Social Diagnosis: The Spanish Experience

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Abstract

The article aims to reflect on the methodology of Social Diagnosis in Spain, in the professionals related to the Social Welfare System.It explains the different ways in which it has undergone diagnostic methodology in Social Work in Spain, reaching current diagnostic formulations, heirs of the precepts of the profession set in the early twentieth century. In Spain the need / opportunity of making diagnoses in a systematic way, as a preliminary phase before intervention and as a cornerstone of the process of decision-taking, which becomes powerful with the appearance of an entire legal formulation on User data privacy and their right to know the methodological processes of information treatment. In the article, then, we will go overdiagnostic methodologies that take place today and include, among others, the formulation of indicators (which allow the systematization of social needs), the "selfvaluation" or professional support based on the evaluation empowerment

Keywords: Social Diagnostic; Social Needs, Empowerment; Methodology; Spain Social Work

Mary Richmond's seminal book entitled *Social Diagnosis* was published in 1917. In it, Richmond stated that social diagnosis was "the attempt to make as exact a definition as possible of the situation and personality of a human being in some social need (…) that is, in relation to the other human beings upon whom he in any way depends or who depend upon him, and in relation also to the social institutions of his community" (1917:357). The author thus asserted not only the right to use processes of inference and deduction in social work and the right to *diagnose*, but also the scientific nature of this discipline.

Nearly 100 years on, it is admirable to find that this book still engenders reflection and debate within the professional body and that most of its premises are perfectly adaptable to our times.

In this paper, we aim to briefly review the various twists and turns that, in Spain, the diagnostic methodology in social work has taken in order to arrive at today's diagnostic formulations, which are worthy heirs of the profession's precepts as established by Richmond in the early 20th century.

However, it is important to ascertain what exactly we are referring to when talking about diagnosis in social work because there are various definitions of it. For example, Colomer (1979) describes it as the procedure used by social workers to make an interpretative judgment of a person's or a group's situation and to establish a classification of needs according to the nature and magnitude thereof. And Anger-Egg (1982) describes it as a process of successive approaches that, based on the relationship between theory and practice, provides knowledge of a specific reality enabling deficiencies, needs, problems, aspirations (…) their magnitude and origin to be defined and prioritised. Rather aseptically, the most recent Social services Dictionary(2010) describes it as the determination, by means of a study, of the psychosocial situation of a person and of his/her family, and of his/her needs and strengths in order to guide the professional intervention aimed at improving the situation. These definitions already provide us with some interesting pointers on the task that needs to be accomplished:

- They refer to a process of successive approaches: social reality is indeed so complex that it necessarily calls for a gradual and guided approach to it, allowing time and building some degree of trust in and knowledge of each other.
- They refer to a procedure, that is, the most organised, systematised and rigorous method possible.
- They involve classification and prioritisation, that is, the need to sort and order – at some time in the process – everything that has been identified and is known.

- They refer to the individual's/group's aspirations and deficiencies, that is, they aim to find out about his/her/its limitations as well as his/her/its main hopes, objectives and motivations.
- They involve a professional judgment in accordance with accepted standards that focuses on the effects of our assessments or interventions on people's lives.

We can therefore see that what we will ask of a diagnostic process is considerable: to provide us with a rigorous, exhaustive and holistic method to point us towards the professional path we need to take; to give us guidelines on the work plan that needs to be developed in our future intervention; to allow us to describe, assess, prescribe and so on. As already mentioned, it is important because we are dealing with the vicissitudes experienced by the subjects of our interventions.

