

A green social work perspective on social work during the time of Covid-19

Lena Dominelli

Department of Social Sciences, University of Stirling, United Kingdom of Great Britain and Northern Ireland

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Corresponding Author:

Prof. Lena Dominelli

Department of Social Sciences

University of Stirling

Colin Bell Building

Stirling FK94LA

United Kingdom of Great Britain and Northern Ireland

E-mail: lena.dominelli@stir.ac.uk

Abstract

Covid-19 has challenged social workers to engage with health pandemics and provide essential services in conditions of uncertainty and high risk. They have safeguarded children, older adults and diverse adults in 'at risk' groups under tough conditions mediated by digital technologies, adhered to government injunctions, maintained social and physical distancing under lockdown and worked from home remotely. Social workers and social care workers have risen to the challenges, providing services with inadequate personal protective equipment and limited supervision and support. This article highlights the degraded physical environments, socio-economic and political contexts that intensify precariousness and constraints that neoliberalism imposed on professional capacity before and during this health pandemic. It provides guidelines to protect practitioners and service users. It concludes that practitioners ought to understand zoonotic diseases, environmental concerns, acquire disaster expertise and training, widen their practice portfolio and value their contributions to this pandemic.

Key Practitioner Message: 1) Develop technological skills and innovate to support stressed individuals, safeguard children, adolescents and elders and deal with poverty and unemployment.

2) Use digital technologies involving peers to explore tricky situations, examine ethical dilemmas through scenario building exercises, and tips for self-care.

3) Contribute to environmental protections that prevent the spread of zoonotic diseases like Covid-19.

4) Seek supervision and support for disaster-based training from your line manager.

Introduction

The 2020 decade began with the arrival of a new coronavirus which caused the Covid-19 pandemic, a specific disaster that spread globally, having initially crossed the animal-human transmission barrier to infect people in Wuhan, China in December 2019. The transgression of this barrier and humanity's environmental impact, generally ignored in social work, should become a major interest in routine practice (Dominelli, 2012). Covid-19 numbers vary daily and those given should be used cautiously. By 10 October 2020, there were 37,313,888 confirmed cases, 1,075,358 deaths, and 28,012,697 recovered ones. The USA topped these figures with 7,920,729 confirmed cases and 218,936 deaths. India was second with 7,037,329 confirmed cases and 108,046 fatalities. Brazil followed with 5,073,483 confirmed cases and 150,023 deaths (www.worldmeters.info/coronavirus). Straightforward comparisons between countries are difficult because each country decides who to include and how to count casualties. Some counted only those who had tested positive for Covid-19 and died in hospital. Others included deaths attributed to Covid-19 whether these occurred in hospitals, establishments caring for older people, or communities. Others reformulated their strategic direction upon realising that the media ascribed controversial and negative interpretations to their figures, thereby making numbers political. For example, the British government, concerned about England having the highest number of confirmed Covid-19 deaths in Europe, changed its formula for calculating these on 12 August 2020 by reducing the number of days accorded to Covid-19 deaths from 60 days to 28, and overnight, the number of Covid-19 deaths was reduced by 5,377 (www.gov.uk). So, instead of 46,724 such deaths, it acknowledged only 41,357 (Duncan et al., 2020). Meanwhile, the Office for National Statistics claimed that by 31 July 2020 (reported on 8 August), England had 49,183 deaths attributed to Covid-19 (ONS, 2020).

Overall numbers will continue to increase for some time in both the Global North and Global South as new cases come to the fore. These include new clusters in Hong Kong,

Singapore and Vietnam which had previously successfully controlled Covid-19's spread; another spike in figures in France, Spain and Germany; and inclusion of unaccounted ones from rural areas in India, the USA, Africa and Latin America. Fear of second waves occurring in the Global North with the onset of winter and counting all those with Covid-19 symptoms regardless of setting once nations adopt more robust 'track and tracing' systems as has been practiced in Taiwan, South Korea, Hong Kong and Vietnam, exacerbates this trend. Others utilising 'Track and Trace' did not include people with Covid-19 symptoms in community settings dying without having been tested for it, even when carers had alleged that they had had its symptoms, for example, the UK.

This new coronavirus challenges scientists, virologists, health professionals, social care practitioners and undertakers alike. Knowledge about Covid-19 is inadequate, and humanity lacks immunity to it. Global susceptibility became evident as nation-states scrambled for a 'contain and control' strategy to reduce Covid-19's spread and 'flatten' the sharply rising curve of cases that threatened to overwhelm health services. The 'flattening the curve' strategy sought to buy time by reducing immediate demand for treatment so that ill-equipped health services could cope with those most seriously ill and for scientists to discover effective medical treatments and vaccines to eradicate it. Governments also sought to reduce transmission rates between people, by imposing social and physical distancing ranging from 1 to 2 metres depending on other mitigation measures in place exemplified by the compulsory wearing of masks, and social distancing from susceptible groups to prevent spread by asymptomatic or mildly ill people unknowingly carrying the coronavirus. This is referred to as the R ratio (reproduction rate or value, i.e., R_0), or the number of individuals one person carrying the virus would infect. Ideally, it should be well below one to control community, or person-to-person, transmission and 'flatten the curve'.

