

## The social services primary healthcare model subject to debate: professional dilemmas and reflections arising out of the Navarra case

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**Abstract.** The social services system was conceived in a social context highly different to the present one, characterised by full employment, the high integrative potential of traditional families and the low volume of dependent older adults. Social changes in recent decades in terms of employment, family models and increases in life expectancy, as well as the drastic consequences of the crisis for many households, have given rise to certain professional difficulties that fuel traditional debates revolving around the vagueness of the object of their action, the target population, its general or polyvalent character, the appearance of new actors and the delineation of powers as regards design, management and financing.

The aim of this report is to develop reflections on the appropriate response of the current social services model to the new social and professional needs. The issues presented are the preliminary outcomes of a process of reflection among social services professionals that has begun to take place in the Foral Community of Navarra. Though Navarra's primary healthcare model contains important particularities in comparison with those of other autonomous communities in Spain, the reflections that have begun to spark debates intended to contribute in addressing key issues for social services in Spain.

**Key words:** social services; primary healthcare; new needs; decentralisation; specialisation.

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### 1. Social Services of primary healthcare in Spain

On numerous occasions the social service system in Spain has been referred to as the youngest social protection system, in fact, its implementation arose from the democratization of public institutions. Until then, attention to the poverty

situations and necessity was linked to charity, where a fundamentally institutionalized, fragmented model prevailed and usually operated under high criteria of discretion (Rodríguez Cabrero, 1996; Subirats; Adelantado; Fernández Prat; Iglesias; Rapoport, & San Martín, 2007).

The universalization of social services aimed mostly, to overcome this intervention

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model linked to charity, to create a more integrated care system that would allow to decrease the fragmentation of the health care network and bring services closer to the population. In this way, the progressive implementation of a social service system closer to the territory and flexible to social needs started, but also intended to serve people with specific difficulties in the open environment and without the need for hospitalization (Aguilar, 2013). Although this model relies on a particular level to deal with situations that require greater specialization, its philosophy is based on what is known as the Community Care, implemented since the 60s in the United Kingdom (Sullivan, 2009). The model therefore provided primary primary healthcare proximity proximity to the citizenship, community involvement, prevention of social needs and universalization of the system. Based on both a good reception and orientation, and on design and action over the environment (Aguilar; Corera; Laparra; Liberal, & Pérez Eransus, 2001).

Likewise, the process of decentralization of autonomous competences has closely marked the development of the Social Services system in Spain. Article 41 of the Spanish Constitution stated “The public authorities shall maintain a public social security system for all citizens, which guarantees sufficient social assistance and benefits in situations of need, especially in the event of unemployment. The assistance and corresponding services will be free.” This fact was the result of strong debates related to the characteristics and the nature of the system, in such a way that a decentralized system was chosen to answer the regional proximity and the development of the preventive and communal functions.

As a consequence, the social services management model advanced under a dual network model, primary and specialized. The assignment of these competences set up management and implementation models with important differences between regions. To what extent progress has been made in the implementation of this model in each of them, has been the subject of numerous discussions, and even processes of reordering (Gil, 2010; SIIS, 2015; AEDGSS, 2016). However, in spite of these differences in development, all territories share substantive issues that can lead to similar dilemmas and debates.

Throughout this article we present the lines of professional reflection initiated in Navarre

as a result of a technical process that intends to evaluate the management of the primary primary healthcare proximity model in the social services of Pamplona. The text does not aim to propose alternatives and to address the open debates, which must be tackled collectively with all the actors involved. However, it is the driving force of this work to share with the academic and professional community the first advances of a reflection process that brings back to the table basic questions related to the object of social services. The goal is ultimately to encourage this debate, sharing some issues and to initiate a collective process of reflection that allows advancing with greater precision around the target population, the models of intervention and the interdepartmental coordination. Ultimately, focusing on the debate of professional polyvalence and the relationship with other private or third sector suppliers.