1. Brief Historical Reference

Despite the fact that there was a considerable quantitative increase in the number of institutions, programmes and bodies devoted to social care tasks in Spain between 1980 and 2000, we believe that no parallel advances were made in diagnostic methodologies. Quite the contrary in fact, as their application and experimentation experienced ups and downs over time, as well as some degree of stagnation at certain moments. Many circumstances came together to produce this situation, and we shall try to separate and succinctly describe them based on those elements that, according to Robertis (1998), converge in any social intervention: the work body and sector from which we work; the social worker and the user. Although the contracting bodies (both public and private) considerably increased the number of social care programmes and projects (and, therefore, the number of professionals), they mostly did so from a quantitative perspective, giving priority to increasing the number of users and the budget allocated to them. This led to the most qualitative part of care being ignored, that is, the time devoted to work prior to the intervention (the stage of coming into contact with each other, of getting to know each other, of exploring – the stage that is eminently *diagnostic*). Thus, the simplistic view of the social worker as an immediate care professional and/or a service provider made it hard for him/her to have this period of time available prior to an intervention. Likewise, the proliferation of excessively rigid and bureaucratic intervention protocols put a damper on professional creativity. Furthermore, the contractual conditions that these bodies offered (project-based or half-time contracts) were an added difficulty for making a good initial diagnosis.

As far as the social worker is concerned, the mainstream discourse in the 1980s was against the systematisation of the intervention process (and, therefore, the existence of overly standardised diagnostic methodologies); it advocated casework-based social work that was unique to the "client". Beyond this finding, it is an undeniable fact that making a good diagnosis has sometimes been hindered by social work professionals themselves. Hindrances such as methodological difficulties or doubts ("I don't know how to do it"), a lack of time ("I don't have time to do it"), a lack of necessity ("if nobody asks me, then why do it?") or simply lethargy when faced with innovation ("if I've never done it, then why start now?"). Finally, we come to the user. Given the retraction of responsible bodies and professionals, the user has neither missed nor demanded a prior diagnosis of his/her social situation. Thus, the majority of users have participated in this structural framework as passive subjects who receive replies from institutions without considering their ability and right to decide or participate in their diagnosis.

The trigger that brought about a change on this issue may have been purely legal (as opposed to methodological). We are referring to Spain's 1999 Data Protection Act (*Ley Orgánica 15/1999 de Protección de datos de carácter personal*) and the Royal Decree (*Real Decreto 1720/2007*) implementing it. The principles of this Act, given its organic status, were respected in the drafting and implementation of the various Social Services Acts deployed by Spain's Autonomous Communities in the early 21st century [As an example, we refer to the Law of Social Services of the Catalan Autonomous October 2007 (Law 12/2007)].

Among its provisions, the 1999 Data Protection Act included the compulsory nature of asking the user for authorisation to use – and to keep him/her informed of – any information collected on him/her. The Act stresses the need to let the user know about anything the professional does with his/her personal data and the information held or collected on him/her. In other words, the user must be aware of the information held on him/her and, above all, how it is being combined to arrive at a professional assessment (in other words, how it is brought together to make a social diagnosis). In addition, the user has the right to ask for this diagnosis in writing, to take part in the making of it and to challenge it (if he/she does not agree with the assessment), by articles 9 and 10 of Law 12/2007 of Social Services of the Autonomous Catalan.

As already mentioned, this fact, the nature of which was formal and legal rather than professional, led to a rethink within the social work sphere of the methodological bases on which social diagnoses were being made and led to a in-depth reformulation thereof; a reformulation that we shall now go on to explain in more detail.

2. Diagnosis In The Intervention Stages

The intervention stages proposed by Aguilar (2013), Ander-Egg (1982), Barbero (2002), Conde Mejías (1998), De la Red and Cruz (2003) and Thompson (2002), among others, are widely accepted as a professional intervention model. These stages are shown in Chart 1.Chart 1. (at the end of the article)

This model advocates the circular nature of the intervention based on a process of successive approaches, which runs from initial contact with the social and personal situation to the process of assessing the interventions made in it.

In Spain, though, there is constant debate about whether the diagnosis *exclusively* forms part of the preliminary stage or the social, personal and family study stage, or whether, on the contrary, the diagnosis *continues* throughout the professional intervention and is permanently open and subject to any changes/inputs that may suddenly arise in the vicissitudes experienced by the subject of the intervention. Hamilton (1987), for example, considers diagnosis asa continuous, flexible process that is constantly evolving, while Aguilar and Ander-Egg (1999) consider it as an aprioristic synthesis that will allow a prognosis to be made (associated in turn with an action plan).