In January 2020, China initiated an immediate lockdown of 60 million people, a Covid-19 ‘contain and control’ strategy to ‘flatten the curve’ to enable medical personnel to respond to urgent Covid-19 cases in hospital. This strategy was later adopted in Italy, France, Spain and the UK upon realising that Covid-19 numbers would challenge the capacity of their health systems to cope as numerous people succumbed to the virus. Lockdown measures were not adopted in countries as diverse as Sweden, the USA and Brazil. However, social and physical distancing have joined the ‘new normal’ for a period in many countries to ‘flatten the curve’ and preserve medical capacity in the East, West, North and South. Globally, neoliberalism has been accompanied by an austerity that has substantially reduced spending on public sector services and undercut public medical sector capacity. In Africa, Latin America and South East Asia, structural adjustment programmes (SAP) imposed by the International Monetary Fund (IMF) and World Bank (WB) during the 1980s decimated public health provisions (Ruckert & Labonté, 2017). Thatcher and Regan popularised neoliberalism in the West by privatising publicly funded health and social care services (Dominelli & Hoogvelt, 1996; Isaković, 2020; Maynard, 2017). In Eastern European nation-states, neoliberalism replaced communist ideology as countries rebuilt after the fall of the Berlin Wall. In Latin America, except for Chile briefly under Allende, globalised neoliberalism drove government policies (Demmers et al., 2004). In Asia, China, India, Vietnam, Singapore, Malaysia, the Philippines and Indonesia adapted specific neoliberal policies (Wunderlich, 2009; Labaoa et al., 2018).

This article considers the challenges and opportunities that social workers encounter when devising new approaches to support people remotely while fulfilling their responsibilities to them. I conclude that the Covid-19 pandemic has a silver lining. Globally, social workers can endorse human rights in disaster interventions including health pandemics, undertake disaster training, lobby for funding to support the eradication of Covid-19 globally,

and ensure that every person has access to soap, water, health care, medicines, decent housing and well-paid sustainable environmentally friendly jobs and advocate for ecosystem-friendly development. Social work can reframe itself as an environmentally oriented, human-rights, social justice-led profession that behaves morally and ethically (Dominelli, 2012). I utilise a green social work (GSW) perspective to contextualise the zoonotic origins of Covid-19 in the environmental degradation caused by industrialisation including agribusiness, political and wider socio-economic developmental frameworks including public expenditure cuts (Johnson et al., 2020), and argue for social workers to take an active interest in this backdrop for the profession to contribute to the eradication of zoonotic diseases (Dominelli, 2012).

Structural considerations from a GSW perspective

The Anthropocene (age of humans) and climate change as the outcome of modernist industrialisation processes have been key drivers of environmental degradation, loss of biodiversity, environmental inequalities and human ill-health (Jafry et al., 2020). A GSW perspective underlines the importance of environmental protection to human well-being and argues that the profession adopts one to address disasters including health pandemics. This perspective promotes anti-oppressive approaches that encourage ethical behaviour, social and environmental justice and human rights in responses to Covid-19. A GSW perspective adopts a holistic, environment-friendly, transdisciplinary, relational and political power relations slant to the 'person-in-the-environment' to encompass both environmental and socio-economic, political contexts within which humans live and act (Dominelli, 2012). In destroying animal habitats, environmental degradation facilitates animal to human transmission of viruses, as occurred with SARS, MERS, H1N1 and Covid-19, and increases human susceptibility to future health pandemics (Johnson et al., 2020). Environmental degradation intensifies climate change, animal-human interactions and the likelihood of

coronaviruses passing from wildlife to people (Ye et al., 2020). Markets selling wild animals ranging from pangolins to snakes for human consumption exacerbate such trends, as does the monumental failure to tackle environmental issues including climate change globally.

GSW perspectives recognise national socio-economic contexts as locality specific, culturally relevant and nationally focused. National self-interest and sovereignty, major forces within the international order, have stymied attempts to find global political solutions to global eco-social problems, including climate change and this pandemic. Other problematic factors cover limited availability of personal protective equipment (PPE) and medicine within nation-states and globally, competition for these among diverse countries, neoliberal austerity policies, and nation-state unpreparedness for health pandemics. Nationalistic approaches to Covid-19 have undermined international solidarity and support for sufferers everywhere. Social workers can no longer ignore these realities. Adopting a GSW perspective encourages their speaking out against the exploitation of animals and ecosystems that support these and humanity.