This text is articulated in four sections, preceded by the methodological notes. Firstly, the characteristics of the model of social services of primary primary healthcare proximity in Navarre are analysed. Secondly, this reflection is contextualized based on the impact the social changes took place in the typology of demand, available resources or intervention models of social services. Thirdly, we present the professional dilemmas identified in the process of reflection initiated in Navarre. Finally, we point out ways of debate and common reflection around the model of primary healthcare of social services in Spain.

## 2. Methodology

The results of this work are part of an assessment process on the management model of primary healthcare of social services initiated by the city of Pamplona. The choice of territory is due to the fact that both the volume of the recipient population and the level of decentralization of the programs, make it a relevant case analysis to test the results of the model derived from Regional Law 15/2006 of December 14, of Social Services.

The process of collecting information from the first phase of the process has followed an eminently qualitative methodological development. In the first place, a collection of information on the difficulties and professional dilemmas involved in the current model of primary primary healthcare proximity was developed.

To this end, a preliminary group was created consisting of 12 social work professionals from the municipality of Pamplona. From this group, the information gathering incorporated: weaknesses, threats, strengths and opportunities of the current model. Professionals from the 12 Neighbourhood Offices of Pamplona worked out this SWOT analysis. In each of these teams a total of two social workers and one educator participated. The size of each of the neighbourhood office depends on the social needs of the territory, so a homogeneous criterion of small team involvement was agreed. Therefore, 36 professionals participated in this phase of data collection.

Subsequently, two focal groups of social service professionals from the different areas of Navarre were established. In each group two professionals from each of the 6 areas of social services were involved. That is, a total of 12 participants per group. Although the study began around Pamplona area, it was considered interesting to open the debate to the experiences that the model was having in other areas of the region, mainly rural areas.

Both field phases analysed casework, group or community methodology; time management, team work or direct support; scope of action; assessment of intervention tools and information collection; and professional dilemmas.

Based on the information obtained, a document was prepared and returned to all participants, in order to prepare a preliminary agreed diagnosis. It was found that, in addition to the limitations and potentialities identified in relation to the management model, the results reveal important debates related to the target population of social services, the model of social care and / or the relationship with other systems and institutions. The reflections presented in this text are the result of these two phases and seek to contribute, to the extent possible, to face some of these debates within the framework of Spanish Social Work.

### **3. The social services primary healthcare model**

The development of social services in Navarra goes back to the Law 14/1983 of Social Services, one of the pioneering standards in the Spanish state. In general, the first regional Social Service Laws were based on general

principles that established the basis for developing a regional social protection framework, fundamentally aimed at alleviating situations of poverty and social exclusion (Arias et al., 2004). To this Navarre norm was added, 7 years later, the Provincial Law 9/1990, of November 13<sup>th</sup>, on the regime of authorizations, infractions and sanctions in social services, which contributed to lay the foundations to develop different intervention resources in the system.

This first regulatory framework made it possible a very significant progress in the development of social policies in Navarre. However, as in the rest of the Autonomous Regions, they were norms based on assistance, so that the population had not yet reached the true right to the system (Aguilar et al., 2001). This reason, combined with a need to adapt services to social needs, motivated the Law 15/2006, a law currently in force. The new law was the result of an intense debate and consensus that led to the reordering of primary healthcare in social services. However, in spite of the progress regarding recognition of public responsibility with the development of the Social Services Portfolio through Regional Decree 69/2008, one of the most significant changes of the Regional Law 15/2006 was undoubtedly the design of a new structure of social services. Through the primary healthcare teams, it sought to break the traditional separation between a first care based on the reception and the subsequent referral to specialized social services.

After a collective and participatory work, a more specialized primary healthcare model was agreed, which included actions to detect needs and prevention, and was more integrated in the community. For this, a model of primary healthcare was designed amid 4 programs:

- The Program of Reception and Social Orientation, directed to the whole population, that offers social intervention to the people who make demands through social services.
- The Program for the Promotion of Personal Autonomy and Care for People in a Dependency Situation has the objective of enabling people in a situation of dependence to remain in their regular environment as long as possible.
- The Social Integration Program in Primary healthcare, whose purpose is to promote

the social inclusion of people at risk or in situations of social exclusion in any of its areas.