Our position on this issue is postulated on the first of the two aforementioned formulations: we consider that an "open" diagnosis throughout the entire process leads to an inconclusive diagnosis that renders it inoperative for the decision-making process, a process that is the true reason for the existence and usefulness of a diagnosis.
The professional intervention process is summarised more specifically in Chart 2, which sets out the details of diagnosis – fundamental for deciding on the action plan and allowing us to systematically collect data; priority setting and decision-making for future action; strategy and action implementation; and outcome gathering. It also includes assessment, which must be ongoing throughout the process, as a quality guide for that process and a method for outcome validation and for new decision-making. Chart 2.(At the end of the article)

It is an extensive approach adapted to what Hamilton (1987) refers to as the study of the subject's environment. This author also considers that a distinction can be made between three types of diagnosis: the descriptive diagnosis, which involves a descriptive account of the situation under study; the causal diagnosis, which tries to establish cause-effect relationships in a situation susceptible to intervention; and the evaluative diagnosis, in which personal elements and resources are weighted in relation to the positive/negative situations of the subject and of his/her environment (Hamilton, 1987).

Red (1993), on the other hand, considers that the diagnostic approach can be taken from four perspectives: empirical (based on direct observation and experience as a source of information); phenomenological (based on making an assessment of the meaning that subjects give to the circumstances affecting them); critical (which assesses events according to the professional's principles and objectives); and structural or systemic (which aims to cover the group and/or community as a whole for the professional assessment thereof).

The studies by Conde Mejías (1998) are interesting too. This author notes the existence of the principle of constancy of diagnostic categories in social problems, through which she understands that various social causes can be processed, analysed and systematised into three categories or diagnostic groups:

a) **Need:** Variables related to the lack or deficiency of instruments to protect oneself from adversities found in the social environment.
b) **Dependence:** Variables subject to an external agent in order to find a way out of manifestly critical states in the individual's area of social activity.
c) **Social risk:** Situational variables that produce insecurities when faced with the possible manifestation (in a potential state) of various problems.
The author introduces the *variable* rubric that, as we shall see, is substantive for interpreting the diagnostic formulations currently made in Spain.

3. *The Diagnosis As A Tool For Decisions*

Once the need to/appropriateness of systematically making diagnoses as the stage prior to intervention and as a basic part of the decision-making process had been unanimously accepted in Spain, a number of interesting experiences related to it emerged. The premise on which they were based was that, in social work, we should continue to endow ourselves with nomenclatures or common diagnostic assessments (that are widely known and accepted by the entire professional body) and that such "diagnostic labels" should in turn contain quantitative and qualitative descriptive indicators to delimit each of them. That is, a chained table of variables/indicators that would provide the profession with a common working methodology.

In this formulation, one of the first categorisations was the one proposed by Maite Martín Muñoz (2003),who articulated a diagnostic model based on the delimitation of a person's/family group's basic needs that ought to be covered and on the possibility of identifying this group's deficiencies or deficits, that is, which of these needs are not covered and to what extent. Thus, the author chains variables and indicators until arriving at five possible diagnostic categories (one of which will be the one the subject of the intervention receives in writing):Table 1. (At the end of the article)

This designation, which was widely used in its early years, was a huge step forward in diagnostic methodologies because, as already pointed out, it enabled work processes to be systematised, assessments to be shared and compared, and aprioristic judgments to be evaluated.

Thus, the diagnostic method based on the delimitation of variables/indicators took hold in Spain and a variety of formulations emerged that basically responded to the same logic. Hence, for example, the "*Manual diagnòstic social ensalut mental"* [Manual for social diagnosis in mental health], produced in 2010 by the Mental Health Social Worker Group of the Professional Association of Social Work of Catalonia. Although based on the same premise as the previous one, this diagnostic method aims to optimally adapt indicators to the characteristics of the users of these services and manages to create a very useful and operative instrument for working with people with mental health issues and their relatives.

