

Welcome to the third edition of volume 28 of your journal, and the first since the last Annual General Meeting of the Social Services Research Group. At that meeting, the implications of the current unprecedented cuts in public services due to the banking crisis were discussed. It became clear that SSRG would not be immune as local authorities try to save money. One important decision made at the AGM was to permit SSRG to produce the journal in an 'electronic only' format if necessary in future, and to reduce the number of editions from three per year to two. There are compelling reasons for this. The costs of postage have increased dramatically even though the costs of printing the journal have decreased. We may therefore be sending you future editions of the Journal in electronic format.

On a less sombre note, this edition of the journal includes five interesting papers and some lively book reviews. The papers variously reflect important themes of social exclusion and inequality, challenges in delivering cohesive local multi-agency services and the extent of research mindedness in social work culture in the UK.

Greenfields and Smith's paper focuses on the social exclusion of housed Gypsies and Travellers – people whose culture and identity is intimately connected to travelling but who are housed in 'bricks and mortar' accommodation. Their paper provides a powerful analysis of the consequences of what could be described as forced assimilation, which includes pervasive racism, both personal and institutional, as leading to multiple deprivation, and often to social dislocation, distress, depression and anxiety. As well as a cogent analysis, the authors present a series of practical recommendations and actions.

Grant's paper looks at the compulsory Work Focused Interviews for Incapacity Benefit claimants and the fear and distress caused to claimants. Her paper uses case studies to explore different impacts of these compulsory interviews on IB claimants.

Stock and Lambert consider the views of carers who have received a carers' assessment since the Carers Act of 2004. Their findings describe the difficulties and delays experienced by some carers in finding out about their entitlement to an assessment, and goes on to describe both benefits from being recognised as a carer but also problems encountered by carers in trying to work in partnership with professionals. A key finding of their paper is that carers often find their needs are not adequately met, and the authors call for a more holistic and personalised approach from agencies whose job is to support them.

Lots has been written over the last decade about the importance of research in improving the quality of social work practice and of the need for social workers and their managers to have some degree of 'research literacy'. **Webber and Salter's** paper reports on findings from an evaluation of a pilot online research training course for social workers. The authors' study is focused on the effectiveness of online versus classroom based approaches to the delivery of a short course intended to improve the ability of social worker participants to write a research proposal. Although based on small numbers, the authors report that e-learning may have potential in enhancing research capacity amongst social workers.

It's sometimes said that in public sector services, re-organisation is often a solution looking for a problem. In the final paper, **Ray Jones** offers a thoughtful and thought-provoking paper which reviews the impacts of successive attempts by governments over the last couple of decades to integrate health and social care. The paper makes the important point that continual re-organisations are disruptive and, far from bringing about more effective working relationships between health and social services, can frustrate attempts by these agencies to work more closely together at a local level.

John Woolham

A question of identity: the social exclusion of housed Gypsies and Travellers

Margaret Greenfields¹ and David Smith²

¹ Buckinghamshire New University

² Canterbury Christchurch University

Abstract

This article draws upon a series of survey-based and qualitative studies in the UK to examine the experiences of Gypsies and Travellers resident in 'bricks and mortar' accommodation. Many reported experiences of racial discrimination and being 'othered' by the surrounding population and by providers of public services. Despite sharing spatial proximity in often deprived locales of social housing, social relations with neighbours commonly displayed a notable degree of social distance. However, recourse to social networks which, in the absence of appropriate formal support mechanisms, provide important informal sources of support and a means of maintaining cultural identities helps to offset some of the difficulties associated with housing. Respondents frequently dwelt on the strength of their identity as a Gypsy/Traveller as a source of strength in a hostile environment and as a way of maintaining a boundary in relation to mainstream (sedentary) society, albeit often at the expense of developing close inter-ethnic/community relationships. Policy implications include the need for local authorities and other agencies to engage meaningfully with Gypsies and Travellers in housing, many of whom perceive themselves as 'officially' de-racialised once not living in caravans, and to recognise the particular difficulties experienced by many Gypsies and Travellers in housing.

Keywords: Gypsies, Travellers, housing, resilience, communities

Introduction

This article draws upon a series of studies conducted by the authors, examining the accommodation 'careers' and experiences of 'bricks and mortar' housing of Gypsies and Travellers. The article reports findings from a comparative qualitative study of housed Gypsy and Traveller communities in two localities of Southern England and also draws upon findings from three surveys of housed Gypsies and Travellers conducted in the same regions. These include a survey of 158 Gypsy and Traveller households (of whom 103 were living in conventional housing) commissioned by a social housing provider and two Gypsy, Traveller Accommodation (and other needs) Assessments (GTAAAs). Since the 2004 Housing Act, there has been a statutory requirement on local authorities to undertake GTAAAs, which require that a sample of housed Gypsies and Travellers are interviewed to ascertain their accommodation

preferences. (This arose as a result of campaigners lobbying the Department of Communities and Local Government to recognise that a high percentage of housed Gypsies and Travellers were resident in housing as a result of shortage of authorised sites and not through choice.) In total we have data mined 202 GTAA questionnaires relating to housed Gypsies and Travellers in the areas surrounding the two study locations.

Secondary analysis of GTAA data, was undertaken through examining responses to a number of pertinent GTAA questions which had been entered into large scale Excel datasets. Qualitative comments entered into open text-box questions embedded within the GTAA questionnaires and which had been entered into cross-referenced files were then explored to enable a picture to emerge of the demographic structure and accommodation preferences of housed Gypsy/Traveller families. Findings from the GTAA data are

broad-brush and confined to reasons for entering ‘bricks and mortar’ accommodation and statistical data on satisfaction levels with housing and percentages of respondents who have experienced discrimination or racism whilst housed. The findings from these surveys raised several neglected issues - high levels of prejudice and racism experienced by housed Gypsies and Travellers from their neighbours as well as from professionals and service providers; poor inter-community relations; a high proportion of respondents who were dissatisfied and unhappy in housing and the corollary of this: a significant number of informants reporting that they would move onto a caravan site if such accommodation was available. It was felt that these issues warranted further investigation and the two qualitative studies, which form the basis of this article, are unique in undertaking an in-depth consideration of the experiences of housed Gypsies and Travellers living predominantly in public sector accommodation. The qualitative studies explored a range of issues emerging from the surveys and consisted of depth interviews with housed Gypsies and Travellers focusing on routes into and attitudes towards living in ‘conventional’ accommodation; housing ‘careers’ and perceptions of the estates on which they lived; local, community relations; the methods utilised to retain a sense of community within a potentially hostile environment, and social relationships and areas of conflict with neighbours from other ethnic backgrounds. In addition, two focus groups were held (one in each study location) with individuals who had not previously been the subject of a depth interview (although they had in some cases participated in surveys). In one study area the participants were all young people aged 14 to 25, the majority of whom had spent their entire lives in housing, yet retained close links to ‘sited’ relatives. The other focus group consisted of 14 adults most of whom were resident in housing, including some who had relatively recently made the transfer from site or ‘roadside’ residence to conventional ‘bricks and mortar’ accommodation.

Data from the qualitative studies (depth interviews and focus groups) were transcribed from audio tapes and analysed manually using the ‘Framework’ system – an approach which enables the researcher to develop a hierarchical thematic framework used to classify and organise data according to key themes, concepts and emergent categories (Ritchie *et al.*, 2003).

This article presents findings from 37 in-depth qualitative interviews and two focus groups (consisting of a total of 25 participants) undertaken in two locations in Southern England. One of the qualitative studies was undertaken on a housing estate along the South Coast, which housed a large concentration of Gypsies and Travellers (Study Area One). A second comparative study was implemented in the South East of England (Study Area Two), in an area renowned for having a large Gypsy and Traveller population, to explore whether findings from Study Area One would be replicated or if regional variations in attitude to accommodation, socio-economic opportunity and community relations resulted in differing outcomes. In the two localities in Southern England reported in this article the majority of participants are Romany (English) Gypsies, with a small sample of Irish Travellers and New Travellers also included (Table 1).

Table 1 Ethnicity of respondents (Study Areas One and Two)

	Study Area One	Study Area Two
Sample Size	28	34
Ethnicity/Identity		
English Gypsy/Romany	17	32
Irish Traveller	1	-
New Traveller	8	-
Mixed/Other	2	2

It has been estimated that there are over 300,000 Gypsies and Travellers in the UK with as many as two-thirds resident in conventional housing (Clark & Greenfields, 2006). Whilst some have willingly entered housing (often for health/age related reasons) the pace of transfers into housing has increased in recent years due to the closing off of traditional stopping places, a shortage of pitches on council caravan sites, difficulties gaining planning permission to develop private sites and a legislative assault on nomadism, in particular the 1994 Criminal Justice Act (CRE, 2006; Crawley, 2004). The cultural impact of the transition from caravans to conventional accommodation on this sizeable 'hidden' population is profound.

The duty to enquire into the housing or site requirements of this population, contained in the Housing Act 2004, arose in response to increasing public disquiet over the growth of highly visible unauthorised caravan sites (both on self-owned land without planning permission and 'roadside'). Secondly, the policy focus on accommodation issues emerged as part of a wide-ranging Government review of Gypsy and Traveller issues which sought to establish whether long-standing anecdotal evidence of health and other social inequalities were borne out (Greenfields & Home, 2007). The genesis of this series of studies is thus intimately connected to the policy focus on Gypsies and Travellers in recent years and an increasing recognition by central and local government that housed Gypsies and Travellers have been effectively 'lost' within administrative statistics. For families who neither dwell in a caravan nor have school age children who are known to the Traveller Education Service, a lack of census or ethnic monitoring data means that many members of these communities have been essentially 'de-racialised' in terms of recognising their culture, ethnicity and support needs. Gypsies and Travellers have been included in the category of 'White British' or 'White Irish' whilst, in many ways, having profoundly different experiences from members of these majority populations. In particular, the extent

of racial discrimination to which they are subjected and the reluctance of statutory bodies to identify and respond to anti-Traveller prejudice (CRE, 2006; Richardson, 2007; Cemlyn *et al.*, 2009). Emerging evidence demonstrates that a transfer into housing does not lead to assimilation and a homogenised culture of 'white Britishness' but often creates as many (if different) problems for housed families as they experienced when 'on the roadside'.

It is against this background of sparse data and a lack of institutional awareness of the needs and experiences of these communities within local authorities and amongst service providers that the qualitative studies were undertaken. In a situation where choices are severely restricted in relation to accommodation preferences it is noteworthy that a high number of respondents reported reformulating, as far as possible, 'traditional' community life through activating networks of kin living in close proximity (see Greenfields & Smith, 2010). Co-residence with or amongst other Gypsies and Travellers provides a structured system of social support for families in transition or who are subject to racism and hostility within their neighbourhood. However, as Putnam (2000, p.23) notes, 'bonding' (or exclusive) social capital, while creating strong in-group loyalty, may simultaneously result in strong out-group antagonism. The unintended consequence of such 'clustering' may be that the development of 'bridging' (or inclusive) ties to the wider community is inhibited and pre-existing social and economic exclusions are compounded leading to the creation of closed 'parallel communities' (Cantle, 2005).

Gypsy and Traveller communities

Gypsies and Travellers are amongst the oldest and yet most invisible minority ethnic communities in Britain. Romany Gypsies, a people of Indic origin are first recorded as entering Britain in the early 16th century (Mayall, 2004). Since that time, and despite the enactment of frequently draconian legislation, the population has retained a

constant presence in Britain (Fraser, 1992). Until the early-mid 20th century the majority resided in tents or wagons and travelled for seasonal work, with many experiencing movement in and out of housing in response to employment opportunities, illness or weather conditions (Mayall, 1995). Historical evidence indicates the existence of significant populations of housed Gypsies/Travellers in London and other urban centres since at least the 19th century (Griffin, 2008). Irish Travellers are known to have travelled between Ireland and Britain as early as the mid 17th century with an increasing population making their homes in England and Wales (and to a lesser extent Scotland) from the late 19th century. Significant waves of Irish Travellers arrived in Britain in the 1950s associated with post-war employment opportunities and again from the 1990s in response to the introduction of severe legislative restrictions on nomadism in Ireland (Power, 2004).

New Travellers are not a distinct ethnic group but a loose-knit community of people who may have grown up in conventional accommodation but who have lived 'on the road' for a considerable period of time. Although popularly associated with 'alternative' and 'festival' movements from the 1980s onwards, an increasing percentage of New Travellers have been individuals who have left care or the armed forces or who are unable to find employment (Earle *et al.*, 1994; Greenfields, 1999; Webster & Millar, 2001). For some who were at risk of social exclusion during the major recessions of the 1980s-1990s, opting to become nomadic was identified as a more positive form of homelessness, offering the opportunity to undertake field labour and associated work whilst living cheaply and communally in vehicles. Although many have returned to conventional accommodation, a significant number were born 'on the road' and have parents and even grandparents who have followed the same way of life since the 1970s.

Over the past fifteen years Romany Gypsies and Irish Travellers (and since late 2008 indigenous Scottish Travellers) have been legally recognised as Minority Ethnic communities (CRE, 2006). Whilst 'ethnic' Gypsies and Travellers are, in theory, subject to (limited) protection from racism and discrimination under the Race Relations Acts, New Travellers are not included within this legislation.