- The Program of Attention to Children and Family in Primary Healthcare that aims to ensure minors, an environment that allows their personal development through mechanisms of protection, personal, family and social support.

As in the germ of the state system, the new Social Services model of primary healthcare in Navarre was based on the philosophy of integrating the Social Services System in the community. The main objective was to try overcoming the difficulties the Model of general primary healthcare developed: a fragmented network, a lack of professional specialization, a demand-dependent model of care, unequal community development, and low stakeholder participation (Aguilar, 2014).

The implementation of this model in Navarre, between 2007 and 2008, concurred with the impact of the economic crisis and the austerity policies. The change in the scenario and game rules completely altered the dynamics of attention of social service offices. It gave rise to debates and professional dilemmas derived from both the conjectural reality of the services and from the need to undertake some deliberate debates to better define an action strategy on the target population and the prioritization of resources, among other issues.

In addition to the crisis, the model showed some insufficiently defined aspects that also helped to complicate the implementation of this new structure. For example, the Social Services Portfolio, which had its mission to equip professionals and ensure equitable territorial development, showed a certain general character. On the other hand, the possible and imminent privatization of some specialized teams was not considered, reason why the process was insufficiently planned. Finally, the portfolio also collected funding channels for social entities that were not guaranteed and in practice have not just consolidated as professional tools. In short, the new model, despite having very innovative elements and great potential, found restraints both in the crisis scenario and in some design issues insufficiently foreseen.

#### **4. A change of scenery that spurs traditional debates**

The Social Service system was conceived in a social context very different from the current one. At that time, full male employment and stable employment would offer certain economic stability to many households. Likewise, the integrative potential of traditional families provided care and attention to children and dependents. However, social services have been facing new social risks for a number of years (Moreno, 2010; Taylor-Gooby, 2004): the heavy job destruction and precarious labour conditions, a large increase in life expectancy that has contributed to an escalation in the volume of dependent population, as well as, family transformations that sometimes lead to dysfunctions in the coexistence of households. The connection of these economic, social and coexistence problems contributes to an important increase of the potential demand of primary or specialized social services.

Parallel to these changes, the economic situation led to a strong containment of social spending. The austerity in this space augmented and resulted in social policy deterioration that strongly affected social services (Mestrum, 2014). In this sense, in recent years there has been a progressive assistance in minimum income benefits, the level of participation of private actors in the provision of public services increased, and the activation policies discourse has intensified (Carter & Witworth, 2016). All these changes impact the Social Service Network across Europe, leading to an increase in the demand for social services with a strong constraint on the capacity for protection (European Social Network, 2016).

However, in Spain, these trends of generalized change have intensified. First, there is a strong process of job destruction and precariousness that leads to a growing number of unemployed households or in labour poverty. Secondly, the unemployment protection system presents important gaps to protect people with precarious labour trajectories. Finally, the access to housing purchase, has led to important situations of indebtedness and / or processes of residential exclusion (Foessa, 2014).

The combination of these three factors characterizes a vast portion of the demand that reaches social services in Spain: poverty, lack

of employment or precarious employment, exhaustion or absence of benefits and high housing costs. From here, the presence or not of children, physical or mental health problems, and the passage of time itself contribute to the situations' complexity (De la Red, 2014).

The volume and nature of these conditions undoubtedly transcends the integration capacity of social services, demonstrating the need to promote cross-cutting actions that imply comprehensive solutions for both the labour market and income guarantee system and for the public housing management model (Fantova, 2014). However, as will be shown below, one of the most immediate results is the increase of professional dilemmas related to the subject and potential subject of the services. Issues that were also present in other contexts but not in daily basis.

Professional dilemmas in social services primary healthcare

The evaluation process of the primary healthcare model in Navarre has stimulated debates related to decisions already undertaken in social services but which continue to be a focus of discussion. Again, the services decentralization, coordination between programs, the need for new action strategies, the target population and the prioritization of resources or the promotion of community social work have revealed as key elements for professional discussion.