The model of working with indicators to make social diagnoses has been employed very successfully in Spain. The following instruments have emerged as a result: *Escala de Valoración Socio-Familiar de Gijón* [Gijón social and family assessment scale]; "*RegistreUnificat de MaltractamentInfantil"* (RUMI) [Unified register of child abuse], produced by the Government of Catalonia; "*Propuesta de un sistema de indicadoressobrebienestarinfantilen España"*[Proposal for a system of indicators on child welfare in Spain] (2010), published by UNICEF España; "Guía para a asignación de servizossociais a persoasensituación de dependencia" [Guide for assigning social services to dependent people], in the Autonomous Community of Galicia (2013); and the proposal by Raya Díaz (2006).

At the same time, sets of diagnostic indicators were devised to gain greater knowledge of social exclusion processes. An example of that was the highly detailed proposal by the Government of the Basque Country, which as a result of a broad-based participation process involving that Autonomous Community's professionals, has recently published the *Instrumento de Valoración de la Exclusión Social* [Social exclusion assessment instrument] (2014), which enhances and increases the set of diagnostic variables and indicators to a total of 171, 41 of which allow an initial diagnosis to be made while all 171 allow an in-depth diagnosis to be made. Furthermore, 77 indicators separately allow a diagnosis of the social exclusion situation to be made; these indicators run across the various areas and dimensions (Table 2).

All of these indicators are in turn sorted into dimensions, which are consecutively organised into five major areas (referred to as life areas). The order structure is areas > dimensions > indicators (Table 2).In order to initiate the professional intervention with the user, diagnostic feedback, a situation prognosis and the starting point of a work plan is extracted from this set of indicators. Table 2. (At the end og the article)

At this moment in time, this model is the ultimate expression of indicator-based diagnostic processes undertaken in Spain. As shown in Table 2, it is a holistic chain of variables that is well devised, ordered and developed to gain knowledge of many (if not all) the social problems and/or social exclusion and inclusion processes experienced by users of social services. As already stated, it also aims to make nomenclatures and assessments more uniform.

However, and despite the obvious usefulness and progress that these codifications represent, some voices consider that such formulations lead to an overly rigid interpretation of the diagnostic variables; on the one hand, these labels are too rigid and do not allow enough room for the professional to interpret them freely, and on the other, the systematisation of indicators is somehow an inconclusive diagnosis because it does not allow for the inclusion of either the subject's self-assessment of his/her potential/deficiencies or of the potential resources that need to be combined to redress the situation.

In this respect, it is worth remembering that what we demand of a diagnostic procedure is that that it should enable us to arrive at an interpretation of the situation; take into account not only risk factors but also positive aspects; identify available resources (both existing and potential); and communicate or give the assessment that we make of what is happening to the subject and explain our action plan, which involves being objective in terms of the care options that we are able to offer from our workplace. Two of the techniques proposed to fill these gaps are criteria weighting and SWOT analysis.

Criteria weighting is based on the logic that, despite having enumerated the indicators defining a specific social situation, in our discipline the diagnosis cannot be considered final because the last part of the decision-making process is missing. Considering every identified deficiency, the missing part is judging which one is a priority, which one cannot be worked on, which one is not acknowledged by the subject/family group and so on. In other words, a process of prioritisation, of re-ordering the indicators, has to be initiated. It is worth remembering that what has traditionally defined the profession and what the community mostly expects from us is that we should take action, that we should initiate identification/knowledge-gathering (diagnosis) processes to guide us towards satisfactory action.

To perform this weighting, we propose a partly graphical grid analysis consisting of a simple double-entry table where we situate a selection of the indicators identified in the specific situation on the Y-axis and those elements that need to be taken in to account in our decision-making process on the X-axis. The latter elements will contain one aspect on the subject, one aspect on our care service and one aspect on our professional assessment. An example is shown in Table 3.Table 3.(At the end of the article)

In this example, we select three indicators defining the situation identified for a specific subject (Y-axis) as well as three criteria that could be useful to us in our decision-making process:

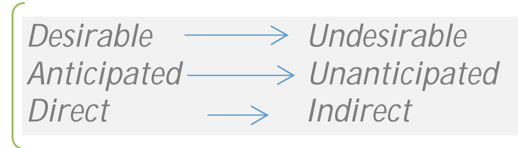
a. As a technical criterion, we select the magnitude, equivalent to the size, enormity and importance that we consider the indicator has, which is comparable with the extent to which that indicator is apparent in the specific situation.
b. As a criterion of the subject, we select the weighting according to whether he/she feels this need as his/her own, if he/she acknowledges it or if he/she is in agreement with it being worked on together.
c. As an organisational criterion, we select the resources available to our institution or community of reference, that is, whether we have resources available to include and combine in the work plan.

