any awareness of the current regulatory bodies, regulation procedures or standards of conduct. Clear, accessible information on the codes must be published in order for people to be clear what the standards are and aware when they are not receiving their entitlements and for the potential for redress.

Research and consultation with people who have experienced the input of a social worker has been remarkably consistent in revealing the qualities people value in social workers. From adults and children across all fields of social work there has been a clear desire for social work practice that:

- Approaches the person as an individual with their own unique needs and concerns and without making assumptions as to the impact of their culture, background, status or age.
- Respects the person’s individual autonomy and takes into account their needs to be informed about, understand and make their wishes clear and known about all actions and decisions that will impact upon their life.
- People clearly value a particular type of relationship with their social worker. They seek a relationship characterised by courtesy, integrity, honesty,

trustworthiness, openness, respect, compassion, reliability, reassurance, empathy and warmth. People desire relationships that inspire confidence, are empowering, enable choice and control, are non-discriminatory and non-judgemental and offer informality and flexibility.

- Other factors which people see as essential in social work practice are: confidentiality and privacy, awareness of the potential for discrimination and clear communication in English. The provision of clear, up-to-date, factual and comprehensive information and expert, targeted, holistic and efficient help was also listed as important.
- Many people refer to their social worker as a 'friend' and value the 'friendship qualities' that can be shown within a professional relationship. Reciprocity and continuity and a sense of equality (as a human being of equal worth) are key.

Considering the above findings there is a danger that a code of conduct for social workers could be too restrictive. Any code needs to take into account the quality of a relationship with a social worker that is appreciated – particularly in terms of the expressed desire for an informal relaxed and tailored relationship that may in some ways can be seen as a 'friendship' and involve a sense of reciprocity.

There is also danger that over-regulation or an overriding concern to enforce safety can impact on the care and rights of the individual. Safeguarding can be experienced as 'safety at the expense of other qualities of life, such as self-determination and the right to family life'.

A key theme voiced throughout many different consultations was that any code of conduct or set of standards should clearly 'put the person first'; they should promote person-centred support that enables people to be fully involved in decision making and assist them to fulfil their own agendas.

A strong emphasis on human rights, the United Nations Conventions on the Rights of the Child (UNCRC) and the Rights of Persons with Disabilities, together with the

potential to challenge discrimination within the standards have also been suggested as important for inclusion in any standards.

It is recommended that all organisations foster a supportive environment for its care professionals and a protective environment for the public; advocacy services should always be available and offered to help with any issues raised or complaints that individuals make. Furthermore, care councils should clearly present themselves as independent, and using the code of conduct in practice should be seen as normal so that individuals feel able to do so. Different mechanisms, both formal and informal, should be available for complaints processes.

Although there has been some research looking at service user views on the setting and maintenance of professional standards for health and social care professionals sample sizes have generally been small and there has been very little research specifically on the conduct expected from social workers and links with associated competence. This is an area, which needs to be addressed, with inclusion of a wide range of participants to cover the range of settings in which social workers may work.

This review encountered a dearth of studies looking at complaints about social work and social care. In our view this is a further area that should be attended to. There has also been little work that has considered *public* perceptions of standards and competence. More knowledge and understanding about public perceptions of what sort of qualities social workers should possess and the standards that should be maintained are required.

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## Appendix 1

**The fourteen HCPC Standards: including comments made during service user consultations by the Matthews and Meakin (2013) and Change (2013) consultations.**

### **Standard 1: You must act in the best interests of service users**

Participants shared different understandings of the term '*best interests*', with common interpretations being: recognising that the service user is the expert in their care; listening to service user's needs; offering choice and involving the service user in decisions; putting the person first, not the problem; ensuring equal treatment without discrimination; treating the service user with dignity and respect; behaving with professionalism; being transparent and honest about outcomes. All agreed that their best interests were important and a couple of people stressed that financial concerns should not get in the way of what is best for the individual.

### **Standard 2: You must respect the confidentiality of service users.**

Confidentiality was felt to be important by all. It was acknowledged that information sometimes needs to be shared but should only on a 'need to know' basis. Respondents were particularly concerned with the protection of information, and the accessibility of electronic information. Some people agreed that permission should be obtained before information is shared, however others pointed out that it could be detrimental if information was not shared. Some respondents thought it could be beneficial for useful information to be shared with other parties such as other patients (for example to help with their decision making), or students (as study aids). A couple of participants gave examples of carers and parents of adult service users being given information without consent.

**Standard 3: You must keep high standards of personal conduct**

Again service users put forward their interpretation of the terms used and there were some similarities with the first standard; 'respect', 'integrity' and 'meeting my needs' were most commonly seen as indicative of a 'high standard of personal conduct'.

Other attributes felt to reflect a 'high standard' of professionalism were: being motivated and caring; putting their client's best interests first; being transparent in their dealings and disclosing information; being polite, welcoming and friendly; being well presented (e.g. having clean premises and personal appearance), and having safeguarding awareness. The 'Connect' group additionally felt this should also include personal conduct in terms of not smoking, drinking or breaking the law as well as meeting expectations of presentation and behaviour appropriate to the professional's work.

**Standard 4: You must provide (to us and any other relevant regulators) any important information about your conduct and competence.**

There was some feeling that this standard was not fit for purpose in all situations. Current stretched resources such as in social services departments can sometimes mean that conduct and competence are compromised outside of a worker's control; this raised a query around what duty of care HCPC has to practitioners whose conduct and competence is challenged. There was some scepticism that asking practitioners to be self-regulating and inform on themselves would work effectively. A few people wanted issues outside working life, such as a criminal conviction to be explicitly covered by this standard. Several interviewees also expressed that other professionals should have a duty to monitor colleagues. The Connect group felt that an obligation to report the misconduct of others as well as the professional themselves should be clearly stated.