The cultural impacts of residence in housing

It has been well established that residence on deprived housing estates can have a negative impact on members of all communities (Harker, 2006). However, particular concerns exist for the health and well-being of Gypsies and Travellers who have moved into such accommodation (Matthews, 2008). The cumulative effects of enforced settlement, low levels of literacy and a lack of familiarity with bureaucratic procedures associated with housing, separation from family members and a familiar cultural milieu and exposure to pervasive prejudice and racism from the wider society can lead to extreme distress and social dislocation (Cemlyn *et al.*, 2009). When combined with a deficit of institutional knowledge among public service professionals concerning the distinct cultural and support needs of housed Gypsies and Travellers, a form of 'cultural trauma' not dissimilar to that recorded amongst Aboriginal communities in Australia and First Nation peoples in North America may occur (Chandler & Lalonde, 1998; Alexander *et al.*, 2004). Indigenous communities who find themselves subject to oppression, racism and destruction of their community norms and way of life tend to experience heightened levels of substance abuse, suicide and self-harm and indications exist that amongst housed Gypsies and Travellers similar patterns are emerging (Tatz, 2004; Health Council of Canada, 2005; Richardson *et al.*, 2007; Cemlyn *et al.*, 2009). Parry *et al.*'s (2004) Department of Health funded research found that housed Gypsies and Travellers have the lowest health status of any other

BME group in the UK with particularly high rates of depression and anxiety.

Many of those interviewed felt that they had been forced into housing through a lack of alternative accommodation options and considered this as a racially motivated assault on their culture and lifestyle. One Romany Gypsy couple interviewed in Study Area Two, who had been housed for six years after failing to obtain planning permission on their own land, observed that “the councils make it nearly impossible to get planning permission and that’s because they don’t want us round here”. Despite official lip service paid to equality and diversity, survey and interview data indicates that many Gypsies and Travellers feel that a persistent and insidious institutional racism is directed towards them. Another man, who at the time of interview was fighting a legal battle to gain planning permission on land that he owned, pointed to discrimination in the planning process:

I’ll tell you the difference between us and you. You can put in for planning permission. You haven’t gotta say who you are. We put in for it, we’ve gotta put in as a Gypsy. Then, you’ve gotta turn round and prove that you are a Gypsy. Now you tell me if that happens anywhere else.

The reluctance to provide sufficient local authority caravan sites or to grant planning permission on private sites supports a commonly held view that the social status of Gypsies and Travellers has not improved alongside those of other ethnic minority groups, and that they are denied the rights and respect now given to other minorities. A female focus group member in Study Area Two who has been housed for over ten years commented that:

all the other groups in society are allowed to keep their way of life so why not us? I hate it here in this house but where can I go? There’s no pitch on the site and they won’t give us planning when we buy our own land.

In some localities in which the authors have worked, as many as 75% of housed respondents to GTAAs moved into ‘bricks and mortar’ due to site shortages and a lack of suitable alternative accommodation. The majority of housed Gypsies and Travellers surveyed for GTAAs are resident in public housing with many living in socially deprived localities, supporting evidence that many members of this community are frequently accommodated in ‘hard-to-let’ properties, or may deliberately transfer to ‘undesirable’ estates in order to reside in close proximity to relatives who already live there.

That a cultural aversion to housing exists among many Gypsies and Travellers is evident from several studies (Parry *et al.*, 2004; Power, 2004; Greenfields & Smith, 2010). Of 103 housed Gypsy and Traveller households surveyed for a social housing provider in the South East - whose tenants include a high proportion of Gypsies and Travellers - 45% would willingly give up their houses and return to life in a trailer or on site if this option was available (Smith, 2008). Cross-referencing whether respondents would return to living on site by length of time spent in housing revealed that the largest group who would remain in housing were those who have been housed for twenty years or more and considered themselves either too old or too accustomed to ‘bricks and mortar’ to return to living in a caravan:

when I was a bit younger probably, but I’m too old to be out on the roadside now.

My babies have all grown up in houses, it’s the only life they’ve ever known.

Sixty-five per cent of those who had lived in housing for between one and fifteen years reported that they would move onto a pitch on a caravan site if this was available. The most common reason mentioned by over half of respondents, was the alien nature of life in bricks and mortar: “I want to be in a trailer, it’s my way of life the way I was brought up”. Another respondent pointed to the impact of

enforced housing on the communal nature of Gypsy/Traveller culture, observing that:

we're all in houses now. It's not our way, it's scattered our people.

Over 10% of those who would move out reported disliking 'everything' about housing and of experiencing feelings of claustrophobia, insecurity and anxiety:

I feel shut in. I want to be in a mobile.

Another commented that:

I hate it. It's a house. It's not natural to us. (Smith, 2008, p.43)

A key factor shaping attitudes towards conventional housing is the proximity of other family members. Gypsy and Traveller communities have been noted throughout history for the kin-based nature of their culture and the move into housing has impacted on this traditional communal and kin-based social structure (Greenfields, 2006). In the survey discussed in the previous paragraph, separation from family and kin was the second most frequently cited reason for wishing to move out of housing and return to a site, accounting for almost 40% of responses. Participants in both our study localities made frequent reference to the psychological and social isolation that can result in the absence of kin and other Gypsies and Travellers. One Romany Gypsy woman who had been housed from the 'roadside' three years previously commented:

I'm among strangers here. I don't feel safe, there's no family nearby.

Another man, housed for three years in the South East noted that:

I don't like it (in housing). Miss the old days travelling with the family. ... I'd give up this house tomorrow if I could but they don't want Gypsies on the road no more.

Another woman, housed for over fifteen years complained that:

I've been stuck in this council house for so many years now and living in this house has ruined my life. I would have liked to live on a site with my family if there were any spaces.

It is, therefore, unsurprising that many housing placements for previously 'sited' or nomadic Gypsies and Travellers break down. Davies (1987) found that in the period 1981-1985 approximately 20% of Traveller families in housing returned to a nomadic way of life while other reports put the rate as high as 50% (DoE, 1986). Reports of tenancy breakdown regularly involve experiences of social isolation exacerbated by poor relationships with surrounding residents; 'racist harassment' or 'neighbour trouble'. Difficulties adjusting to housing are often compounded by the sense of being 'othered' by both neighbours and authority figures with whom respondents come into contact (discussed below). Studies have indicated that, compared to other ethnic minority groups, Gypsies and Travellers are more resigned to racial hostility and are less likely to report it to the police than other ethnic groups (Netto, 2006). This reflects a widespread belief, often based in personal experience, that complaints of racism will be ignored by local authorities, social landlords, schools and the police. One male commented during an interview that:

we have to put up with racist comments because nobody takes the complaints seriously but the gavvers (police) are always banging on our doors.

Another recalled that:

the people [are] always ready to call the police on me and they always come. If I call them about my neighbours' abuse or throwing stones at the window they never come.

Institutional racism and relations with officials

Gypsies and Travellers claim to receive an inferior standard of service in respect of health, education and in the criminal justice system compared to all other sections of society and research evidence supports this (Cemlyn *et al.*, 2009). Members of this community have the worst health profile and die younger than any other BME group (Parry *et al.*, 2004) while Gypsy and Traveller pupils have the worst school attendance rates, highest levels of exclusions and lowest proportion leaving school with five or more GCSE's at grade A*-C compared to all other minority groups (Derrington & Kendall, 2007). Evidence also indicates that Gypsies and Travellers receive discriminatory treatment in the criminal justice system, being more likely to receive custodial sentences and less likely to receive community sentences than other groups (Morran, 2001; Cemlyn *et al.*, 2009). Respondents frequently claimed that local authority and social housing officers were as hostile towards them as were their neighbours, offering them a poor-quality service and being reluctant to intervene when racist incidents occurred in the neighbourhood. A common perception exists that:

the government let the police and council discriminate against us from the day we're born. We're rejected because they don't want anything to do with us.

Consequently, many avoid dealings with non-Travellers, hold a strong mistrust of officials and may display defensively hostile behaviour that increases already poor relations between Gypsies and Travellers and officials (Parry *et al.*, 2004, pp.49-50).

In 2008 the homeless charity Shelter published a good practice guide to consulting with housed Gypsies and Travellers, noting that many hide their identity both from neighbours and local authority support workers (2008, p.12). While discussing social and community relations in a focus group

interview in Study Area Two, one English Gypsy who had been housed for six years acknowledged concealing his identity from his neighbours, adding that "they don't know so they're none the wiser and they won't point at me whenever anything goes missing or stop their lads playing with ours". The wife of a family housed for eight years after being evicted from a family owned plot of land commented that they were 'very happy' in housing, though adding that "we never get any trouble from the neighbours but they don't know we're Gypsies so that helps". In the following quote the respondent complains of experiencing double-discrimination, from housing officers initially and then from local residents:

they (housing officers) put you in the worse council estates that you could imagine 'cos they know you're as they say, 'the pikeys' (when) they know who you are you're instantly classed as the villains.

The complaints concerning hostile and discriminatory treatment from agencies and service providers highlight the need for trained Gypsy and Traveller liaison officers to assist members of this community, who may have poor literacy skills and find bureaucratic systems unfamiliar and alienating, to access services and provide an advocacy service for members of this community.

Community/neighbourhood relations

The enforced settlement of nomadic communities has brought them into close spatial proximity with other deprived and socially excluded populations who are increasingly concentrated into areas of social/local authority housing. Following disturbances in Oldham and other Northern towns in 2001, and a belated recognition that social relations between different social and ethnic groups are often non-existent, 'community cohesion' has received increasing governmental attention in recent years and has become a key policy objective (Cantle, 2001). The Denham Report (Home Office, 2001) identified a deficit of civic

identity or polarisation of shared values along racial, social class and cultural lines as key factors behind social and community segregation. Community cohesion, therefore, is an extension of the concept of multiculturalism and attempts to balance the increasing diversity and heterogeneity of communities with interaction between different groups and the nurturing of a sense of community and inclusiveness (Home Office, 2001).

The increasing settlement of formerly nomadic communities is resulting in a significant reformulation of social and community relations on many housing estates, especially in Southern England where Gypsies and Travellers have always constituted a significant minority population. In both our study locations, social relations between Gypsies and Travellers and their neighbours were generally marked by social and emotional distance and mutual (unspoken) agreement to retain social separation from their 'gorger' (non Gypsy) neighbours. A female Gypsy interviewed in one of the South East locations remarked on the lack of social contact between housed Gypsies and their neighbours:

people round here don't have much time for us because they think we Gypsies are dirty people. If only they knew.

A number of focus group participants reiterated that with respect to their neighbours they:

don't have much to do with them. Most just ignores us.

One participant reflected the experiences of many when she observed that:

I don't know many Travellers that mix outside their own community other than for work reasons. Usually we avoid each other.

Social separation is partly a response to the antagonism experienced (or anticipated) from

the wider society based upon widely held stereotypes associating Gypsies and Travellers with dirt, criminality and disorder (Turner, 2002). However, similar derogatory stereotypes concerning standards of hygiene, child-rearing practices and immorality are attributed by Gypsies and Travellers to their 'gorger' neighbours, further encouraging social distance and division. One woman commented "I can't stand the gorgers - most of them round here are filthy dirty and would argue over a penny piece because most of them are scag heads". Although the notion of 'parallel lives' featured prominently in the interviews and focus groups, such divisions revealed a clear social class dimension. Respondents differentiated between the established working class community and newcomers to the area. Despite criticisms of the type discussed above, all of which provided a stimulus to social separation, such divisions were not complete and social interaction with their neighbours did occur:

some gorgers is alright. If they're not stuck up and think they're too good to talk to us.

Mutual suspicion and avoidance was not always so prominent in relation to 'locals' alongside whom the Gypsy and Traveller community may have previously worked in seasonal agricultural and labouring work and with whom they have long lived in close proximity. A localised and intimate history of conflict *and* cooperation between the two groups has led to the recognition that there is "good and bad in all, Gypsy or gorger". One man noted that:

I live with mostly travellers, up the same road as me, but I live with gorgers as well. I get on quite well with them actually 'cos I've been brought up with them. I've known them all my life.

Rather, the trend of 'parallel communities' is more prominent among newcomers who are moving into new private housing developments. In Watts' (2009) study of a suburban private housing estate, he employs

the concepts of 'elective belonging' and 'middle class disaffiliation' to analyse how the middle classes concentrate in areas with people of their own class, spatially and socially excluding those who do not belong. His findings raise concerns regarding the value of 'social mixing' policies in reducing social segregation and the findings in this article contain similar implications:

A lot of it is because of outsiders moving into our community ... you've got Londoners moving in ... and all our locals, all the original old locals that we grew up with, the outsiders well their children have never had that opportunity to grow up together. All they've grown up with is these Londoners coming in and everyone else from up-country and cities, saying how bad we are. How do they know? They've never lived with us.

Housed Gypsy and Traveller communities

Given the importance of creating and sustaining a community network in response to policy-driven settlement and frequent local hostility, patterns of 'migration-networks' are emerging which parallel 'chain-migration' processes identified among other BME groups (Haug, 2008). In spite of the difficulties experienced by many housed Gypsies and Travellers, positive social relations and immersion in localised networks were also prominent themes. In both study areas the majority of housed Gypsies and Travellers were concentrated in particular neighbourhoods in relatively tight-knit cohesive communities, usually in areas with a long historical association with travelling communities due to seasonal employment opportunities and/or the location of traditional stopping places. Thus the concentration of housed Gypsy and Traveller communities appears to be the outcome of a combination of historical and more contemporary 'push' and 'pull' factors (Ratcliffe, 2009). The main 'push' factor is housing allocation processes: many were offered accommodation on certain 'hard-to-let' estates and found themselves living in proximity to others from their

community after the closure of local sites and stopping places. The main 'pull' factors are those associated with age, ill health or in order to gain access to education and services.