Thus, in a fictitious example, our diagnosis and decision-making would involve designing an intervention plan that gives priority first to redressing the subject's lack of resources, second to problems related to the subject's isolation and third to the subject's health problems. Diagnostic feedback (to both the subject and our institution) would include the reasoning for using these criteria, that is, an explanation would be given as to why a decision has been taken to work firstly on one of the identified indicators in particular.

Another technique that, in our view, should be incorporated into social diagnosis is SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis. Although traditionally applied to organisational analysis, we consider its application useful to social services support processes for a number of reasons: the simplicity of its approach; the ease with which it can be explained to the user; the opportunity it represents for the user to approach his/her situation in opposite terms (positive/negative, internal/external), thus allowing him/her to see his/her situation from two points of view; and the fact that it can be used to work with a user individually, as well as with his/her partner or a family group by performing several SWOT analyses simultaneously or consecutively (at different times). In short, we advocate its use for the joint assessment (professional-user) or self-assessment (family group) of a specific social and personal situation (Table 4). Table 4. (At the end of the article)

The use of SWOT analysis for diagnostic processes in social work may indeed seem novel or unconventional, but we consider it highly effective. Above all, it fosters a process of working *with* the subject and not *for* the subject.

In other words, it encourages not only the professional and the subject to work together towards a successful outcome, but also the subject – with his/her family group – to reflect freely on sorting and ordering his/her deficiencies/opportunities. Furthermore, the results enable new feedback to be had within the professional relationship along similar lines to those advocated by Perlman (1970), who reminds us that a diagnosis must implicitly include the user's participation for it to be considered as such. In fact, SWOT analysis is not very different from what Smale, Tuson and Statham (2000:128) refer to as "feedback and monitoring consequences of change", which they break down into:



This self-diagnosis can also be used in *empowerment* processes like those advocated by Labonté (1990) and Berger, McBreen and Rifkin (1996) for overcoming personal difficulties by delimiting and knowing one's own weaknesses; and for "understanding the presenting problem" as formulated by Goldstein and Noonan (1999), which is based on successive approaches to the subject's feelings and problems in order to subsequently explore his/her ability to overcome them.

In this respect, we also feel that it would be interesting to incorporate the use of the culturagram as a diagnostic methodology (Congress, 2008; Congress and Kung, 2013). The influx of migrants from other continents with more diverse socio cultural patterns is a relatively recent phenomenon in Spain (the latter third of the 20th century), though possibly more concentrated in time. Specific techniques had not, therefore, been developed within the social work sphere to compile this cultural diversity and incorporate it into its professional description and assessment processes. Thus, the culturagram allows a significant period of time to be covered in both the description and knowledge of a specific social situation. Therefore, for a social diagnosis to be considered complete, it must include these two elements: a procedure for including the subject's (user's) self-assessment and a procedure for combining the potentially available resources to initiate the intervention plan.

4. Final Remarks

Having reached this point, it would seem that, in Spain, progress has been made along the lines suggested by Mary Richmond in her day: the necessary systematisation of social diagnosis processes in order for social work to be considered really scientific, on a par with the incipient sciences that bloomed in the early 20th century (sociology, anthropology and psychology, among others).From our point of view, the methodology presented here has shaped greater scientific rigour in the assessment of needs: diagnostic processes have been standardised and progress has therefore been made with regard to the profession's systematisation; knowledge creation has developed because systematisation allows for a more in-depth examination of inference and deduction processes within the professional discipline and in the description of social situations for the rest of the scientific community.