The General Secretary of the United Nations (UN), António Guterres, asked nations to support one another through ‘solidarity, hope and a global coordinated response’. On 19 March 2020, he uttered these memorable words, ‘Our human family is stressed, and the social fabric is being torn. People are suffering, sick and scared’. He also proposed a *Response and Recovery Fund* of £1 billion for low- and middle-income countries to fight Covid-19. This important initiative is inadequate. Much more solidarity, money and working supply chains are required to meet demand for medical resources and handle this pandemic. Also, scientists need to harness their own knowledge and the production capacities of pharmaceutical companies, especially ‘Big Pharma’, to make whatever discoveries are forthcoming freely available everywhere. This is an ethical choice because the costs of

development have been largely underwritten by public purses (Matthews, 2020). Social workers can advocate for such measures.

Low-income people everywhere have been badly hit, making more resources necessary to meet local and international demands for the billions likely to be affected by illness, loss of livelihoods and changes in accustomed lifestyles. Substantial solidaristic funding has not materialised. Furthermore, it is extremely difficult for people living in fragile ecosystems with inadequate environmental policies, built infrastructures and public health systems to maintain frequent handwashing with soap and water and social/physical distancing of 2 metres. Following this advice is virtually impossible in global slums where medical services, sanitary systems and running water are scarce. Other differentiated adverse experiences of the coronavirus surface to reveal that black and minority ethnic groups (BMEs) in white majority countries such as the USA and UK are most likely to succumb to the coronavirus and die from the disease (Cook et al., 2020). For instance, in the UK, BMEs constitute 21% of all staff, forming 21% of nursing and 20% of support staff, and 44% of medical staff. BME deaths recorded for each category were 63, 64 and 95%, respectively. Men dominated the numbers of deaths among medical staff, while women were over-represented among nursing and support staff, the ranks where mainly women are employed. Additionally, within the UK, data have revealed that residents in disadvantaged areas are disproportionately represented among those affected by Covid-19. Existing inequalities have been magnified (Blundell et al., 2020). Globally, the poorest people are over-represented among sick and dead individuals in India, Brazil, Mexico, South Africa, Colombia, among others. Women, comprising 70% of poor people globally and primarily responsible for cleaning the home, fetching water and caring for sick, older people and children, are adversely affected by carrying the heaviest domestic load in such scenarios, often to the detriment of their own health. However, gender disaggregated statistics of confirmed Covid-

19 deaths collected by the Global Health 50/50 Campaign reveal a mixed picture: out of 44 countries that provided such figures in April, women formed more than 50% of cases in 19 of them. The gender ratio was 50-50 in 3 countries. Men formed the majority in 22 (<https://globalhealth5050.org/covid19/sex-disaggregated-data-tracker/>). By 06 October 2020, men dominated deaths in 63 countries (<https://globalhealth5050.org/the-sex-gender-and-covid-19-project/dataset/>).

My international experiences of supporting social workers remotely in diverse countries since early January 2020 indicate enormous variability in experiences and access to information (see www.iassw-aiets.org). Hence, I describe the key symptoms of Covid-19, impact on social workers and social care workers, and steps that social workers can undertake to assist the process of controlling this coronavirus.

Covid-19: a new disaster challenges the profession

What is Covid-19?

Social workers can distil medical information about Covid-19 into accessible forms to empower service users in protecting themselves and others. This new coronavirus, known as SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2), attacks the respiratory system. The International Committee on Taxonomy of Viruses called the disease this coronavirus produces, Covid-19. Its main symptoms are:

- Cough
- Fever over 38°Celsius
- Difficulty breathing (affecting the lungs).
- Loss of sense of smell and/or taste.

These symptoms occur together when a person has been in close contact with someone who has Covid-19 (close contact is remaining within 1–2 metres for 10 minutes or longer of a person carrying the virus), travelled to an infected area; acquired the virus from an infected person during the incubation period (when a person is unaware that they are carrying and spreading the virus), or touched Covid-19 contaminated materials in a laboratory, medical facility, office, public transport or home.