Gypsies and Travellers have been noted throughout history for their autonomy and tenacity in resisting assimilation (Gmelch, 1977; Fraser, 1992) and evidence indicates that, within a restricted range of accommodation options, members of this community are adapting to life in housing through the re-creation of social networks and an approximation to traditional Gypsy/Traveller cultures. Interviews with local authority and social landlord housing officers report that on certain estates in both localities the population comprised of up to 50% Gypsy and Traveller households with initial housing allocation failing to account for the size of the population. Where an established housed Gypsy/Traveller community exists second and subsequent generations often request accommodation on the same estates as their own parents and siblings. This tends to have a cumulative effect as other residents transfer out when a locality gains a reputation as a 'Gypsy area' (Clark & Greenfields, 2006). Social networks then circulate information concerning potential 'swaps' and traditional kin-based communities evolve through these informal channels. Such strategies result in increasing socio-spatial segregation and the maintenance of cultural boundaries as different sections of the community live separate lives in ethnic enclaves. As one focus group member commented:

As much as people try to separate Gypsies in housing in this area, they're wheeling and dealing to be in houses near their own families, so then you end up around this area with estates full of Travellers, and people don't understand why they want to be together. But it is that family network.

When questioned on what respondents liked about housing, the proximity of family members and other Gypsies and Travellers was the most frequently cited response:

I'm comfortable when I'm among my own. I've got family all over this estate and we're always in and out each others houses.

The impact of housing exchange, either informally or through mechanisms such as Choice Based Letting, also make possible a high level of mobility *within* housing. A study of Irish Travellers in London reported more mobility among those *in* housing than among those living in caravans as many were unable to settle and moved through a succession of housing between squatting on sites or on unauthorised encampments (Emmerson & Brodie, 2001). Similarly, in the housing association commissioned study, just under half of the housed sample of 103 Gypsy/Traveller households had moved at least once in the previous five years, including over 20% who had moved three times or more (Smith, 2008, p.19). A local authority housing officer interviewed as part of the study observed that the mutual exchange system underpins the development of housed Gypsy and Traveller communities and facilitates a degree of mobility within conventional housing:

they're moving around and using houses like wagons. The lifestyle doesn't stop just because they're in housing.

Conclusion

The findings reported here draw attention to both the positive and negative aspects of ethnic residential concentration. Clustering provides a structured system of support and protection:

the gorgers wouldn't dare give us any trouble round here. There's too many of us and we can take care of ourselves.

However, over-reliance on localised forms of 'bonding' social capital (Putnam, 2000) may also intensify existing forms of social and economic exclusion through hindering the development of wider 'bridging' ties to other sections of the community (Iddenden *et al.*,

2008). Procedures could be implemented in partnership with the Gypsy and Traveller community and relevant service providers through the establishment of forums to consider issues related to housing such as budgeting, sources of advice, advocacy and access to services. Indeed, such multi-agency mechanisms and dedicated Gypsy/Traveller liaison officers have already been established by some housing associations in recognition of the large numbers of housed Gypsies and Travellers in their properties, and these models of best practice could be implemented more widely.

Secondly, a proactive approach to tackling racism and harassment of this community, akin to the seriousness with which racism is taken when experienced by any other minority group, should be implemented by local authorities, social landlords, police, schools and race equality councils. Appropriate publicity material to encourage Gypsies and Travellers to report racist incidents should be introduced as well as formal monitoring of racist incidents. This should apply not only to racially motivated aggravation at the neighbourhood level but also to hostility and discrimination from local authority, housing and other 'officials' who deal with this community in their work. Many front-line workers may have internalised negative stereotypes of Gypsies and Travellers which will shape the manner in which they interact with this community in their work. This highlights the need for cultural awareness training and a more informed and knowledgeable approach to the history, culture and support needs of this group as well as an awareness of the difficulties experienced by many in housing, especially when housed for the first time and when separated from other family or community members.

Finally, it is worth noting that forcing a Gypsy or Traveller to live in '*bricks and mortar*' housing when they experience a strong '*cultural aversion*' to such accommodation has been recognised in law as not only having a devastating impact on well-

being and mental health but also being contrary to the Human Rights Act. In one leading case (*Clarke v SSETR [2002] JPL 552*, in Johnson & Willers, 2007) the Court of Appeal upheld the decision of the High Court Judge who at first instance found that refusing planning permission for a Gypsy site merely on the grounds that the applicant had been offered conventional housing was an error in law. In the Clarke case, the judge at first instance held that:

If [an immutable antipathy to conventional housing] be established then, in my judgment, bricks and mortar, if offered, are unsuitable, just as would be the offer of a rat infested barn. It would be contrary to Articles 8 and 14 to expect such a person to accept conventional housing and to hold it against him or her that he has not accepted it, or is not prepared to accept it, even as a last resort factor.

Whilst the Court of Appeal support for such an interpretation does not preclude local authorities offering conventional housing to homeless Gypsies and Travellers, the principle thus holds that an individual cannot be penalised for refusing such an offer.

Yet the findings presented here raise an even more fundamental question concerning the rationale behind effectively forcing Gypsies and Travellers into housing through a lack of alternative accommodation when many would prefer to live on a site. The provision of adequate sites is certainly a much cheaper option than the development of new housing stock and would, moreover, free up an already insufficient supply of social housing as recognised by many of the participants themselves:

why are they putting us into housing when we don't want to be there? Build us more sites and give our houses to those who need them.

Indeed, when asked how their local authority's services could be improved to meet their needs the most common response,

by over 60% of respondents, was to build sites for those who would like to be moved out of housing (Smith, 2008, p.62). Whether such a policy materialises depends on the depth of anti-Traveller prejudice in the media, local authorities and among councillors, and whether they adhere to a mistaken belief that housing Gypsies and Travellers will result in their assimilation. Certainly, historical and contemporary evidence points to the contrary. One focus group member was adamant that Gypsy/Traveller culture will survive and adapt despite the decline of nomadism:

it will never disappear, because my kids, all these little kids, and their kids - there'll still be Gypsy generations even 20 years down the line. When mine grow up they'll say 'my mum was a Gypsy'.

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Notes on Contributors

Margaret Greenfields has worked with Gypsy and Traveller communities in the UK for over twenty years. She initially trained as a lawyer with a particular interest in family and housing law before moving into the field of social policy. Margaret's PhD was undertaken into Gypsy and Traveller engagements with family law proceedings. In recent years she has undertaken commissioned work on behalf of the EHRC, worked with central and local government agencies and specialist charities engaged with Gypsies and Travellers and with community members involved in capacity building exercises. She is a founder member of the national charity Travellers Aid Trust and is currently employed as a Reader in Social Policy and Director of the Institute for Diversity Research at Buckinghamshire New University.

Email: Margaret.Greenfields@bucks.ac.uk

David Smith is a Senior Lecturer in Sociology and Social Sciences at Canterbury Christ Church University and has a particular interest in social exclusion, the social consequences of industrial and labour market restructuring and the impact of welfare reforms, in particular the development of 'social inclusion' policies. His PhD was an ethnographic study of social and economic change on a white working-class community in South London. This was later published by Policy Press ('On the Margins of Inclusion: Changing Labour Markets and Social Exclusion in London' (2005)) and won the Social Policy Association's 2006 award for 'Best New Publication'. More recently he has been pursuing a long standing interest in Gypsies and Travellers and has worked on several projects in this area including the *East Kent Gypsy Traveller Accommodation Assessment* with Jo Richardson and Margaret Greenfields.

Address for Correspondence

David Smith
Department of Applied Social Sciences
Canterbury Christ Church University
Canterbury
Kent
CT1 1QE

Email: david.smith@canterbury.ac.uk
Tel: 01227 782406

Fear, confusion and participation: Incapacity Benefit claimants and (compulsory) Work Focused Interviews

Aimee Grant

Cardiff University

Abstract

This article describes Incapacity Benefit (IB) claimants' experiences of attending compulsory Work Focused Interviews. It presents findings from a qualitative study which involved observation of Work Focused Interviews (referred to henceforth as 'Interviews') and the conduct of semi-structured interviews with IB claimants. In doing so, challenges in accessing vulnerable groups are described. The findings demonstrate that levels of fear regarding compulsory attendance at interviews were high, and that this could be exacerbated by earlier negative experiences of claiming benefits. The article also describes claimants' experiences of participating in Work Focused Activity, if any, before outlining attempts the claimants had made to move towards work. It concludes by considering implications for policy in light of the increased conditionality introduced by Employment and Support Allowance and the proposed changes by the Coalition Government.

Keywords: Incapacity Benefit, Pathways to Work, Welfare Reform

Introduction

During New Labour's 13 years in Government, welfare reform was high on the political agenda from the outset (Labour, 1997). However, it was not until 2002 that the long-term sick and disabled were also subject to conditions if they were to claim IB. The changes to IB were contained within the Green Paper, Pathways to Work (DWP, 2002). The Green Paper argued that support should be given to IB claimants because it was wrong for them to be denied the opportunity to work. Alongside this, the benefits for the (expanding) economy of increasing the availability of labour and the health benefits of work were noted. Briefly, the policy made attendance at Work Focused Interviews (Interviews), conducted by Jobcentre Plus Advisors, compulsory for new IB claimants¹ (DWP, 2002).

Many authors criticised the intent behind the policy and the likelihood of it achieving its objective of returning one million IB claimants to work (Grover & Piggott, 2007; Puttick, 2007). Furthermore, some disability

rights groups, whilst cautiously welcoming the support that was promised, had concerns about the possibility of claimants being persuaded to take up work that was not appropriate for them (see for example, National Autistic Society, 2002). However, Pathways was viewed less critically by some of the medical profession as a tool for making IB less attractive to claimants who, it was believed, were capable of working (Henderson *et al.*, 2005). Empirical research was conducted largely by those working on the DWP official evaluation (see, for example, Corden & Nice, 2006a; 2006b), which was conducted within the constraints defined by the DWP, and was largely published in-house, leaving the area under-explored in peer reviewed publications.

For claimants living in the pilot areas, attendance at Work Focused Interviews, conducted by Jobcentre Plus Personal Advisors, became compulsory. Non-attendance could result in benefit sanctions. As part of compulsory Interviews, claimants were offered a package of support known as the 'menu of choices', including work

experience training, which had always been available to IB claimants. However, two major changes occurred in the nature of this support. Firstly, avenues of financial support when seeking or entering work were increased. Secondly, the Condition Management Programme (CMP) was introduced. During the pilot period (2002-2007), CMP was delivered exclusively by the NHS, although this was widened in the roll-out period to include private providers. Within the pilot, NHS staff provided a bespoke service which aimed to increase the confidence of claimants; to help claimants understand their conditions; and to support claimants to return to a productive role. The service was delivered by qualified health care professionals such as occupational therapists and physiotherapists. Within the four Pathways to Work areas involved in the research, Jobcentre Plus and the NHS provided Pathways to Work in two areas, and Jobcentre Plus and Action for Employment (A4e), a private provider, delivered the package in the other two areas.

The paper will describe how IB claimants experienced their compulsory participation at Interviews. In doing so, the difficulties of accessing a group of vulnerable and frightened IB claimants will be outlined. The empirical findings of the research are split into four subsequent sections. Firstly, initial experiences of claiming benefits, where claimants were largely confused and frightened by the process. The second section will examine claimants' participation within Interviews with Jobcentre Plus Advisors. The use of non-participant observation alongside interviews with claimants allows differing experiences to be seen and highlights the continuing impact of fear for claimants. The final two sections discuss voluntary activity: participating in back to work programmes and returning to work.

Research design: methods and accessing IB claimants

The empirical findings discussed here were part of a PhD study on Incapacity Benefit

reform. The research began in 2007, alongside the enactment of the controversial Welfare Reform Act, which rolled out the Pathways to Work model nationally. The research adopted a qualitative mixed-methods approach to investigating 'how Pathways to Work was experienced by users'. The project involved five different groups of users: Jobcentre Plus Advisors, Condition Management Programme clinical staff, employers and two groups of IB claimants (engaged and unengaged). This approach was utilised to give as full an account of the changes to IB as possible. In this article, however, only the views of IB claimants will be given, as their experiences of having to comply with the policy change or face benefit sanctions were not experienced by the other groups. As such, the research here draws on the experiences of 21 IB claimants, as told through semi-structured interviews, and as viewed by the author through the observation of compulsory Interviews during a period of non-participant observation lasting one week. Claimants lived within seven different counties, covering four of the six Pathways to Work areas in Wales. All claimants are fully anonymised and identified by pseudonyms.