It has also enabled diagnostic feedback to both the user and the interdisciplinary team. In other words, it helps both the subject/family group and the rest of the professional team to distinguish and value the specific diagnostic procedures that our discipline has available to it to make social assessments. We consider, therefore, that it is characterised by utmost seriousness and respect for the user, and that it allows the so frequently lambasted *subjectivity* of the social worker to be overcome because assessments are no longer based on the professional's intuition or perception. Likewise, it has involved a process of continuous learning and of enhancement of the verification instruments, and has also facilitated the drafting of reports and the final assessment.

We must undoubtedly continue along this path and benefit from its ripple effect. However, this enthusiasm should not divert our attention from the dangers that excessive standardisation of the process may entail. In our opinion, we must be careful not to fall into the trap of excessive mechanisation of the process, which would cause the professional to lose his/her leadership of the process and his/her capacity to develop an intervention that is suited to the specific characteristics of the family group; too many codifications, which would lead to the construction of contrived instruments that are neither very versatile nor manageable; and excessive quantification of needs, which would lead to a divergence from its quality precepts. We should not forget that ours is a profession of assistance, of work *by the side* of the user and not *opposite* him/her.

The technique (of professional intervention) in its own right is the culmination of a path that begins with the delimitation of basic values [Brill (1995), aforementioned in Berger, McBreenand Rifkin (1996:200)] the method is neither good nor bad, neither useful nor useless; it simply depends on the use that we can and want to make of it.