Social workers may become exposed to people carrying the coronavirus and contaminated surfaces/objects when visiting service users or assisting health professionals, making self-care and using PPE essential. Although poorly recognised in the traditional media, some social workers and social care workers have caught Covid-19 and died. They are widely mourned by those who benefitted from their care. Those who survive have an obligation to research and understand why they died. Many were women, and many were from black and minority ethnic communities. Learning from these developments is imperative in understanding Covid-19 and becoming better prepared for future health pandemics which may be lurking around the corner. Learning from past experiences, social workers and researchers can develop protocols, knowledge and practice skills to tackle better the next wave of the current pandemic. Enhancing capacity in the near-term and training volunteers as support workers enables them to assist overstretched practitioners. Forward planning can avoid PPE shortages. Social work academics and students can participate in practice with adequate PPE and/or lobby politicians to secure appropriate policies and resources for practitioners and the ecosystem. Practitioner preparation should include training in context-specific, environmentally embedded disaster interventions including health pandemics. Such training requires funding at qualifying, continuing professional development (CDP), specialist (Masters) and doctoral levels.

The World Health Organisation (WHO) declared Covid-19 a world pandemic on 11 March 2020. A pandemic refers to geographic spread, not the infectious capacity of a disease, and involves community transmission, i.e., person-to-person infection. Such transmission enables the coronavirus to spread widely and quickly, and if uncontrolled, it can overwhelm a nation's capacity to cope. Reducing person-to-person transmission, or 'flattening the curve', underpins the rationale behind lockdown, physical and social distancing and demands that people with mild symptoms self-isolate at home for 14 days. 'Flattening the curve' aims to keep the spread of the disease as low as possible to ensure that health professionals can cope with those requiring hospital treatment. The history of the virus in China shows that anyone may catch the coronavirus, but certain characteristics can affect individual susceptibility.

Early data in China, Italy, Spain and the UK indicate that: men are more likely than women to catch Covid-19; anyone with pre-existing conditions such as diabetes, respiratory problems, cancer, heart disease or obesity are more susceptible to catching the infection from those carrying the coronavirus, but not displaying symptoms; older people are more likely to die from the virus, especially if they have underlying conditions; young people are less susceptible and more likely to catch a mild version of the disease. In both the UK and USA, current data examining ethnicity suggest that people of BME origins are disproportionately represented in the statistics of confirmed cases and deaths, especially in the health professions (Cook et al., 2020). In the UK, the first nine doctors to die from Covid-19 were from Black and Asian ethnic groups, a trend now evident in social care (Blundell et al., 2020). Research is beginning to examine why this is the case, but cultural practices, (im)migration experiences, poverty, health inequalities and discrimination play key roles. At the beginning of the age spectrum, children and young people with mild symptoms may not know that they have the disease. 'Asymptomatic' people can accidentally spread Covid-19 to others through social interactions. Antibody tests are currently under development and being tested in

several countries, e.g., the UK, USA, China. Others such as Sweden are already using them. These determine whether a person has been recently infected by Covid-19 and may aid in identifying those with immunity to further waves of Covid-19, although some data suggest that antibodies for Covid-19 fade over time.

Another reason Covid-19 has spread so quickly is the lack of national medical and research capacity to deal with large numbers requiring testing and contact tracing for those testing positive; and treating and hospitalising serious cases straight away, for example, India and Brazil. Lack of capacity to meet these demands has produced attempts to ‘flatten the curve’ by controlling requests for medical services and PPE, restricting testing to health professionals and hospital workers and delaying elective hospital treatments in various countries including the UK and Canada (Nepogodiev, 2020). Lockdown is critical in ‘flattening the curve’. Countries, such as South Korea, Taiwan and Hong Kong, which responded by testing everyone, having extensive contact tracing, quarantining those with/suspected of carrying the virus and recommending that everyone used PPE, especially masks, had better outcomes than many countries, including the USA. Shortages of medical equipment, facilities and health personnel in the West can be attributed to the savage cuts foisted upon health and social care services under neoliberalism’s austerity measures (Maynard, 2017; Ruckert & Labonté, 2017).

Making comparisons over substantial periods of time is difficult because neoliberal restructurings and privatisation of health services have undermined universal provisions. In the UK, Thatcher began privatising NHS services, removing services deemed ‘unessential’ from NHS provision and increasing user charges for once free services in an ideological bid to ‘shrink the state’ (Maynard, 2017, p. 49). Neoliberal policies have reduced doctor, nurse and social worker numbers including trainees, and intensified reliance upon (im)migrant labour to reduce the shortfall (Sakellariou & Rotarou, 2017). Despite cash increases, health

budgets have been cut in real terms amid growing demand and rising inflation. This has caused growing numbers of hospital trusts to fail in meeting government targets, not repair deteriorating buildings, overspend their budgets and/or become bankrupt. This picture indicates system strain. Similar cuts were endured in social work and social care. Most cuts in the social care sector have affected women, further exploiting those that remained. For example, in 2010, local authorities funded 700,000 places for older people. This had dropped to 400,000 by 2016. Training cuts and bursary reductions have exacerbated shortages of health and social care professionals, as education became defined as a private commodity that individuals benefitted from and paid for, not a public good. Boris Johnson's government has promised to reverse some of these cuts. Covid-19 might help its realisation. The 2020 Budget did not offer social care additional emergency funds, but it could access funding from the local authorities' £1.6 billion Covid-19 response fund and £1.3 billion allocated to discharge patients from hospital beds. A silver lining might emanate from national populations questioning neoliberal nostrums by valuing the contributions that public service practitioners and civic ethics make to society, as indicated by the ritual clapping to thank NHS workers for caring for others and risking their health to do so. The UK government's motto, 'Stay At Home. Protect the NHS. Save Lives', asked people to favour the public good over the private good.