IB claimants who took part in the semi-structured interviews comprised of two groups based upon how they were accessed, either through their participation with Pathways to Work, or independently of their participation. First, claimants who were labelled as 'engaged' had attended compulsory Interviews with Jobcentre Plus, chosen to attend the Condition Management Programme's (CMP) initial assessment, and attended three further sessions with the CMP. At this point, claimants were asked by their clinician to participate in the research project. The second group of claimants were accessed in a very different way, in order to see if the experiences described by engaged claimants were the norm. It has long been documented that for those at the top and bottom of a society, there may be more reasons to be cautious about revealing personal information (Williams, 2004; Goldstein, 2002). Consequently, it was likely that attempting to

interview IB claimants about their experiences of claiming benefits and their health conditions, both of which are sensitive subjects, would be difficult. For this reason, the researcher aligned herself to organisations likely already to have won the trust of claimants by treating them with respect and promoting their rights.

Firstly, the customer service centres of two Housing Associations were chosen because of their neutrality in terms of the benefits system. This approach resulted in five semi-structured interviews with IB claimants, who had much more diverse experiences of Pathways to Work than the engaged claimants. When this source of claimants ceased to yield results, the researcher was able to use the Citizens Advice Bureau (CAB) as another gate-keeper and accessed a further six claimants. These claimants had all attended the CAB *because* of problems with their claim for IB, and thus it is likely that these cases are less typical of the average IB claimant than those who were accessed via Housing Associations. In total, 21 Interviews occurred with IB claimants. Of these, 12 occurred face-to-face; one engaged, and all 11 unengaged. The face-to-face interviews occurred in various surroundings: a claimant's home, private interview rooms and even a cupboard. All of the locations ensured complete privacy.

As a result of the wide geographical spread of the remaining engaged claimants, and the length of time it took to recruit the ten engaged participants, nine of the engaged claimants took part in a telephone interview. Whilst the majority of research on telephone interviewing has related its positive qualities to quantitative interviews (e.g. Shuy, 2001), Novick (2008) suggests that telephone interviewing can lead to greater sharing of sensitive information, because interviewees feel more relaxed. In the research, the use of telephone interviews did not appear to elicit less rich detail than during face-to-face interviews: interviews were comparable in length, and claimants shared detailed accounts of their lives. Consequently, the use

of both face-to-face interviews and telephone interviews can be seen as adding an interesting methodological dimension.

In addition to the interview data, 14 Interviews conducted by one Personal Advisor in one Jobcentre Plus office were observed over the course of a month. The office in which the observation occurred was more pleasant than other offices visited through the period of the research. Like the majority of Jobcentre Plus offices, the fieldwork office had door staff provided by a private security firm. However, unlike in some other offices, the door staff were very polite and courteous to claimants. Furthermore, whilst all offices were decorated in a similar style, with brightly coloured, attractive and comfortable furniture, the fieldwork office was one of the most spacious, allowing for greater privacy during Interviews. Throughout the observation period, of five full days, the author spent the entire day with the Advisor. However, with the exception of a lunch break each day, the entire period was spent at the Advisor's desk in the open-plan office. During Interviews, the claimant sat opposite the Advisor with a desk between them, and the researcher sat at the end of the desk, to convey as neutral a stance as possible. These Interviews covered a wide range of examples of Pathways to Work interviews, from first interviews, where the scheme is explained and claimants' fears are (hopefully) allayed, through to those who had been successful in finding work and were being offered financial support to ease their transition back into work. The observed Interviews also included one 'Partner Interview', where the non-working partners of those claiming IB must attend an interview, or their partner's benefit can be sanctioned. This is a further departure from previous income maintenance policies and an addition increase in conditionality.

Fear and confusion

Whilst this article relates to attendance at compulsory Interviews, and claimants were not asked to describe their experiences of

bureaucratic processes involved in applying for IB, or medical examinations to determine their eligibility, many interviewees discussed these early experiences at some length. These narratives were universally negative. Claimants found the process of applying for IB confusing and ‘frustrating’. There was a general ignorance surrounding the benefits that claimants might be entitled to, resulting in periods where claimants did not claim benefits and allowances to which they were entitled. The Personal Capability Assessment², the medical test which determined if applicants were incapacitated enough to be awarded IB, was described as humiliating and demeaning, and was also seen as inappropriate to determine incapacity. Furthermore, three of the 21 claimants had ‘failed’ the assessment but been too ill to be able to claim Jobseekers Allowance.

It is therefore unsurprising that, when claimants received letters in the post demanding their presence at the Jobcentre Plus Offices, ‘or your benefit can be sanctioned’, they were scared (Corden & Nice, 2006a; 2006b). Fears were related to being ‘forced’ into a return to work that claimants felt unprepared for. Levels of fear were higher among unengaged claimants, several of whom had had previous negative experiences of ‘the Job Centre’, in its many guises over the course of their working lives. In particular, those who had claimed benefits during the 1980s recalled the hostility of the Job Centre environment and the unpleasantness of their interactions with Benefits Agency staff. Although the Jobcentre Plus offices of today are a considerable improvement on the offices of the 1980s, many of the claimants had not had any reason to enter a Jobcentre Plus office for many years, and as such their negative perception of the environment, and the way in which they expected to be treated, as well as the policy intention continued. On the other hand, one unengaged claimant, Michelle, who was educated to degree level, felt confident that she would not be forced into work. However, this was more to do with acting

assertively towards her Advisor, rather than because she viewed the policy as benign:

I'm not worried, to be honest I'm not worried at all about any of it because I think it's all just a load of flam ... When they want me to (attend a Work Focused Interview), I'll be telling them to come to my house, I don't think people want to go out and discuss with strangers their medical ... I wouldn't go (to the Jobcentre Plus office).

Whilst the claimants’ experiences within the research were of high levels of initial fear, it should be noted that for some IB claimants, who did not take part in the research, levels of fear were even higher. Whilst conducting interviews in the CAB offices, a CAB Advisor provided advice on IB and Pathways to Work to a CAB client. It materialised that the claimant had been considering undertaking a part time college course, and sought information about how this might affect her benefits. After the advice session occurred, in a private room, the CAB Advisor walked the client back out to reception past where I was sitting with the other CAB Advisors. She was visibly upset, and apologised to me for not taking part in an Interview. The CAB Advisor commented that she was ‘terrified’ her benefits would be disallowed, which is why she had decided not to take her educational aspirations further, and why she felt she ‘couldn’t risk taking part in an interview’ for the research.

In addition to the fear already reported, many claimants did not understand why they were being asked to attend a Work Focused Interview, when they had been ‘signed off on the sick’, which to them meant they were legitimately exempt from working. In fact, one claimant who had claimed IB for 14 years, since he was aged 50, described himself as ‘medically retired’. The majority of the claimants also saw attaching conditions to receipt of their benefit as ‘not fair’. Within the 21 Interviews, almost every claimant described their legitimacy as an IB claimant, which amounted to having worked for the

majority of their lives and thus having paid in to the National Insurance system. Consequently, a change in policy, which was seen as disadvantageous to claimants, was seen as breaching the basic contributory covenant which an insurance-based policy represented. Several of these factors can be seen in the dialogue which occurred between myself, Ben (one of the unengaged claimants) and his mother, who also took part in the interview at Ben's request. Ben suffered severely with diabetes, necessitating regular stays in hospital, including a month long stay in the Intensive Care Unit prior to Ben's Interview:

Ben: Because I hate being on benefit.

Mum: He never have.

Ben: I left school at sixteen and ...

Mum: He worked ever since up until.

Ben: I done college, well I was working through college, doing apprenticeship through college and what have you and you know I've worked since sixteen and then to have this on me and not work is ... devastating to be honest with you ...

Mum: Yeah they threw him off.

Ben: And they took me off it and then after that I was just too ill ...

Mum: And our doctor said he wasn't fit enough you know.

Ben: My GP said you are not fit enough to work, there is no way you can go back to work. He said: "it'll kill you"

Mum: It's just not right what they're doing to the likes of him ...

Of the 21 interviewees, despite high internal resistance to attending an Interview, no one reported that they had failed to attend an Interview. Findings from the official evaluation show that 'Failure to Attend', as it is referred to by Jobcentre Plus, is a regular occurrence within the context of Pathways to Work (Dickens *et al.*, 2004), but also more generally across all Jobcentre Plus claimant groups (National Audit Office, 2006). This finding was supported during the observation period. Access had been negotiated to observe 21 Interviews, however, seven

interviewees 'Failed to Attend'. The Advisor who was conducting the interviews reported that this was not an unusually high number.

Experiences of Work Focused Interviews

During the fieldwork period, three initial Interviews were observed, representing the first time a claimant had been required to attend the Jobcentre Plus offices. During these, the Advisor always stressed:

I'm not here to force you to do anything, the only thing you have to do is come and see me, and you really do have to or your benefit might get stopped. But I'm not going to force you into work or anything that you don't feel ready for.

However, none of the claimants who participated in the research interviews recalled being given this information. This is not necessarily to suggest that their Advisors had not said something similar, but that such a statement might have been forgotten: claimants were given a large amount of information, they were frightened and they were distrustful of the system.

Within Interviews, there was a requirement for claimants to 'participate', which entails not only attending the Interview but also agreeing to an 'Action Plan'. The Action Plan contains steps that the claimant agrees to undertake including participating in Work Focused Activity (CPAG, 2009). This process is mandatory, Advisors have targets to meet in this area, and the drafting of an Action Plan occurred in all of the Interviews observed. The process, however, was not labelled or defined for claimants, who thus might not have understood that they were forming a binding contract. This is very different to the process involved in creating a Jobseekers Agreement, where Jobseekers Allowance claimants must sign their Agreement. Likewise, none of the claimants interviewed recalled creating an Action Plan, or being given a copy of their Action Plan. Such a finding illustrates the complex bureaucratic

process which is incomprehensible to many claimants.

As part of the menu of choices introduced by Pathways to Work, claimants were supposed to be offered one or more of a plethora of 'choices' by their Advisor, who was able to tailor this information to the claimant's circumstances. During the observation period, it was obvious that the Advisor knew the choices well, and was comfortable using them. Consequently, individualised support was offered to claimants. For example, a 43 year old man who had previously worked as a ceiling fitter, who was desperate to return to work as he was in danger of having his house repossessed, had been claiming IB for just over six months and was offered advice on the Permitted Work Rules. By participating in Permitted Work, the man would be allowed to work part time whilst claiming IB for up to a year in order to facilitate the transition back to full time work, whilst retaining the security of IB. Furthermore, the Advisor was able to offer the claimant the £40 a week Return to Work Credit, money towards buying tools from the Advisor Discretion Fund, and a Return to Work Grant of £200 (if he visited a 'job broker' - brokers were private companies who delivered some support towards returning to work).

On the other hand, claimants who presented as further from the labour market were offered advice on less work-focused choices such as the Condition Management Programme. The Advisor was a clear advocate of the policy, and told one claimant that she would attend herself if she was allowed to. In exceptional circumstances, the claimant's requirement to attend further Interviews could be waived. Whilst the Advisor in the observation period appeared to provide the most appropriate information based upon claimants' self-reported medical and work history, some of the claimants interviewed for the research felt that the (factually correct) information that they had been given about 'choices' available to them was inappropriate. For instance, one man, who regularly spent extended periods in

hospital, found it absurd that he had been told about the Return to Work Credit when he had been told by his consultant that a return to work might never be possible.

The research shows that many claimants were generally still fearful of the system, or did not understand why they were being offered 'support' to return to work when their GP had told them they were too sick to work. The complexity of the system, alongside media coverage which suggested that one third of IB claimants would be obliged to return to work (The Sun, 2008), did not help to alleviate this distrust. Furthermore, for claimants who were furthest from the labour market, the policy seemed punitive, unhelpful and inappropriate.

Participation in (voluntary) Work Focused Activity

Whilst Advisors in the study reported detailed consideration over which 'choice' to recommend to claimants³, the claimants themselves were generally unaware that there were different options. The ten engaged claimants were recruited from the Condition Management Programme (CMP), and as such, had all taken part in voluntary Work Focused Activity. For the engaged claimants, the decision to participate in the Programme could be related three factors; desperation, apathy or being allowed the space to make an informed decision.

Firstly, two claimants, both with anxiety-related conditions, were keen to 'try anything' in order to hasten their return to work. Jacob, a 26 year old man suffering with debilitating anxiety and panic attacks, had attempted to return to work under the Permitted Work Rules. When this had failed, as a result of increasingly severe symptoms, Jacob's Advisor was going to waive his requirement to attend a subsequent five Interviews. At this point, out of sheer desperation, Jacob stated that he asked if there was anything she could do to help. He then reported, '(the Advisor) said "Oh, we do... there's an NHS thing now..." So she explained it to me, she said "it's up to you,

you don't have to go for it...'. The second claimant was Rachel, a 46 year old woman who had been claiming IB for four years before deciding to volunteer to participate in Pathways to Work. She was the only claimant to participate in the research who was not mandated to attend Interviews. Rachel's experiences of Interviews and Work Focused Activity were the most positive of all of the claimants, because of her voluntary decision to engage at a time that felt most appropriate to her (Dickens *et al.*, 2004; NAO, 2010). The desperation to try anything shown by Jacob and Rachel is consistent with results found in the DWP official evaluation (see for example, Corden *et al.*, 2005).

The majority of claimants were apathetic about attending CMP. There was evidence that some thought participating in CMP might be of some benefit, based on an informal cost/benefit analysis. Whilst for some claimants, the benefits were related to trying what they thought of as a new treatment or appeasing their Advisor by "showing willing". For other claimants, a feeling that there was "nothing to lose" resulted in the decision that they would participate.