Under these matters it is inevitable embarking on this discussion. Below are the reflection lines open in Navarre. In the same way, each of them incorporates some alternatives and measures that are part of the discussion within the social services. From this, the work seeks to contribute to collective reflection and to continue advancing in the adaptation of primary healthcare social services to the new social context.

### **5.1. "We work in a stagnant sector" Inputs on the need to improve coordination to compensate for the decentralization process**

The configuration of a first care model with a certain specialized character in the area of reception, social incorporation, family, childhood and dependency, sought to confront the debate on the specialization and / or polyvalence of professionals profile. While it is true that Navarre's model gave an answer to this question, the process of service decentraliza-

tion and specialized programs has intensified the risk of working in a stagnant manner, especially when the daily workload is high.

The decentralization of services has very positive assessment among professionals. Programs are closer to family's reality. On the other hand, there is a greater potential to meet the demand as a whole. Finally, it is appreciated that the context is now more conducive both to teamwork within service offices and to development of community work.

However, decentralization has not been fully developed, generating in the daily practice some misalignments related to the identification of functions, target population to be attended by each program and the absence of combined work strategies that lead to "work in a stagnant sector", according to professionals themselves.

The daily dynamics and the implementation of such an innovative model demonstrated the need to look for coordination spaces between programs. This would allow answering some questions such as what is the difference of profile between the assisted population by each programme? Do duplicities occur in the diagnoses and assessments of the cases?. While it is true that the boundaries between programs such as autonomy and dependency have been less permeable, the rest of the programs share cases and internal referrals, so they sometimes find it difficult to define their target population. This evidence is especially strong with profiles that accumulate intense difficulties in terms of exclusion and / or mental health.

In this sense, it is observed that, in practice, there is a certain disparity of criteria in relation to the profile of users that must be taken care of by each program or at the appropriate time for its derivation. This lack of consensual criteria also complicates the connexion with other areas (education, health and others) as contacts are established with different professionals within the same unit of Social Services.

Therefore, in response to this reality, a certain professional consensus is identified on the need to plan actions that promote teamwork, group intervention actions and community social work. It seeks to build a "culture of service" that arises to a more comprehensive practice. For this, it is considered indispensable to release some professionals to perform coordination functions. This proposal, which is part of the discussion, is defended in order to promote case supervision spaces, coordination

in cases shared by different teams or professionals, and even for the key communication for daily work (Changes in policy, new guidelines, changes in the portfolio, etc.).

## **5.2 “It is necessary to allocate time for social intervention.” Reflections on working times**

Another central issue of discussion is the time devoted to management and more direct intervention. In general, the high workload of all services and the care demand-driven model, avoid intense professional intervention processes. This reality has multiplied in recent years; the increase in demand reduced the time of attention by appointment, restraining the ability to examine important issues beyond explicit demand.

Waiting lists are perceived with a lot of concern. Some services exceed the month and a half hence, people who after that waiting time don't show up for the appointment increased. Reducing waiting times to reduce “absenteeism of appointments” has been a goal of many services, because it is an indicator that shows the barriers to access the system. The phenomenon is known in social policy as “non take up”, of which there is some international consensus to consider it as an indicator of the system inefficiency (Eurofound, 2015).

This reality amplified the concern of professionals on their daily work. As a result of this discomfort, a primary attention professional points out with anguish: “Sometimes I see a paper in the bag of the client, probably about a delicate issue and I think, please, don't bring that out, I don't have time”.

From these reflections, there seems to be some consensus on the need to limit the number of appointments in order to advance information collection, social diagnostics and assessments. Likewise, the importance of making appointments flexible and reserving internal management spaces, allows professionals with the latest information, to prepare the reports or referrals that the case may require.

On the other hand, it emphasizes the need to simplify administrative procedures, involving these professionals in some of these management tasks, introduce and reinforce team social work methodologies or to taking advantage of new technologies to connect with citizens.

Many of these proposals would significantly change the organizational model within the

primary healthcare services. First, because they require the involvement of the entire professional spectrum in the service. And secondly, because it would change the current form of organization, focusing on a common intervention model, centered on the user and more agile in the management of first appointments and demands.