Lockdown, wherever it has occurred, has disadvantaged individuals on low incomes, those who are employed in precarious and/or essential, undervalued jobs or are homeless (see <https://www.iassw-aiets.org/covid-19-updates/>). Social workers engage with these groups, albeit contact now occurs mainly online, by phone or through social and physical distancing, adding additional layers of complexity to the job, especially when investigating concerns about child and/or elder abuse. In contrast to higher income, white collar professionals, those on low incomes may have no food, no home or live in overcrowded homes with limited sums

to cushion the demands of remaining indoors for lengthy periods. Social isolation, being left at home with abusers for days on end, are factors that exacerbate existing stresses among individuals and families. Service users who abuse alcohol and drugs may engage in intimate relationship violence; both behaviours increase during disaster situations (O'Neil, 2016; Parkinson & Zara, 2013; country reports at <https://www.iassw-aiets.org/covid-19-updates/>). Consequently, people are suffering from intimate partner violence, abuse and neglect, without being able to access services. Those suffering mental ill health and attempting suicide require various forms of psychosocial and practical support. Their needs are outside public consciousness and the services that they rely upon require further financial and practical resources. Social workers can highlight their needs because they know the hardships individuals endure from collecting their stories through technological information systems alongside face-to-face relationships.

The general populace's rejection of austerity during Covid-19 in diverse countries globally (Roy & Sinha, 2020) provides opportunities for social work to publicise its contributions to maintaining services during the pandemic. Remote working facilitates service provision including food, shelter, safeguarding children and adults, income generation schemes and emotional support without home visits in challenging circumstances. Practitioners have responded to this crisis with fewer home visits by utilising remote forms of digital communications such as smart phones, Facebook, Skype, Zoom. These technologies raise ethical dilemmas about action that is consistent with a human rights and social justice-based profession, given the uneven spread of digital technologies in communities, access to information, and practical support ranging from food to housing globally. Some practitioners are concerned about their reliance on risk assessments, knowing that information accessed remotely may be limited or difficult to interpret. Also, they lack confidence in their technological skills. In contrast, social workers in community settings, for example China,

have expanded their roles by participating in community development, public education, outreach to new service users, consciousness-raising, explaining the pandemic and what service users in communities can do when they lack access to ‘high tech’ means of communications. In several other countries, they have raised funds to purchase laptops and iPads for service users. Everywhere, practitioners worry about protecting themselves and their families (country reports on <https://www.iassw-aiets.org/covid-19-updates/>).

Responses to Covid-19 challenges

Covid-19 presents unprecedented circumstances, a constantly evolving situation, and contested responses that vary by nation-state, geography, political arrangements, socio-economic contexts and other factors. Many countries have faced shortages of health resources ranging from doctors to carers and disposable masks to ventilators and care beds. Inadequate resources have impacted testing and hospital bed availability even in emergency rooms and intensive care units. This has led to improvising, prioritising, targeting and restricting the use of protective gear to essential workers such as health professionals and those most vulnerable to the coronavirus or seriously ill (Sharma et al., 2020). This creates impossible ethical dilemmas for health and social care workers, who should not have to decide whose life is worth more when ventilators or hospital beds number less than the people requiring them. Medical equipment shortages had knock-on effects on residential care providers who had to care for people seriously ill with Covid-19 when lacking PPE, medical expertise and protocols to reduce the spread of Covid-19 within their walls. Such practices have resulted in more residents and workers in such homes succumbing to the coronavirus (Oliver, 2020; ONS, 2020; Samuel 2020; <http://www.iassw-aiets.org-covid-19-updates/>).

One innovation to address medical shortages was the construction of temporary hospitals and commandeering of hotels in China. In the UK, some ‘Nightingale’ hospitals,

built to solve bed shortages, have been mothballed as demand did not materialise. Concerns remain around fitness for purpose, location and format (dormitory accommodation). Could such facilities provide easily accessible venues of care for people seriously ill with Covid-19 in residential homes and communities who pose risks for other residents and care workers? Eventually, research data will show whether these facilities were *warehouses of death* or *life support machines*, notwithstanding the ‘labour of love’ that health professionals poured into patient care and social care workers into social care. Practitioners in Canada and Slovenia wondered whether numerous Covid-19 deaths in residential care and communities could have been avoided if medical resources, especially hospital beds had been available when and where needed (<https://www.iassw-aiets.org/covid-19-updates/>).