**Standard 5: You must keep your professional knowledge and skills up to date.**

Some participants in Matthews and Meakin's consultation exercise (2013) did not know how they could verify that a service provider does have current knowledge. A handful of respondents remembered professionals displaying up to date certificates. Some felt they would have to educate themselves for example by looking on the Internet to update themselves before going to their appointment. A couple of respondents were confident about their own knowledge, having had their condition since birth. Some felt a regulator such as the HCPC checked registrants' qualifications and monitored continual professional development. Some participants in the 'Connect' study felt that the standard might need to specify how it is to be measured.

**Standard 6: You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.**

Some people expressed scepticism, based on personal experience, about how much choice there could be in practice due to geographical and budgetary restrictions. A number of service users felt that the wording of this standard implied that the service user themselves does not get a choice in whom they are referred to. People felt they should be able to make an informed choice themselves when being referred, and that to do so it would be helpful to have access to a register of other providers listing their skills and experience. Trusted reviews from other service users (especially friends, relations) or the original provider could also be useful.

**Standard 7: You must communicate properly and effectively with service users and other practitioners.**

Respondents felt that 'effective' communication in practitioner-service user relationships involved information being presented in a manner appropriate to the individual service user. Several respondents emphasised the importance of the practitioner having disability awareness and to be able to accommodate additional needs, for example by using large print and an easy read format. 'Connect' participants were keen to emphasise that practitioners should be friendly and take time with each person. They also suggested that information and explanations should be given at every stage of care to the person and (if appropriate) their family.

**Standard 8: You must effectively supervise tasks that you have asked other people to carry out.**

After some exploration in Matthews and Meakin's (2013) consultation, both interviewees and focus group participants expressed that practitioners could not properly supervise someone if they were not trained, or not from the same discipline. A couple of people felt it was the *responsibility* of the referee to make sure the second party had the right skills and experience but not necessarily *supervise* them. *'Responsibility for is a better word than supervised.'* (p.21)

**Standard 9: You must get informed consent to provide care or services (so far as possible).**

All but one respondent in the Matthews and Meakin's consultation were confident they understood the concept of informed consent in terms of what it meant for them.

Various definitions were given:

*'...even if my consent is different from those around me, it is for me personally to say what I want.'*

*[The] practitioner should have gone through all the options, even procedures that they cannot deliver, and shared this with me'.*

*'No good recognising the words, have to understand the meaning and the implication.'* (p.21)

The 'Connect' consultants felt this linked to standard 7, and that communicating information and explanations in an accessible should be seen as an integral part of getting informed consent.

**Standard 10: You must keep accurate records.**

Virtually all Matthews and Meakin's (2013) interviewees felt this standard to be 'very' or 'extremely' important. Some examples of good practice were given: for example being copied into correspondence between hospital-based staff and their GP, or being asked to sign and date notes at the end of an appointment. Most interviewees said that they could check that their records are accurate by asking to see them. And most felt they *would* want to see them, however a few people said they would not. A few people felt that viewing records would not be a straightforward process.

There could be distressing information in them, and also voicing a request to see them could result in the service user being viewed as a difficult patient.

**Standard 11: You must deal fairly and safely with the risks of infection.**

All respondents agreed with this standard; it was felt to protect therapists and all service users. Some people felt that clear information about the risks of infection in a particular environment was important so they could make a decision about using a service. A couple of interviewees noted that it was also a responsibility of service users to declare *their* infections. One interviewee pointed out that in managing infection risks practitioners should ensure basic hygiene measures, such as antibacterial gel dispensers, were accessible to all service users. A focus group member pointed out that this standard applies to practitioners undertaking home visits.

**Standard 12: You must limit your work or stop practising if your performance or judgement is affected by your health.**

The majority of Matthews and Meakin's (2013) participants agreed with this standard. However empathy was shown for practitioners who may have suffered periods of illness or were disabled. It was noted that although the standard referred to *stopping* work, it did not mention enabling a practitioner to come *back* to work. There may be those who need support in their return to work after a temporary problem, for example after a period of poor mental health. There was also a feeling that many disabilities or health problems would not affect the job concerned and it would only be an issue if they did. A concern for practitioner confidentiality was also expressed. Three people did not agree with the standard. It was felt that reasonable adjustments should be made to accommodate health needs. Workers with lived experience of a condition or impairment can also be highly beneficial to users. Two people pointed out problems with practitioners assessing themselves. Some suggested that a regular review over a certain age or a mandatory retirement age might be helpful.

**Standard 13: You must behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you or your profession.**

All but one interviewee in Matthews and Meakin's (2013) consultation agreed with this standard and felt it was appropriately worded. One person raised the issue of blurred boundaries between professional and personal life, and there was uncertainty as to whether the standard covered both. One interviewee felt that this was the standard that related most to whistle blowing, and provided protection for the practitioner accordingly.

**Standard 14: You must make sure that any advertising you do is accurate.**

There was a general sense that this standard states the obvious, in that any practitioner advertising inaccurately would be doing something very wrong. Interviewees were asked to further reflect on what they thought was important when a therapist is advertising a product or service. This gave them the opportunity to expand upon the concept of accuracy and phrases such as honesty, transparency, and truthfulness were used, as well as making it clear an alternative product is available, or that the service or product not be necessary. In addition: *'The language/wording should not be medicalised – the language used should be plain English.'*