Finally, two claimants, both experiencing depression and anxiety, were initially reluctant to participate. Catherine was a 52 year old woman who had claimed IB for two years prior to the Interview, although she had been unable to work for much longer. When her Advisor suggested participating in the programme, Catherine was extremely reluctant. At this point, Catherine recounted, her Advisor suggested that she should discuss the situation with her GP. Once Catherine's GP suggested that 'anything' that could boost her confidence would be worthwhile, Catherine agreed to participate in CMP, although she was pessimistic about its potential effectiveness.

The only unengaged claimants who undertook Work Focused Activity reported a very different experience of being referred to the CMP. Having claimed IB uneventfully for 13 years, one day Jo's benefit was not paid

into her bank account. The DWP insisted that she had not completed a form that had been sent to her in the post, although Jo said she did not receive any correspondence from the DWP. Consequently, Jo began a new claim for Employment and Support Allowance (ESA), IB's successor⁴, and participated in Work Focused Interviews. Within one Interview, Jo stated that her Advisor 'just managed to sneak it into the conversation' that she would be seen by an occupational therapist at her next appointment. Jo believed that this was part of the medical test to determine her eligibility for benefits and participated because she felt she had to. Jo attended three CMP sessions before 'Failing to Attend' sessions she was expected to participate in. Whilst the engaged claimants generally reported positive experiences of CMP, Jo's experience was entirely negative and did not result in any improvements to her health. This shows the importance of allowing claimants to decide when they are ready to make steps towards returning to work:

And I said well I don't really want to (attend the Condition Management Programme) but being that I thought I was under threat ... that I was going to have my benefit stopped, that they were trying to get me to go back into work within a certain length of time. I agreed and I went ... So I didn't rate condition management at all, I just thought it was a load of old rubbish and I felt as if they were just, trying to say, well you passed all this, you are fit enough for work mentally and I knew I wasn't mentally fit for work so ...

Returning to work?

Within the Pathways to Work Green Paper, the intention to return one million IB claimants to work was made very clear. The policy change failed to have the radical effect hoped for, and the support aspects of Pathways to Work were found to have little effect in returning claimants to work (NAO, 2010). Within this study, two of the 21 claimants returned to work. Firstly, Mark, a

33 year old man who had suffered from depression following the breakdown of his marriage. Having decided, in a similar vein to Rachel, that it was time to return to work after eight months of claiming ESA, Mark, who was a builder, was able to find work with relative ease using local contacts. Subsequently, a friend mentioned the Return to Work Credit and Advisor Discretion Fund to him. These are the two elements of financial support available as part of Pathways to Work to facilitate a return to work. It is not unusual for those who return to work to be unaware of the existence of such support (Corden & Nice, 2006a; 2006b). Consequently, Mark visited his Advisor in the Jobcentre Plus office and then had to meet with a Job Broker to claim the Return to Work Credit. This process shows the way in which the bureaucracy operated was inflexible and that it did not work proactively to reward those who sought and obtained work on their own initiative. The ineffective publicity surrounding the Return to Work Credit can also be seen as failing to provide the incentive it was intended to (DWP, 2002) for those who might have been enticed to return to work by a financial incentive.

The other claimant who returned to work was Jacob, one of the engaged claimants who participated in the Condition Management Programme. Jacob was a 26 year old man who had claimed IB for 15 months as a result of severe anxiety and panic attacks which often left him completely incapacitated. After attending four one-to-one Condition Management Programme interventions with an occupational therapist, Jacob felt he was ready to return to work despite his occupational therapist's reservations. Jacob, who previously worked as a plasterer, retained a good relationship with his previous employer who was able to offer him a job. Accordingly he signed himself off IB and returned to work. However, Jacob experienced a worsening of his symptoms and, after two weeks, had to resign and rapidly reclaim IB.

Failed returns to work, or other productive roles, were experienced by two other IB claimants. Firstly, Joanne, a 49 year old ex-auxiliary nurse, who suffered with clinical depression and anxiety. Joanne had secured a position working in a care environment but in the weeks leading up to her start date, Joanne became increasingly depressed and anxious and, following a consultation with her GP, decided not to attempt the transition. Rebecca got slightly further than Joanne in her transition to voluntary employment. Rebecca was a 50 year old woman who had been employed in a variety of manual occupations throughout her life-course. Her last job, working as a catering assistant on a mobile burger van, had ended two years prior to the research, when she had injured her back. Following her engagement with CMP, Rebecca began working for a local charity shop. However, the job involved a lot of lifting and her back pain increased to an unmanageable level. Thus, Rebecca's return to work only lasted a matter of hours.

These cases show that even if IB claimants move into work, their conditions are still significant barriers to remaining in work. This is something that Pathways to Work and other statements of the Government's intent in this area failed to address sufficiently (see for example, PMSU, 2005).

Conclusions

Those who were claiming ESA were not a major part of the research, as most claimants encountered during the fieldwork were still claiming IB. This situation is proposed to change over the next few years through the Coalition Government's proposal for migration, via medical tests for all claimants. Within the two-tiered system introduced by ESA, those who are defined as less ill following their medical assessment will be required to not only participate in Interviews, but also to participate in work-based activity, or their level of Allowance will be decreased. It has been suggested that this can be seen as a major step towards full workfare (Bambra & Smith, 2010) and the policy change is also

to the financial detriment of many claimants (Grover & Piggott, 2010).

Whilst the New Labour Government described the use of increased conditionality as being essential to ensure equality of opportunity in the workplace for IB claimants (DWP, 2002), the Coalition Government has largely removed these discourses from the policy agenda (DWP, 2010). Whilst it has been argued that the policy intentions within Pathways to Work (DWP, 2002) and 21st Century Welfare (DWP, 2010) are very similar (Patrick, 2011), it is noteworthy that the discourses surrounding such policy agendas have changed. Consequently, the policy may become more punitive in the future in line with its new harder rationale.

It is still unknown how many people will be removed from either tier of ESA by the new Work Capability Assessments, although the BBC reported that (unpublished) Government research showed that almost one third of IB claimants were thought to be ready to move into work without the need for any support (BBC, 2011). The number will depend entirely on the strictness of the test, but reassessing all claimants has the potential to significantly reduce the numbers claiming ESA, in a way that the package of support offered by Pathways was unable to do (NAO, 2010). However, as IB claimants are largely concentrated in areas with high levels of unemployment (Beatty, 2010) it is likely that many will be unable to return to work, even if their health conditions would permit them to do so. Consequently, whilst these cases might be labelled as a success, with fewer people claiming IB, it is likely to have significant impacts in terms of poverty and stress, both of which can exacerbate many health conditions.

Footnotes

¹ It is not possible to provide a detailed outline of Pathways to Work. For a more comprehensive account, readers should consult Barnes & Hudson (2006).

² The Personal Capability Test was the test used from 1995-2007 to assess eligibility for IB, it was replaced in 2007 by the Work Capability Assessment, which determines eligibility for ESA, IB's successor.

³ Advisors' perspectives on Work Focused Interviews will be covered in a separate article.

⁴ ESA was introduced to replace IB by the Welfare Reform Act 2007, and divides the category of sick and disabled workers into those who are 'least able', who have no conditions attached to receipt of their Allowance, and those with 'more manageable conditions', who have to participate in Work Focused Activity or they will receive a lower rate of the Allowance (which is the same amount as Jobseekers Allowance).

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Notes on Contributor

Aimee Grant has recently completed her PhD thesis 'New Labour, Welfare Reform and Discretion: Pathways to Work for Incapacity Benefit claimants'. Her interests lie in income maintenance policies, poverty and social justice.

Address for Correspondence

Aimee Grant
School of Social Sciences
Cardiff University
1-3 Museum Place
Cardiff
CF10 3BD

Email: GrantA2@cardiff.ac.uk

Who cares wins? Carers' experiences of assessment since the introduction of the Carers (Equal Opportunities) Act 2004

Christine Stock and Susan Lambert

Centre for Innovative Ageing, College of Human and Health Sciences, Swansea University

Abstract

This paper examines the views of carers who have received a carer's assessment following the introduction of the Carers (Equal Opportunities) Act 2004. The Act ensured for the first time that a carer's desire to take part in paid work, education or training, and leisure opportunities was considered. Semi-structured interviews were undertaken with carers to illuminate their lived experiences. Six themes emerged from data analysis: finding out about entitlement to an assessment; gaining recognition as a carer; partnership working with service professionals; carers' awareness of support availability; desired outcomes; carers' unmet needs in relation to education, work and leisure. Some carers were knowledgeable about the support that was available to them and others were quite unaware. This affected their ability to access help in order to cope with their roles. Carers welcomed the opportunity to discuss their individual needs and wanted to be treated in a holistic way by practitioners. The complexities around partnership working with care organisations permeated several of these themes and thus carers' experiences may be defined as a 'wicked issue' requiring creative responses to the issues that concerned them. Solutions offered should be tailor-made and not delivered from a menu of 'what is available'.

Keywords: Informal carers, assessment, qualitative research

Introduction

This article investigates the experiences of working age carers who have undertaken a carer's needs assessment and explores whether legislation has had a positive effect on their ability to lead a life beyond their caring responsibilities. Currently there are around 5.2 million carers in the UK, including 4.4 million of working age (ONS, 2003). Fourteen per cent of working age women and 11% of working age men have caring responsibilities. Pakistani and Bangladeshi Asian men and women living in England and Wales are more likely to be carers than their White British or Black Caribbean counterparts (Buckner & Yeandle, 2005). The likelihood of becoming a carer increases with age, with most carers aged 45-64 years (Arksey *et al.*, 2005). Carers are not a homogenous group, they reflect the diversity of the wider society in which they live (Lloyd, 2006). However, they share a

sense of moral responsibility towards the person they care for (Baldwin & Twigg, 1991). They require support in order to maintain their own health and well-being.

Population projections show that the number of older people is due to grow as a proportion of the UK population. The latest projections show an 81% increase in people aged over 65 years from 9.3 to 16.8 million between 2000 and 2051. The population of over 85s is predicted to rise from 1.1 to 4 million and the 'elderly support ratio', the number of working-age people for those of pension age, is projected to fall from 3.3 in 2002 to 2.4 in the 2050s (Dini & Goldring, 2008). Thus, caring for older people is likely to be performed by a smaller segment of the adult population. The growth in the older population is due to increased birth rates, better survival rates, improvements in public health and socioeconomic factors. Nevertheless, people aged over 85 years are

more likely to experience mobility problems and poor health in later life and thus to increase demand for health and social care providers, as well as informal carers.

The 2004 Act extended the provisions for carers contained in two previous Acts of Parliament. The Carers (Recognition and Services) Act 1995 gave carers a statutory right to receive an assessment of their needs. This provision was largely rhetorical since entitlement to an assessment was not accompanied by a right to services to meet identified needs (Baggott, 2004). The Carers and Disabled Children Act 2000 extended the right to receive an assessment to the parents of disabled children and gave carers access to an assessment in their own right for the first time. Prior to this, carers' needs may have been assessed but only during an assessment of the cared for person. Official recognition of carers has taken much time and effort:

'Carers' did not exist as such prior to the development of the discourse of informal care in policy and other discursive domains. (Heaton, 1999, p.769)

Under the legislation, a carer is entitled to an assessment if they "provide or intend to provide a substantial amount of care on a regular basis" (Section 1, Carers (Recognition and Services) Act 1995). Implementation of carers' assessments continues to be patchy. For example, Keely and Clarke (2005), who surveyed 2,790 carers in England, found that 50% had not heard of assessment, a quarter had received an assessment and, of these, 14% said that the assessment had delivered a positive outcome. Carers provide practical and emotional support. As this reflects a regular pattern within family relationships, it is often difficult for carers and others to draw the line between *normal* family life and a *carer/cared for* relationship.

Assessment may highlight the lack of availability of appropriate services to meet carers' preferences. The Wales Carers' Alliance *Carers' Assessment Survey* (Bowen, 2004) found that 54% of carers refused the

support they were offered post-assessment because it was not what they wanted. On the other hand, help they wanted to improve their lives - such as respite care, training on the best ways to perform intimate tasks or advice to improve job prospects - was often not available.

Caring involves engagement with providers of health and social services (Nicholas, 2003). Responsibilities between informal care, statutory, private and voluntary providers should be shared, negotiated and re-negotiated. Arksey *et al.* (2000) stated that carers whose assessments did not lead to an ongoing relationship with service providers felt ambivalent about making contact again. This conflicts with policy imperatives to create person-centred initiatives to support carers' needs. A facilitative approach involving a 'carer as expert' model has been suggested by Nolan *et al.* (1996). Such a support model helps carers to sustain their caring relationships with the people they support. Practitioners who did not recognise carers' knowledge failed both the carer and the cared for person (Bucknall & Holmes, 2001). However, not all carers need or want to be seen as 'experts'. Some carers will gradually progress towards achieving the status of expert. Practitioners should consult carers at each stage of their caring careers as to whether they want to participate in decision-making and support those who wish to and not pressurise those who do not (Byrt & Dooher, 2003). Twigg and Atkin (1994) outlined a framework to investigate how service providers interface with carers which includes four models: carers as resources; carers as co-workers; carers as co-clients; and superseded carers. They suggested that service providers implicitly adopted one of these models, tending to see 'carers as resources' more often than not (Twigg & Atkin, 1994, p.13). Each model of support has consequences for the partnership formed with the carer.