Many governments have urged healthy individuals not showing symptoms of Covid-19 to stay away from test sites and hospitals, especially emergency rooms, to protect resources for ill people and not waste time that health professionals require to assist seriously sick patients. Huge backlogs ensued globally as ‘non-essential’ (elective) treatments including chemotherapy were cancelled (Nepogodiev, 2020). These treatments are recommencing as lockdown restrictions ease but waiting times have increased substantially. Patients, unable to visit doctors’ surgeries, have had to consult experts by phone (often engaged) or online where the frequently asked questions rarely provided the reassurance or answers required.

Even when PPE has been available, social care workers have encountered various difficulties: inadequate PPE, PPE of poor quality, inadequate numbers of test kits, problems reaching test sites. Residents’ social isolation has been compounded by disallowing visitors, and some family members could not easily connect remotely. Other complexities have included the emotional turmoil caused by being unable to attend to loved ones near death or

participate in funerals celebrating life. Virtual attendance at deathbeds or graves has been no substitute for presence and touch.

Social workers found accessible self-care guidelines useful in addressing stress, especially when supplementing official health guidance. The following protective guidelines require contextualisation to become locality specific and culturally relevant:

- Self-isolate for 14 days to avoid spreading Covid-19 if you have been: exposed to affected areas; in contact with those having/suspected of having it; suspect you are carrying it, even if lacking overt symptoms; or confirmed positive, but not sick enough to warrant hospitalisation or other measures including mandatory quarantine.
- Wear protective clothing, including eye goggles, use disposable or sanitised reusable masks, coveralls and disposable gloves if offering services to people testing positive to protect them and yourself.
- Remove a mask with disposable gloves because the coronavirus can lie on both outer and inner surfaces.
- Maintain a diary, collect information to facilitate tracing contacts whom you may have infected if you are suspected of carrying the coronavirus or confirmed as having Covid-19.

Social workers respond to support health professionals and service users affected by Covid-19

Social workers' activities vary globally, ranging from one-to-one work to sustainable community development and expressed in the joint IASSW-IFSW definition of their tasks (www.iassw-aiets.org). Practitioners work within groups, families and communities, connecting people and resources. Alongside these activities, social workers in China tested people's temperatures and disinfected community buildings. Social workers require PPE and

physical and social distancing when engaging directly with service users. Social care workers can assist social workers to collect information for risk assessments, identify service user needs, and monitor access to domiciliary or other specialised services. Social workers, subject to national legislation outlining specific roles and responsibilities in a pandemic, must consult national legislation and guidance as these define specific tasks including safeguarding children and adults, reuniting families, mobilizing communities, and disinfecting community surroundings. For example, the UK's legislation includes the 2004 Civil Contingency Act, and the Coronavirus Act 2020. Social workers collectively resisted provisions in the latter that reduced the requirement to undertake home visits through the British Association of Social Workers (BASW).

In this pandemic, social workers' activities globally included:

- Referring people to other services, especially health care ones.
- Gatekeeping access to services, including scarce ones and explaining why rationing was necessary.
- Finding and mobilising resources at community level, supporting citizens' initiatives and reorganising existing socio-cultural projects and initiatives to make these 'corona-proof'.
- Maintaining the usability, accessibility and reliability of social services for users during lockdown.
- Promoting community public health education to explain how people can take care of themselves, their loved ones, communities, and physical environment and why.
- Addressing emotional needs, fear, anxiety, emotional reactions, distress, grief and insecurity among residents, colleagues and health care workers on both collective and personal levels.
- Facilitating access to counselling, psychosocial and mental health services.

- Helping people to identify how to keep themselves safe, especially when socially and physically distancing.
- Promoting solidarity and social justice within safe parameters including using PPE and maintaining 2 metres of physical distance when interacting with others.
- Advocating with and for people to ensure that social and environmental justice and human rights are respected.
- Lobbying politicians for local, national and international resources and using existing networks and organisations to ensure equality of access.
- Creating allies to support collective action for transformative structural and policy changes.
- Translating government policies to people in easy to understand language, especially for minorities like undocumented migrants.
- Supporting health professionals in doctors' surgeries.
- Supporting children in schools when open and at home when these are closed, using remote means to encourage small-group activities that avoid close contact and exposure to Covid-19.
- Supporting children to access food, essential goods and services, especially during school closures.
- Supporting adults to access food and other essential goods and services.
- Training, supporting and utilising volunteers appropriately.
- Being innovative and using technology to develop new games that families play remotely, e.g., 'Virtual Find the Object Hunt', and 'Hide and Seek' games.