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Chart 1

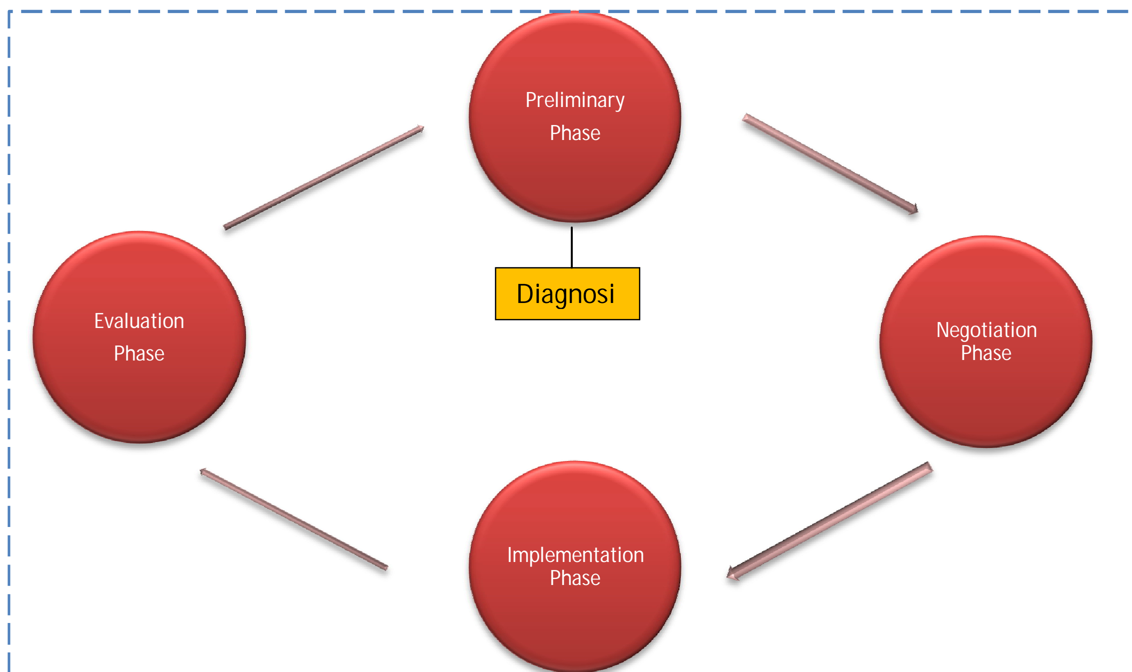

Chart 2

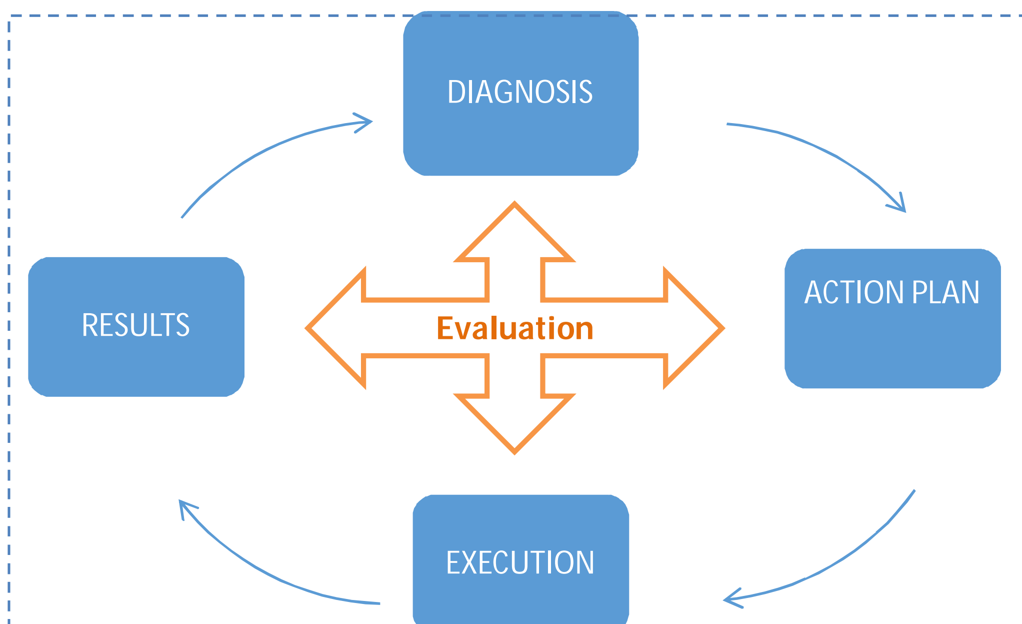

Table 1

BASIC NEEDS	DIAGNOSTIC CATEGORIES
A. INFORMATION B. SOCIAL SKILLS C. PHYSICAL AND MENTAL AUTONOMY D. COEXISTENTIAL RELATIONSHIP E. UNIT ORGANIZATION F. COEXISTENTIAL G. TRAINING H. WORK SITUATION I. FINANCIAL SITUATION J. RESIDENTIAL SITUATION K. SOCIAL PARTICIPATION L. SOCIAL ACEPTANCE	1. Cyclical deficit situation 2. Long deficit situation duration 3. Social disadvantage 4. Social exclusion 5.Exclusion

Table 2

Life Areas	**Dimensions**
Financial, occupational and residential	1. Financial situation 2. Occupational/Work situation 3. Residential situation
Coexistential	4. Accommodation and housing 5. Emotional bonds/relationships, bonds and receipt of social support for personal, family and primary and secondary coexistence 6. Relational, coexistential, personal and family situation 7. Organisation of daily life 8. Coexistential relationships in other contexts
Personal	9. Social competencies/skills 10. Upbringing, education, information and training 11. Vitality 12. Readiness to change – use of protection systems
Health and social health	13. Health situation 14. Incapacity to work, disability and dependence
Social	15. Social acceptance and coexistence 16. Adaptation to the social and normative environment relationship 17. Availability of social relationships 18. Social participation

Table 3

Criterion / **Indicator**	Magnitude	Acceptance subject	Resources Institution/Community
Insufficient Resources	-	+	+
Isolation	+	-	-
Health problems	-	-	+

Table 4

SWOT	POSITIVE	NEGATIVE
INTERNAL	STRENGTHS Aspects of the subject that may be used to deal with the situation	WEAKNESSES Aspects of the subject that may negatively affect the intervention plan
EXTERNAL	OPPORTUNITIES Situations within the context that may be used to deal with the problem	THREATS Situations external to the subject that negatively influence him/her and/or condition him/her