Caring has both positive and negative effects on the well-being of carers. There may be:

- *Financial costs* due to reduced working opportunities and lower entitlement to pensions, transport and care costs;
- *Emotional costs* due to increased isolation and social exclusion, depression, time pressures, anxiety caused by supervising a vulnerable person full-time and stress caused by changing relationships, for example, from husband or wife to carer or cared for (Edelmann, 2000);
- *Health costs* due to lack of sleep, unmet personal health needs or injury caused by lifting an adult incorrectly. Carers are twice as likely to suffer poor health as those without caring responsibilities, 21% compared to 11% of the general population (Carers UK, 2004).

On the positive side there may be:

- *Emotional rewards* including gratitude and affection from the care recipient (Grant *et al.*, 1998), a sense of providing a worthwhile and meaningful service (Cohen *et al.*, 2002), the development of coping strategies to manage the day-to-day challenges of being a carer (Kinney *et al.*, 1995; Pakenham, 2005);
- *Social rewards* such as being seen as a 'good citizen', having a social identity as a carer (Graham, 1984) and being recognised as an expert in the care recipient's condition;
- *Financial rewards* including carers' benefits, access to subsidised transport and career opportunities using their caring skills.

The care sector is changing, with an emphasis on personalised provision based on individual needs and choices. Personalisation, including a strategic shift towards early intervention and prevention, will be the cornerstone of public services and will affect assessment and commissioning of services. Many people prefer to live in their own homes with informal and formal support and direct payments may sustain this. The government's aim is to transform social care and to increase

the take up of direct payments and to pilot the introduction of personal budgets (DH, 2006). The new system offers 'opportunities and threats' to providers and the social work profession including scarcity of funding and resources for care, together with cultural shifts towards a less profession-dominated system (Sawyer, 2008, p.41). Self-directed care should be focussed on the outcomes that service users and carers wish to achieve and the impact that services they prioritise will have on their lives.

Methods

The aim of this small-scale research was to undertake an in-depth study of carers in order to understand whether assessment led to improved access to work, leisure and education. Criteria for inclusion in the study were that carers had undertaken a carer's assessment in the previous six months and to be of working age. Written information and invitations to participate were sent to voluntary sector carer organisations in three local authority areas for distribution to carers. The sampling approach was therefore purposive (Patton, 2002) in order to recruit carers who would have in-depth, recent experience relevant to the aims of the study. Semi-structured, face-to-face interviews were undertaken with carers in their own homes, or at a carers' centre. Eight carers were approached by written invitation through the carer organisations and six agreed to participate. Interview questions were informed by the Social Care Institute for Excellence's practice guide to implementing the 2004 Act (SCIE, 2005) including:

- Availability of clear, published eligibility criteria and ease of access to an assessment;
- Provision of information to carers;
- Whether the assessment focussed on the desired outcomes of the carer;
- Identification of gaps in services and actions taken in partnership with carers to address these; and

- Awareness of and signposting to the multiple agencies involved in supporting caregivers and recipients.

Participants were also invited to discuss their own views and the topics they prioritised were given attention (Green & Brown, 2005). Qualitative research seeks to capture respondents' perspectives and experiences (Silverman, 2005).

Data management and analysis

Tape recordings of interviews were transcribed. Participants were offered copies of the tapes but all declined. Familiarity with the data was developed by reading and re-reading and data coding was undertaken manually (Lofland & Lofland, 1995; Coffey & Atkinson, 1996). A coding framework identified themes emerging from the data (Patton, 2002; Richards, 2005). Contradictory evidence and anomalies were searched for and noted (Silverman, 2001).

Ethical issues

Ethical approval was granted by the Swansea University School of Health Science Research Ethics Committee. Participants were given written information about the study and signed consent forms. Taped interviews and transcripts were anonymised and data that could identify participants were stored separately. Pseudonyms were used to protect participants' confidentiality. The researcher undertook a Criminal Records Bureau check.

Findings

Four women and two men took part in the study; they were all of White Welsh ethnicity which reflected the majority group of the local population - further research with minority ethnic groups is required to find out whether they have benefited from the 2004 Act. All carers requested additional services so that they could have more free time. Jane cared for her elderly mother, worked full-time and also had a young family. She had limited

support from family members and provided care 5 days a week. She wanted extra home care for her mother and emotional support from social services to persuade her mother to attend day care. Kath worked full-time, was undertaking a college course and had school-age children. Her elderly mother had moved in with her 12 months before because of increased frailty and ill-health. She had limited help from family members. The local authority provided a home help and she wanted a sitting service for her mother to give her more free time. Theo provided full-time care for his elderly father who had Alzheimer's disease. He had some support from a local church. He required day and night sitting services several days a week. Social services had suggested he contact gardening and shopping services but he could not afford the charges. Gary had given up paid work to become a full-time carer for his wife. Both his parents were also frail. Eve had three disabled children in their teens and early twenties. She did not work and her husband had given up employment to be a full-time carer. She had requested support with education and training for her children. Anne cared for her severely disabled daughter, with some support from her sister. She wanted paid carers for her daughter so that she could return to work when her daughter left school to attend day care. Anne, Gary and Theo were, or had been, treated for depression. All carers had been caring for at least one year and, in some cases, for many years before they received an assessment.

Five main themes emerged from analysis of interview data:

- Finding out about entitlement to an assessment;
- Gaining recognition as a carer;
- Partnership working with service professionals;
- Carers' awareness of support availability;
- Did the assessment meet carers' desired outcomes?;
- Carers' unmet needs in relation to education, work and leisure.

Finding out about entitlement to an assessment

The most common source of information about entitlement to an assessment came from voluntary sector carers' organisations or disease-specific charities. Nevertheless, information about assessments was not always clearly written, understandable or easy to access. Despite having had an assessment one carer still did not understand what entitlement to an assessment meant:

I learned about them through the autistic society, but I didn't understand what it meant. I still don't know exactly what it means. (Eve)

The best informed were two carers who had work-related links with social services but this source of contact did not necessarily lead to acceptable outcomes. Five out of six carers were assessed following a crisis situation, with only one of these five carers having an assessment soon after the crisis arose. Only one carer, who had cared for another elderly relative in the past, had her needs assessed at an early stage in her new caring role. Gary cared for his wife for six years and received a Department of Work and Pensions (DWP) carer's allowance before his needs were assessed by a social worker. He found the information he had been given confusing:

Carers Wales sent me a booklet, it was confusing really, lots and lots of information and I still didn't really know where to go, it was a bit too much. I wasn't aware I could have my own assessment until six weeks ago and I've been officially registered as a carer for six years.

His 'officially registered' status also highlights the lack of communication between agencies when carers' needs are identified. Despite having regular contact with primary and community mental health services over a five year period, Theo had not been told of his right to a carer's assessment:

I've looked after dad for five years and it wasn't until now that I found out I could have an assessment myself, it was the Carers' Centre who told me.

Carers' legislation advocates multidisciplinary working but there was little evidence of partnership working between health and social care in the experiences of this study's respondents. As most carers have regular contact with health services, this is a weakness in the current working of the 2004 Act and reflects the evidence provided by the Audit Commission of the lack of GP referral to social services (Audit Commission, 2004). However, some progress has been made since 1999 when Seddon (1999) found that local authorities adjusted eligibility for assessment according to the resources they had available. Since then, Seddon *et al.* (2008) have also reported that local authorities are taking a more consistent approach to eligibility for an assessment.

Gaining recognition as a carer

Carers reported that the assessment process confirmed their status and identity as carers. Carers did not always acknowledge the role they had 'slipped into' or believe they deserved the label 'regular and substantial carer', as these extracts illustrate:

It's the way you slide into it. I'd have humorous arguments with the Carers' Centre saying 'I'm not a regular and substantial carer, no, I'm not a carer.' (Jane)

Well, first of all he's my dad, he always will be, and he doesn't want to be like he is. It's very difficult but I don't complain. I try and cope the best I can without bothering people. (Theo)

Until they contacted their local authority social services departments, Jane and Theo were 'hidden carers' unacknowledged by health or social services. Those who had accepted the label of 'carer' voiced how they had come to identify with the role:

I'd taken on that duty. (Kath)

They're my kids. What else can I do?
(Eve)

Maybe I should have started asking sooner for help rather than wait until it got really to a head. (Gary)

Coming to terms with the label 'carer' may involve a complex re-evaluation of one's own identity and the impact of caring on the relationship with the care recipient (Henderson, 2001). Four carers appreciated the opportunity the assessment offered them to discuss their own needs with a professional, in contrast to discussing their relatives' needs with health and social care staff over many years:

What I wasn't expecting ... was how amazing, how wonderful it was just speaking to somebody for two hours about me, and how it was affecting me. (Jane)

The psychosocial benefits of having a carer's assessment are demonstrated by the value Jane placed on the recognition the assessment process gave her. She appreciated the exploration of her own needs and feelings. She valued 'being listened to' and the recognition of her work by social services.

Partnership working with service professionals

The results in this section explore carers' experiences of the process of negotiating an assessment with social services and provide feedback on services that were put in place following the assessment. Some carers expressing mixed feelings about relationships with the professionals they routinely came into contact with. Others found partnerships worked well - for example with health professionals - but barely worked in contacts with social care. Five out of six carers were frustrated by the length of time it took to secure an assessment. Four carers were able to access some services as a result of the assessment and two received no ongoing

support. Reasons social services gave for refusing support included lack of resources and a perception that the carer's needs were not high enough. None of the carers who received services as a result of the assessment were satisfied that their needs had been met. The following extracts demonstrate the range of experience of the carers interviewed. Initially, Eve telephoned the local authority adult services team to request an assessment but she was unsuccessful:

They said they couldn't do anything for me because he [her son] wasn't disabled enough so we ended up with the complaints officer. (Eve)

The local carers' support group advised her and she eventually secured an assessment for herself. Gary was also frustrated by delays:

Then social services when I rang them said, 'Oh, we'll get someone out tomorrow.' But then my wife was admitted to hospital so they then said that it will have to be done through the social worker at the hospital. That then took two weeks before I could get hold of anyone.

When his wife was admitted to hospital, Gary spent several weeks worrying about what would happen when his wife was discharged from hospital because of the lack of communication between social care and health. Partnership working around carers' needs has to be intra-agency (within social services departments) as well as inter-agency (between social services and health services). Shortcomings emerged in the approach to partnership working in Jane's case. Her mother's social worker knew that Jane was providing extensive care but did not recommend a carer's assessment for several years:

A lot of the discussion was with me so at the end the social worker went away knowing that I'd got two dependent children, I did have a partner, full-time job, I was cooking all my mother's meals, I was doing all of these various things for

her and was visiting at least three times a week and having her round at weekends and one wasn't offered.

The lack of recognition of Jane's needs demonstrates the ambivalence of some social workers towards carers' assessments. Statutory legislation may raise carers' hopes but does not guarantee entitlement to any service provision (Janlov *et al.*, 2006; Seddon *et al.*, 2006). This can leave social workers in an impossible situation. Jane felt overlooked during her mother's needs assessments:

And I think that because cases are then closed there isn't really anybody to go back to discuss it with.

Five out of six carers did not have a review of their needs following the initial assessment, leaving them feeling isolated and without a continuing relationship with a social worker. Eve was critical of the lack of ongoing support from social services to meet her needs, although she described her relationship with health professionals as excellent. Kath valued the assessment process itself but did not receive any services because of lack of availability of staff and funding. As a result, she made private arrangements with a care agency to sit with her daughter. Theo did not develop rapport with the social worker who assessed him:

I have grave doubts about the social worker that came to see me. She seemed to resent having to give me the assessment, it was as if she thought she had more important things to do, and I shouldn't be wasting her time.

Core to the concept of partnership is the idea of collaboration (Carnwell & Carson, 2005). Anne's experience of partnership working was successful. In her case, trust and understanding had been established between partners so that she was confident that the arrangements around her daughter's transition from education to day care would enable her to return to paid work.

Did the assessment meet carers' desired outcomes?

Just two of six carers (Anne and Jane) had their needs for practical support fully or partially met. Jane's requests had been partially met when her mother's needs were reassessed. However, the offer of a day care place was refused as transport and help to get ready was not available. Kath, Gary and Theo had been promised support but only when it became available. Eve despaired of receiving appropriate support to enable her to continue to care for her adult, autistic sons. The interview extracts in this section summarise the tensions around lack of flexible provision – the emphasis on 'what was available' rather than 'what carers needed' to enable them to improve the overall quality of their lives – and the conflict between meeting the needs of care givers and the cared for person:

It's so stressful babysitting my father twenty four hours a day, seven days a week ... if I don't get a break soon I don't know what will happen. Some of his friends from church call in and will sit with him for me to pop out. I need more time to be able to do little things like going to the dentist and the doctor's by myself, taking my father with me is very difficult. I hope he'll get on with the sitters they send.
(Theo)

Kath was promised the possibility of services in the future:

The outcome of the assessment was, when the staffing situation allowed there might be sitters.

In these examples, services are rationed that are available to others. Arksey (2002, p.15) termed this situation 'rationing by delay'. Eve was frustrated by delays in the assessment process and the lack of provision for autistic adults with social rather than health needs:

Up until now, I haven't had anything, I'm still waiting to hear months later.