The team/profession, not the individual, is responsible for performing the totality of these tasks. Social workers carrying out their duties must protect their own health and well-

being by using PPE and demanding regular debriefing and supervision, both peer and managerial. Peer support groups are useful in creating and role-playing Covid-19 scenarios that raise problematic issues that require resolution. Practitioners should ensure that peer support groups follow ground rules and provide safe spaces to discuss difficult issues and move forward.

Upholding ethical behaviour and human rights

IASSW's and IFSW's global ethical document (<https://www.iassw-aiets.org/wp-content/uploads/2015/10/Ethics-in-Social-Work-Statement-IFSW-IASSW-2004.pdf>) and country codes of ethics articulate social work's ethical principles. For example, India has city-specific ethical codes, not a national one. In the USA, the National Association of Social Workers (NASW) defines the ethical code. In the UK, national regulatory bodies and professional associations like BASW provide ethical guidance. Globally recognised ethical principles include:

- Doing no harm; not endangering others nor yourself.
- Supporting human rights, social and environmental justice and entitlements to services.
- Being locality specific and culturally relevant according to context, including a global pandemic.
- Taking self-care through social and physical distancing precautions; wearing PPE; resting.
- Listening actively and following through with appropriate action and/or explanations.
- Using the precautionary principle (causing least harm) when solving ethical dilemmas.
- Treating people with respect and dignity.
- Being kind and compassionate, using discretion within existing guidelines where appropriate.

- Reducing sources of fear by explaining issues clearly and simply and staying calm.
- Building individual, family and community resilience and strengths.
- Building individual, family and community connections, using digital technologies to overcome social isolation.

Ethical dilemmas occur when one ethical principle contradicts another. Ethical dilemmas range from practical to profound emotional concerns, creating emotional and mental distress. Whether to undertake a home visit to investigate safeguarding issues exemplifies a profound dilemma, requiring specific risk assessments and PPE availability. If the risk assessment suggests, 'do not visit', think of how remote discussions might work for the individual/family and what other sources of information might be accessed to corroborate this assessment, for example, neighbours, GPs, community nurses, community police.

Ethical dilemmas can produce heart-breaking moments when social workers: cannot deliver needed services; address precarity in people's lives, especially around safeguarding children from physical and/or sexual abuse and neglect; protect elders from financial abuse; alleviate poverty; ensure incomes and livelihoods; address grief and loss, including their own when service users, colleagues, family and friends succumb to Covid-19. Being unable to support people during moments of loneliness and isolation intensifies social workers' feelings of powerlessness and worries about possible next steps. Unremitting pressures of work, avalanches of guidance notices and inadequate staffing intensify such feelings and require collective action to achieve structural changes. Social workers draw upon generic skills to tackle issues, but Covid-19 compounds matters, posing complex dilemmas that lack easy solutions. At points of unbearable professional tension, peer support, scenario-building exercises, peer discussions, debriefing, including critical incident debriefing, all endorse de-stressing. Some social workers may experience post-traumatic stress and require psychosocial

support. Employers should be compassionate and understanding, and provide necessary support, including childcare and flexible working hours. Remote interventions create specific challenges for a profession rooted in face-to-face contact. Social and physical distancing can be experienced as disempowering, especially when niggling concerns about child safety cannot be allayed through remote technologies. Social workers feeling uncomfortable about visiting can discuss this with their peer group/line manager. Peer group support might yield innovative ideas for consideration. Line managers have a duty of care towards workers to address concerns and deliver services where possible. S/he can obtain advice further up the command chain. If there is a union, their officers may also help.

Social workers facing practical dilemmas seek innovative approaches to resolve them. In India, practitioners have founded NGOs to provide food and funds for migrants. The UK illustrates individual practitioners reaching into their pockets when families under lockdown awaiting Universal Benefit lack money for food and proprietary medicines such as paracetamol for adults and Calpol to reduce fever in children and local food banks no longer have food. Other options social workers explore when agencies lack resources or funds available for children 'in need' include lobbying local authorities to release some general Covid-19 funds, sharing their own food and asking volunteers working in charities to cover such needs, leaving items on the doorstep to maintain physical distancing. These responses can help individual families, but these situations highlight structural poverty which practitioners must solve differently. Eradicating poverty requires collective action involving professional associations, unions, and local officials lobbying politicians for structural change locally, nationally and internationally.

People who have funds may worry about supermarket shortages and hoard available supplies. Social workers can reassure people by highlighting that such activities are counterproductive because supply chains are more robust than individuals think. Allowing

supermarkets to replenish supplies by following normal routines is more likely to keep the shelves stocked and ensure that everyone has what they need. Limited space for storing food may cause its spoilage before use, produce mountains of food waste while people starve, and highlight distribution problems. Another concern is the lack of masks for personal use.