## **5.3. “The community theme is in the land of no one and everyone.” Notes on the impulse of Community Social Work**

The community issue remains unresolved. In nowadays context, the historical difficulty of promoting community development in the day-to-day primary healthcare has intensified. It is true that, despite the low level of development of this methodology, some good practices in this respect have been observed. However, the general situation in the services characterises by a lack of recognition of this work, resulting in shortage of time for intervention, poor training and deficiency of assessment mechanisms.

The research identifies an important consensus between professionals in relation to the need to recover and promote neighbourhood networking from a community approach. To this end, it is suggested a work plan that allows implementing this level of intervention, as well as the need for continuous training in this area. The results warn that if community work is not included in the professionals' agenda, with allocated time and coordination spaces, it will not become consolidated as a key action space for social services.

## **5.4. “Professional self-care service”. Proposals for support and follow up with professionals**

Finally, the complexity of the new social needs and the changes in the demand, have altered the action dynamics on daily practice. These changes are manifested, in some cases, as an opportunity to rethink some professional practices. However, the feeling most manifested by professionals is of discomfort, overload and worry. In this sense, working groups pointed out some concern for professional well-being. In response, the possibility of creating a “self-care service for professionals” that redefines workloads, responding to training needs but, fundamentally, promotes spaces for reflec-

tion and professional supervision, has been identified.

In short, the evaluation process on primary healthcare model initiated in Pamplona has brought to the table intense questions that affect the purpose of the system: the organizational matter, the model of attention and professionals' well being. These discussions open reflection paths around the definition of functions, type of intervention and target population of each of the intervention layers. They also raise coordination issues between services, programs and other social protection systems (health, education, employment, housing, etc.). All these debates, traditionally linked to the social services system since its creation, have magnified in the existing social context.

## 6. Traditional debates, should we face them?

The above results indicate the need to reach a consensus that guides the future Social Services attention. These debates are complex, but must be addressed in order to advance in the decision-making about the nature of services and care levels. Only through this approach will it be possible to define the place of social services within the guidelines of political intervention itself.

The first debate stimulated by this process deals with the question of universality and / or focus of attention. In a context of high demand, it is necessary to establish criteria for prioritizing the population, both in access to reception services and in other programs. Universality is not at odds with the urgent treatment of the most serious problems, or at least not in the health system. Common criteria prioritization can be established in access to services and resources depending on the intensity of the exclusion or depending on the case prevention possibilities, the "opportunity" criterion or its profile (presence of minors, mistreatment, etc.).

In order to avoid the professional discretion, which may well be positive or negative, it is necessary to review the intervention protocols in order to avoid different prioritization according to each service or professional, thus generating a situation of inequality for the recipients. In this case, a useful task is to reflect honestly on the benefits portfolio through questions such as: what do we say we do, what

do we really do? Which are the rights of our citizens when they come to our services?

The second issue involves the time spent on management. The current context has increased the demand for benefits in social services, involving a great part of the workday of many professionals. It is important to highlight again the relevance of professionals processing benefits and carrying out social intervention at the same time. They are not opposed tasks; in fact, the management of benefits generates important opportunities for the detection and diagnosis around an insertion itinerary. However, increased bureaucratic processes, limited action in cases of aid rejections and poor availability of resources for intensive interventions has hampered social interventions that were based on the aid relationship. Relationship traditionally sustained on the user-professional within Social Work field.

Thirdly, we find the debate on social workers support. There is some professional consensus on what social support is and its implications in case management work. However, a real assessment of the capacity to carry out this intensive methodology, the number of cases and levels where it can be guaranteed, need to be advanced.

Fourthly, it is worth mentioning the models of social and labour insertion. The professional culture of social services has been forged in a social context of full employment, which is why traditional professional action aimed at providing access to employment to population living in poverty. Likewise, the integrative potential that the employment once had, served the social services network as an insertion resource with other situations of need (mental health, marginality, etc.). The current lack of employment questions some of this logic and professional inertia. This difficulty is further intensified when professionals face the service culture of the employment system. The traditional separation between the two systems has generated a great distance between the design of the activation policies and the socio-labour incorporation profiles of employability. Although complex, it is necessary to pursue a more intense coordination and collaboration scenario that allow, from the design stage, users of social services as potential beneficiaries of employment policies and programs.