On the other hand, Anne was content with the services put in place for her daughter as they were built around her work schedule. She looked forward to the opportunity to return to work while her daughter was cared for before, during and after day care attendance:

It was me having assistance for [daughter] really. I plan to go to work when she leaves school. Carers have got to put her on the bus to day services and then be here, to work around my schedule. We've started to introduce carers now in the mornings with [daughter]. It's worked really well. I am confident that everything is going to work out.

The interviews also revealed that, although carers like Anne welcomed support, they were also reluctant to give up some caring tasks. Anne bathed and changed her daughter, even though it was difficult for her to manage single-handed. In this way, Anne was self-rationing the care package available to her regardless of the impact on her own health (Arksey, 2002).

Carers' unmet needs in relation to education, work and leisure

A common experience reported by carers was that their assessments focussed more on the needs of the cared for person than themselves. Some carers agreed that their primary motivation was to obtain services for the person they cared for in order that their participation in work, education or leisure was not jeopardised, in the cases of Kath or Jane, or to give them opportunities denied to them in the examples of the other carers. The interviews revealed the practical and emotional support required by carers. Even though the main reason for an assessment may have been to ask for practical support with caring tasks, carers felt let down if the assessment did not enable them to express their felt needs for emotional competence to deal with the demands of caring (Twigg & Atkin, 1994). These were needs they struggled to express explicitly. For example,

Jane wanted emotional support to help her negotiate her caring role with her mother:

But there was never, there was no suggestion of sort of, I mean I know there's issues with time, but with going back to my mother and in a nice way saying 'Well, you know, I really think it would be worth your while going to day-care for an extra day, now I know it might be a bit of a burden to your daughter to take you but you know £10 a week [for her mother to pay for a taxi to attend day care rather than relying on her daughter to take her] isn't a lot and we'll find someone else that can share it'. There was no possibility of negotiation which was what I would, that's what I would have liked most.

The demands on Kath's time were many so she could not always plan when she needed additional help and would have liked a flexible sitting service rather than the fixed one that was available. Her concerns to have a service in place to meet her mother's needs for dignity and personal cleanliness when she was not available were not therefore met. Soothill *et al.* (2001) found that carers with unmet needs were more likely to be in poorer health themselves. None of the carers were offered Direct Payments that may have enabled them to purchase tailor-made packages of care.

Discussion

Carers' needs display all the characteristics of a 'wicked issue' (Clarke & Stewart, 2000, p.377): they are messy, there are lots of issues combining to create a milieu impossible to navigate through in a classical, linear problem-solving mode. As Scourfield (2005) argues the relationship between practitioners and carers is 'problematic' with conflicting areas of confusion and ambiguity. Practitioners work in a 'maelstrom of competing discourses' including users' and carers' rights, abuse and efficiency, in times when resources are stretched to the limit (p.26). Solutions to perceived needs require a combination of imagination and service

provision. Suggestions to resolve carers' problems may have unforeseen outcomes, for example, a request for respite care may offer a break to the carer but can be seen as a threat to independence by the cared for person. In the experiences of carers interviewed in this study, no attempts were made to be creative with services to accommodate carers' requirements or to pursue the option of Direct Payments in order to provide a responsive solution. Stainton and Boyce (2002) found that family carers could benefit from the flexibility Direct Payments offered but this option has yet to be fully embraced by all Welsh local authorities. Innovative solutions do not necessarily need to cost more than existing services and working closely with voluntary sector agencies may offer opportunities for more creative results to be delivered.

In order to tackle 'wicked issues', thinking around carers' problems needs to be holistic and not cemented in old, linear patterns. Practitioners need to search for new ways of seeing issues as complex interactions that require new approaches to solving problems. All participants in assessments should be willing to learn, to take risks, and to challenge the status quo. Partial responses, from single agencies like social services, can lead to limited success, total failure or the creation of other problems arising from the unforeseen consequences of actions taken. A holistic approach is required that leads to the forging of partnerships between carers, the people they care for, employers, health, education and social services. The whole system should work seamlessly together if carers are to become fully socially included. The implication for social services departments is the necessity to facilitate partnerships with other agencies, with carers and care recipients at the heart of discussions and developments.

Conclusions

One of the requirements of carers' assessments, since the introduction of the Carers (Equal Opportunities) Act 2004, is to recognise carers' desires to take part in paid

work, education or training, and leisure activities. In practice, carers may not identify strongly with these aspirations but, when they do, their expectations are modest. Carers often subordinate their own needs, giving primacy to the needs of the cared for person, even though this adds to their stress. Carers identified the lack of emotional and psychosocial support available to them and were aware of the destructive effect this had on their own health and well-being. The practical support offered to them did not always meet their requirements.

Being assessed gives the carer an opportunity to discuss their hopes, wishes and fears for the future (Arksey, 2002). The carer's assessment validates the work that the carers do, according them social recognition. The findings of this study suggest that there is room for improvement in the provision of information to carers about carers' assessments. Primary care staff could provide a useful signposting service to carers well before they reach crisis point. The Carers (Equal Opportunities) Act encourages local authorities to work jointly with other statutory agencies.

Where carers have complex support needs, a more holistic and creative approach is necessary to address the 'wicked' nature of their concerns. Trying to fit carers into the existing service provision framework may be frustrating and unproductive. Direct Payments are an option to give carers more autonomy and the opportunity to participate in society through work, education, training and leisure activities on an equitable basis (Stainton & Boyce, 2002). More work is needed to identify innovative solutions to the needs of carers with the cooperation of carers themselves.

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Notes on Contributors

Christine Stock is based in the Centre for Innovative Ageing at Swansea University. She is the part-time coordinator of the Older People and Ageing Research and Development Network (OPAN) and a PhD student. She is currently researching the views of stroke survivors and carers on secondary prevention of stroke.

Susan Lambert is also based in the Centre for Innovative Ageing at Swansea University, is Co Director of OPAN and a part-time lecturer with a long-standing interest in policy around ageing and older people.

Address for Correspondence

Christine Stock
Centre for Innovative Ageing
Floor 3 Vivian Tower
Swansea University
Singleton Park
Swansea
SA2 8PP

Email: c.stock@swansea.ac.uk

Gearing practitioners up for research: evaluation of a pilot online research training course for social workers

Martin Webber and Laura Currin Salter

Institute of Psychiatry, King's College London

Abstract

There is a vicious circle of resistance to developing research capacity in social work. Practitioners receive minimal research methods teaching on qualifying programmes which contributes to a low value being placed upon research skills within social work agencies. There are few opportunities to acquire these skills on post-qualifying social work programmes which means that practitioners who go on to become educators possess limited research expertise, thus perpetuating the problem. Increasing the research competence of practitioners may be one way to transform this circle into a virtuous one. We developed two e-learning courses to increase the research literacy of social work practitioners and this paper evaluates a pilot of the second of these, a research protocol writing short course. We compared an e-learning group (n=6) with a classroom group (n=12) using mixed methods. In this pilot, e-learning appeared to be just as effective as providing this training within an advanced-level PQ programme. This suggests that e-learning may have some potential to enhance research capacity amongst social work practitioners.

Keywords: Practitioner research, research capacity, social work education, research protocol writing

Introduction

There is a well-documented lack of research capacity in social work in the UK (Joint University Council Social Work Education Committee, 2006). Factors contributing to this problem include a lack of resources (Marsh & Fisher, 2005), a lack of research skills in the profession (Orme & Powell, 2008), difficulties in defining itself as a separate academic research discipline (Shaw & Norton, 2008) and a low public profile (Joint University Council Social Work Education Committee, 2006).

Orme and Powell (2008) have identified a 'circle of resistance' to developing research capacity in social work. Practitioners receive minimal research methods teaching on social work qualifying programmes due to the demands of learning practice skills. This contributes to a low value being placed upon research skills within social work agencies. As employers play a leading role in shaping

post-qualifying (PQ) curricula (General Social Care Council, 2005), this negatively impacts on the opportunity to include research methods teaching within PQ programmes. Social work practitioners who go on to become social work educators possess limited research expertise, particularly in quantitative methods (Economic and Social Research Council, 2006), thus perpetuating the problem.

A potential way of transforming this vicious circle into a virtuous one is to support the development of practitioner researchers who can promote research mindedness within their agencies and provide a pool of social work educators of the future. Practitioner research is typically employer-led, applied to social work practice and ideally produces results that are directly relevant for practice (Shaw, 2005). Practice-based research can provide data not only on the social problems that practitioners are attempting to address, but also on the actions they take in the course of

their work, helping to make it an efficient means of generating new knowledge (Marsh & Fisher, 2008). Additionally, good practitioner research reveals ‘tacit knowledge’ that is held by practitioners but not otherwise revealed in formal statements or discovered by academic research (Shaw, 2005).

Shaw (2005) has estimated that there are more social work practitioner researchers than academic researchers, but their work is mostly small-scale and their findings are less likely to be published in peer-reviewed journals. The quality of practitioner research has also come under scrutiny. This is particularly apparent in the parallel field of education research where case studies conducted by teachers have been criticised by ethnographers for their lack of methodological rigour (cited in Shaw, 2005). However, whilst ‘inner-science’ considerations such as methodological quality are important in assessing the utility of practitioner research, ‘outer-science’ considerations such as its usefulness for practice should not be underestimated (Shaw & Norton, 2008).

The development of a research literate social work workforce has been frustrated by a lack of coherence and continuity in policy (Marsh & Fisher, 2008). There have been many examples of local initiatives to promote practitioner research (Hess & Mullin, 1995) and a variety of practitioner research training programmes (e.g. Fuller & Petch, 1995; Fook, 1996; McCrystal, 2000). However, in spite of the research priorities for practitioners being quite clear (e.g. Gould *et al.*, 2007; Stevens *et al.*, 2007), funding for practitioner research remains scant.

Practitioner research can be supported by the transformation of social work agencies into ‘learning organisations’ (Maynard, 2010). As Orme and Powell (2008) assert: “reframing organizations as communities and networks of learning opens up the potential for different practices within organizations and across practice and academic settings”

(p.1002). The Department of Health approval of Academic Health Sciences Centres in the UK (Darzi, 2008) suggests that the National Health Service is taking steps towards becoming an effective learning organisation with an increased integration of research and practice. Local authorities, who continue to employ the majority of statutory social workers, however, have largely been unable to develop a similar culture of learning.

Some experienced practitioners interested in undertaking research enrol for advanced-level PQ programmes to acquire research training and supervision, despite the absence of a research pathway in the PQ framework (General Social Care Council, 2005). These practitioners are beginning to make a modest contribution to the evidence-base for social work (see, for example, Dunn, 2001; Slack & Webber, 2008; Furminger & Webber, 2009; Dutt & Webber, 2010; Kingsford & Webber, 2010). However, there are few opportunities for practitioners to engage in this type or level of training.

To widen access to research training we transformed two research modules of our advanced-level PQ programme into stand-alone e-learning short courses. The first provides training in quantitative and qualitative research methods, and critical appraisal skills. An evaluation of a pilot of this course found that social work practitioners can successfully engage with e-learning and develop their understanding of research methods (Webber *et al.*, 2010). Building on this success, we developed a second e-learning short course in research protocol writing to assist practitioner researchers to develop proposals that are sufficiently robust to withstand peer review and the scrutiny of an ethics committee.

e-Learning is becoming increasingly prevalent in higher education and there is good evidence of its effectiveness (Sitzmann *et al.*, 2006). e-Learning approaches in social work education have developed rapidly since the 1990s (Waldman & Rafferty, 2008) and students on qualifying programmes have

found e-learning a positive and enabling experience (Madoc-Jones & Parrott, 2005). e-Learning also has the potential to widen access to advanced-level PQ modules, though progress towards developing courses at this level has been slow. Social care employers would like to see an expansion in the use of e-learning and the majority of employees feel that they had the necessary skills to engage with it (Ipsos MORI, 2006). However, delivering social work education using virtual learning environments is not without its limitations. For example, in their evaluation of a technology-enhanced module of a social work programme, Zeman and Swanke (2008) found that the lack of group interaction in e-learning diminished its capabilities for transmitting professional values. This paper reports an evaluation of a pilot of an e-learning short course in research protocol writing.

Method

Volunteers were recruited in autumn 2007 to pilot an e-learning course in research protocol writing from January to April 2008. This course taught social workers the principles and practice of writing a research protocol which provided 30 credits at the PQ advanced level (General Social Care Council, 2005) and at Masters level in the Common Credit Framework. It was designed to be equivalent to the classroom based module on the programme from which it was derived.

In the research protocol writing e-learning course students were encouraged to undertake their own independent study and focus on developing their own research protocol. The course was tightly structured with instructions provided to students each week on which learning materials to study within WebCT (a virtual learning environment) and which aspects of their protocol to consider. The learning materials included audio presentations of lectures supplemented by bullet-point slides; learning modules containing the lecture text and hyperlinks to relevant resources; asynchronous discussion fora; and online submission of a summative

assignment. The topics covered included structuring a protocol, conducting a literature review, writing questionnaires and interview schedules and research ethics. The learning materials from the research methods and critical appraisal e-learning course (Webber *et al.*, 2010) and accompanying book (Webber, 2008) were also available for learners to gain a critical appreciation of a range of qualitative and quantitative methods. The lectures and learning modules were studied during the first eight weeks of the course and the practitioners wrote their protocols in the final four weeks.