According to the precautionary principle, people can make cloth masks by having 3–6 layers together depending on the closeness of the weave, fit it to cover their mouth and nose, tie it at the back of the head or loop it around the ears, while leaving no gap around the nose, sides and chin. This mask must not be touched when worn. After removal with disposable gloves, it can be washed before reuse. Practitioners can exercise ingenuity to find solutions for unavailable items. Social workers can facilitate collaboration by reinforcing existing skills and strengths, building connectivities between people to innovate and reduce fears, using phones or digital technologies, coproduction and social and physical distancing.

Precautionary behaviours to protect yourself and others

Social workers become so involved in helping others that they forget to look after their own health and well-being. Self-care is critical to keeping well under Covid-19. Consequently, you should:

- Stay home if feeling ill. Discuss your situation with your line manager and obtain the best possible advice. Remember you might otherwise carry the coronavirus to vulnerable others without knowing it.
- Be prepared. Think through different scenarios with colleagues before meeting service users and take information leaflets with you.
- Wear protective clothing/PPE fit for your circumstances.
- Be vigilant and alert to social tensions when connecting to people remotely. People under stress are more likely to abuse others, become violent, aggressive or engage in substance

misuse. Ask probing questions and insist you talk to the child(ren) or older person(s) on your caseload. Ensure that they know how to contact you and which helplines, charities and volunteers can support them.

- Be aware that violence within intimate relationships can increase when people are stressed and living in confined spaces, causing domestic violence and child abuse to rise substantially.
- Look for signs of emotional, physical and sexual abuse which may become more prevalent among family members isolated within their homes. Children can become vulnerable to online abuse if left unsupervised while on their computer or smartphone.
- Look for signs of physical, sexual, emotional and financial abuse among older people.
- Be alert to signs of mental ill health. Individuals may become stressed with worry from many sources and coping badly. Reducing suicide rates requires engagement with appropriate services.
- Become aware of social isolation, not only among older people, but also families with young children, adolescents and adults confined to homes with limited space. Feeling isolated may intensify as the period under lockdown lengthens. What connections can you develop with them? Volunteers delivering items can say 'hello' from 2 metres away. Encouraging them to have a daily walk while keeping 2 metres distance from others might warrant a passer-by's smile. Suggesting they use Skype, Zoom, Facetime, Facebook and other means to chat to family, friends and neighbours online can reduce loneliness and maintain mental health. People have used remote means creatively to hold virtual coffee mornings, celebrate birthdays.
- Promote virtual connections to help deal with loss and grief. Online counselling has provided services to lonely people in remote areas.

- Respond sensitively to people who may be worried about their own, their children's, their family's or their community's futures. Community uncertainty may be heightened when job losses, pending unemployment and reduced incomes, are high.
- Think of activities, including digital ones, that those staying at home can undertake. Make sure that hands are washed before and after playing games, whether board games or computers, and keep physical and social distancing when playing them.
- People may have problems getting groceries, so take your thermos flask with you so that you can say you have/had a drink when invited to have one. Shopping might be an issue for some service users, so have adequately protected and trained volunteers to do this. If taking food into people's homes, make sure you use clean disposable gloves and dispose of them once you return to your car. A new pair should be used for each household. Keep hand sanitizers in your car for immediate use. Keep a bin bag handy. Disinfect your car routinely. Wash your hands with soap and water asap.

Conclusions

Covid-19, a new coronavirus, has precipitated entry to unknown and uncertain territory. Few Covid-19 guidelines have been tested and are precautionary rather than proven. In a crisis with unclear and ambiguous parameters, people fear the unknown and uncertainty. Social workers can empathise with such fears and encourage people to work to their strengths, seek support from others, reassure themselves, reduce anxieties and allay fears. Crises can release the best in practitioners. Social workers' crisis responses have turned this pandemic into opportunities for widening the practice portfolio, improvising, learning from and supporting each other, exploring lessons from overseas, and using reflective, critical and innovative capacities to assess insights, devise new solutions and enact mutual solidarity globally. Locally, through coproduction, innovations can be tailored to provide locality specific,

culturally relevant and environmentally friendly solutions. Working individually, and collectively through their unions and professional associations, social workers can lobby for transformative structural changes in the workplace and society, egalitarian policies and training. They can join social movements to argue for reductions in fossil fuel usage and care for the environment.

Social workers encourage caring for oneself and others. To this mix, GSW perspectives add protecting the biosphere and planet Earth, and challenging land misuse to avoid future pandemics. Working together, social workers can contribute to defeating Covid-19!

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