Fifth, the traditional confrontation between professional specialization and the multi-skill side of the profession must be tackled. It is

necessary to respond to the specialization degree required by the most complex cases. The results show, on the one hand, the potential of versatile profiles, as long as they are capable of giving a first integral response to the population. However, the complexity of many of the cases that seek services, requires a certain specialization that responds to issues related to inclusion, care for families and minors, as well as dependent population. From this, it could be argued that the client reception, with greater capacity of coverage, is an adequate level for the detection, elaboration of diagnoses, preventive interventions or follow-up of cases. While intense intervention requires greater specialization and availability for social accompaniment.

Sixth, there is a need to rethink social services' tools and information systems, so as to help speed up work, promote case coordination, follow up, and even make decisions about workload. The aim would also be to transfer information to other levels of intervention or areas of social policy (employment, health, housing, income guarantee), in order to legitimize tools such as social reports in other public spaces. The lack of recognition of professional tools leads to the risk of duplication and overlapping of assessments. Likewise, there is a professional consensus about the limitations of the current Social Service Users Information System (SIUSS) in order to evaluate the actions and impact of the interventions. So new technologies are also a good way to improve these tools.

Finally, the research has noted the need to rethink the internal organization of services. Teamwork around assessments, case tracking or shared actions strategy becomes key to developing effective interventions that improve the relationship with the user and the response by the service. However, the labour mobility that affects the sector, and even the absence of resources and meeting spaces, creates a certain risk for each professional to work with their users, thus losing a basic essence of the profession.

Therefore, the results presented throughout the text show the need to discuss these basic issues in the system. However, the current context also manifests some key elements for the management of social services. Among them, the type of relationship that is maintained between primary healthcare networks with other commercial and / or non-profit providers must

be addressed. In recent years there has been a significant increase in the number of social actions carried out by different providers, and even the intensification on assessments for access to external resources (food banks, school kits, etc.). This fact makes it pertinent to decide what will be the relationship with these external providers and what level of involvement will public social services have in the implementation of these resources.

The majority of the debates presented are long running in the sector, so overcoming them, from the outset, seems to be complex. However, the recognition of these dilemmas makes it necessary to create an agreement and decision-making space that builds common criteria within the profession.

## **7. Final notes: an inevitable collective reflection**

The results found in Navarre in the first phase of the primary healthcare model evaluation, show the need to review the adequacy of the system to face new social needs that are present in the services. The social context is different from that of a few decades ago, and also from other countries or environments. Therefore, it is not useful for this case to import "good practices" of programs, professional methodologies or benefits that have been successful in other scenarios. For this reason, we inevitably have to decide, based on the criteria and experiences of professionals, how to improve the work of the primary network of social services from the context and available resources.

In this sense, we can differentiate reflection areas to undertake. These include the decentralization of services, coordination between systems, time spent on intervention and actions in the community sphere. In the light of these discussions, a number of substantial issues will inevitably be faced which, while not expected to be overcome, will require a minimum agreement. Among these traditional dilemmas is the question of the universality and focus of attention, the debate on the management of benefits, the time for social support or interdisciplinary work, amid others. Finally, important crosscutting issues such as the presence of various social service providers (mercantile and non-profit) will take part in the discussion.

It seems appropriate, for any reflection on primary healthcare network, to be coherent with the current situation and take into account the volume and characteristics of the demand, as well as their possibilities of intervention and impact on the existing problems (poverty, exclusion, lack of employment). Therefore, in parallel with the discussion, it is important not to lose sight of the assessments of social needs.

This complex process of decision-making can only be successful if it is carried out with

the involvement and participation of all professionals in the field of Social Services. Starting an open and collective process of reflection is a good way to face this task. Both traditional paths of academic and professional debate around specialized magazines, professional colleges or conferences, as well as new technological opportunities through virtual discussion forums or blogs, are spaces that can encourage reflection sharing to improve these issues. Be this work too, a small contribution to it.

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