An e-tutor maintained weekly contact with each volunteer to monitor and support their progress throughout the course. She provided at least four individual tutorials, either face-to-face or on the telephone, to each e-learner. An online discussion forum was also available for the practitioners to share their ideas, pose questions and discuss their protocols with colleagues and tutor. The e-learning group had two face-to-face meetings, one at the beginning for induction and one in week twelve when the e-learners presented their protocols to the group as part of their assignment.

The 2007-9 cohort of social workers studying the MSc in Mental Health Social Work with Children and Adults at the Institute of Psychiatry, King's College London, were the comparison classroom group. They were taught the same course across the spring and summer terms alongside other modules of the MSc programme. The teaching methods were lectures, small group seminars and individual tutorials in the same structure as the e-learning course. The classroom group was also provided with handouts of the same course materials available to the e-learning group and equivalent access to WebCT.

We conducted a pre-post evaluation of the e-learning course and classroom equivalent using mixed methods. To objectively assess change in practitioners' knowledge from the beginning to the end of the course, we asked them to complete a research protocol exercise

at the start and repeat it at the end. We provided them with the following scenario and asked them to write an outline research protocol for a hypothetical study which would investigate it:

You are a social worker based in a Community Mental Health Team in London. Your team leader has asked you to conduct a piece of research investigating job 'burn out' and stress associated with employment in a mental health setting. You are asked to develop a proposal using the following headings as a guideline. If your project received approval from the local ethics committee you will have a half day per week for six months in which to complete your project.

They were given 30 minutes to draft a protocol under the following headings: title; research question; research aims and objectives; methodology; sample selection and size; data collection procedures, instruments used and methods for data quality control; ethical considerations; plan for analysis of results; and timetable. These research protocols were analysed using a qualitative content analysis methodology, with the primary focus being change between the start and end of the course.

We asked both the e-learners and classroom group to rate their confidence in the course learning outcomes on a scale of 1-10, where 1 represents no confidence and 10 represents full confidence, pre- and post-course to help us to appraise subjective knowledge gain. We used t-tests to explore differences between the classroom group and e-learners and paired t-tests to examine change over time within the groups. To explore differences in objective knowledge gain between the e-learners and classroom group we compared their mean grades achieved in the assignment using t-tests.

The research protocol writing course required a moderate level of computer literacy. We evaluated whether there were differences in confidence with computer literacy between

the classroom group and e-learners, and whether this changed after completing the research protocol writing course by asking them to rate their confidence against five items on the same confidence scale (1-10). This was analysed in the same way as the learning outcomes.

Finally, we conducted semi-structured group interviews with the e-learners following their protocol presentations. These interviews focused on the course materials, strengths and weaknesses of the e-learning approach to writing research protocols, technical aspects of using WebCT and satisfaction with the course. Detailed notes of these interviews were made and analysed thematically. The group interviews were supplemented with post-course evaluation self-complete questionnaires to gain additional feedback about their learning experiences.

Ethical approval was provided by the King's College London Joint Schools Research Ethics Sub-Committee for Humanities, Law and Social Science and Public Policy (RESC 07/08-02).

Results

Fifteen social workers expressed an interest in undertaking the e-learning pilot and we accepted eleven of these onto the course. Seven out of the eleven who were invited to the pre-course induction were able to attend. The remaining four received telephone inductions by the e-learning tutor. There were twelve students in the classroom comparison evaluation group.

Six (55%) of the e-learners completed the course and submitted all the assignments. Of the remaining five, two dropped out for personal or workload reasons and three lost contact with the course providers in spite of numerous attempts to re-engage them.

Qualitative analysis of the evaluation exercise revealed several important differences when comparing the pre- and post-course writing samples. However, it is important to note that

there were no systematic differences between the e-learners and the classroom group in the pre-course protocols suggesting that the pre-existing level of knowledge about research protocol writing was similar.

In the pre-course exercise, practitioners' proposals used vague language and a main weakness was the lack of clearly defined terms. Specifically, in the section addressing the research question many practitioners simply repeated the task as set out in the instructions without narrowing the question or clearly linking concepts. In many cases this meant that the proposed question was un-researchable in its current form.

The most obvious difficulty of the pre-course exercise was linking the study aims with an appropriate methodology. Most of the sample (71%) suggested a qualitative methodology although there was never a clear justification for this choice. Data analysis was an area that caused specific difficulty, with nearly half (47%) of the practitioners leaving this section of the exercise blank. Some of the practitioners incorporated research vocabulary; however the understanding of these concepts often appeared superficial, suggesting a lack of research literacy. For example, 'association' was often discussed as evidence of a causal relationship.

When looking at the three e-learning participants who completed the pre- and post-course evaluation exercises there was important evidence of learning. For example, student 'E1' had a much more clearly defined research question and had employed a significantly stronger methodology. She was able to provide details about a proposed sample size and source, and the analytic strategy selected was appropriate for the proposed design. In all, the post-course exercise was a much more viable piece of research. It is interesting that this student also received the highest marks on the course assignment.

As a comparison, student 'E2' struggled with the course assignment. Mirroring this, his

post-course evaluation retained significant weaknesses, specifically with regard to methodology and the structure of the proposal. However the student demonstrated some improvement and the post-course exercise was full of creative approaches to the problem and the sample selection was appropriate.

The final student 'E3' also demonstrated improvement when comparing pre- and post-course samples. The second exercise was much more organised and the research aims and objectives were more specifically tied to the methodology. The proposed analytic strategy was also more robust. In addition this student added a section entitled 'dissemination', demonstrating awareness of the project output even from the proposal stage. This student received near the median for the course assignment.

Given that the three students from the e-learning group reflected the spread in marks from the course assignment, purposive sampling was used to select comparisons from the classroom group who achieved the highest, lowest and median scores. The highest score was achieved by student number 'C4'. Her pre-course exercise stood out from the others in the classroom group as it was the only one in which the methodology was clearly linked with the objectives stated. It suggested that her assignment mark was influenced by higher baseline levels of knowledge about the important concepts in developing a research protocol. Despite the pre-course exercise demonstrating this relatively high level of competence, the post-course exercise illustrated evidence of considerable learning.

In contrast, student 'C5' scored near the median for the classroom cohort. A comparison of her pre- and post-course exercises demonstrated more modest gains. Overall the main improvement was more specificity about the proposed design, but imprecision in outlining the research questions, aims and objectives remained. Given that this was a common weakness of

both the classroom and e-learning group, it suggested that the course should re-emphasise the importance of these concepts.

Finally, student 'C6' received the lowest assignment mark in the classroom group. The pre-course exercise was one of the weakest and lacked details and justification for the choices made. The post-course exercise was much improved. Specifically the student made mention of standardised measures in the methodology and linear regression analysis to account for confounding variables. Given the learning demonstrated when comparing the pre- and post-course exercises it was surprising that this student did not score more highly in the summative assessment.

The content analysis of the pre- and post-course exercises demonstrated an important shift in the practitioners' understanding of the key elements of a research proposal. Post-course exercises were more specific, made greater use of specific definitions, were more likely to consider standardised measures and had a more robust design. However, there were still significant weaknesses in the research questions, aims and objectives. For the most part these areas of the proposal remained vague and lacked definitions even after the course.

Across all the learning outcomes, the e-learners had less confidence in their skills and abilities in research protocol writing prior to the start of the course than the classroom group (Table 1). This difference reached statistical significance for the practitioners' understanding of social work research methods possibly because the classroom group had just completed a research methods and critical appraisal course, whereas only one of the e-learners had done so. No other e-learners had completed any other comparable research methods training in the previous five years.

Practitioners in both the classroom and e-learning groups increased in confidence with all of the learning outcomes by the end of the

course. The change in confidence ratings reached statistical significance for almost all of the learning outcomes (Table 1). In contrast to pre-course, the e-learners were more confident than the classroom group across all the learning outcomes at completion, but this was only statistically significant for 'writing a research protocol for a modest research project' and 'applying to a research ethics committee for approval'. Although the e-learners appeared more confident than the classroom learners upon completion of the course, there was no difference in their assignment marks. The mean grade for the e-learners was 60.8 in comparison with 60.4 for the classroom learners.

The increase in their confidence, and difference between the groups, was also apparent in the qualitative data we collected. For example:

When I started this course I found the idea of developing a research protocol a daunting task. I had had an interview for a DPhil years ago to which I was successful but could not take up due to funding problems. I wish this course had been available then because it is a complex matter to work with and I feel this course has now given me the confidence to try again but perhaps on a part time basis. It has helped me to present a research proposal to a university for a PhD but am awaiting the result. (e-learner, post-course)

Table 1 Ratings of confidence with learning outcomes

Learning outcome	Classroom group	e-Learning group
	(n=12)	(n=6)
	Pre/post confidence ratings	Pre/post confidence ratings
	Mean (sd)	Mean (sd)
Developing hypotheses and researchable questions in response to practice-based issues	4.00 (1.13)	3.33 (1.87)
	5.64 (1.50)**	7.20 (1.92)*
Understanding the structure of a research protocol	3.75 (1.96)	2.78 (1.72)
	6.09 (2.02)**	8.40 (2.07)**
Conducting a literature review on a social work practice issue	4.83 (1.70)	4.67 (2.12)
	6.00 (1.41)*	7.40 (1.82)*
Understanding different methods used in social work research	5.00 (1.13)	3.44 (1.59) ⁺
	5.73 (1.49)	6.40 (2.30)**
Identifying ethical issues in social work research	4.50 (1.45)	4.00 (2.24)
	6.18 (1.89)*	7.80 (2.17)**
Writing a research protocol for a modest research project	3.33 (1.97)	2.56 (2.07)
	5.64 (1.43)**	7.80 (1.80) ⁺ *
Applying to a research ethics committee for approval	3.17 (2.59)	2.44 (1.88)
	4.00 (2.28)	7.20 (2.17) ⁺
Implementing an original research project	3.00 (2.34)	2.44 (1.88)
	5.09 (1.97)**	6.80 (2.05)**

Comparisons between classroom and e-learning groups: ⁺p<0.05

Comparisons within groups pre-post training: *p<0.05, **p<0.01

At the start of the course there were no statistically significant differences between the two groups in confidence with computer literacy (Table 2). Both groups improved in confidence in undertaking online learning and, as one might expect, the e-learners were significantly more confident than the classroom group with this at the end of the course.

Again, this was reflected in the qualitative feedback:

Though I have used the internet in the past when I trained as a lawyer I had got a bit rusty having worked in social services!! So the course helped me greatly to stretch my knowledge in this domain. (e-learner, post-course)

Table 2 Ratings of confidence with computer literacy

Computer literacy item	Classroom group	e-Learning group
	(n=12)	(n=6)
	Pre/post confidence ratings	Pre/post confidence ratings
	Mean (sd)	Mean (sd)
Using the internet in general	7.33 (1.88)	6.44 (2.13)
	7.20 (1.75)	8.40 (1.52)
Using the internet for work purposes	7.17 (2.13)	6.44 (2.19)
	7.50 (1.65)	8.20 (1.30)
Undertaking literature searches using bibliographic databases	4.33 (2.43)	5.00 (2.40)
	5.60 (2.27)	7.20 (1.92)
Undertaking web-based learning	3.67 (2.31)	4.67 (3.12)
	5.30 (2.06)*	7.60 (1.52) ^{+ *}
Giving presentations using PowerPoint	4.08 (2.88)	4.56 (3.71)
	6.20 (1.81)***	6.60 (3.21)

Comparisons between classroom and e-learning groups: ⁺p<0.05

Comparisons within groups pre-post training: *p<0.05, **p<0.01, ***p<0.001

Only two of the e-learners had studied online previously, but the volunteers quickly saw the advantages of e-learning. For example:

[It provided a] better capacity to learn the material at my own speed and to pursue information that would fill gaps in my knowledge. It felt that the flexibility allowed me to tailor the learning to my needs. (e-learner, post-course)

The flexibility of e-learning to fit into busy lives was also a limitation of the modality as it was often the first thing to be dropped when other pressures became insurmountable. Work pressures were most frequently cited as constraining study time, but other problems some e-learners faced during the course included getting divorced and losing a job. However, the flexibility of e-learning meant that most of the volunteers were able to study the course which they would probably not

have been able to if they needed to attend lectures, seminars and tutorials in a classroom each week.

The flexibility of e-learning also meant that it was easier for the practitioners' managers to suggest that they could study in their own time. Only one of the e-learners was given any study time (two days for the entire 16-week course), but it was not clear that this was taken as time owed or was genuine study leave. The lack of a research culture in social work also explained the absence of managerial support for this kind of training. None of the e-learners reported that their managers were able to identify the wider benefits to their agency of having skilled practitioner researchers in their teams. Most saw it as solely for the personal or professional development of the practitioner.

The e-learners perceived their personal contact with the e-tutor as being the most helpful aspect of the course, whereas the asynchronous discussion forum proved the least popular (Table 3). In the group interviews following the course, the e-learners emphasised the importance of the support provided by the tutor and highlighted the value of personal contact on e-learning courses which helped to minimise isolation. For example:

I think that I have much less of an understanding of this course material than if I had been in a classroom setting. ... You miss that link with a teacher and other students that helps you to understand the material better. (e-learner, post-course)

In contrast, the classroom group found the learning materials presented in the classroom to be the most beneficial aspect of the group (Table 3), possibly because the interpersonal

contact with the tutor was taken for granted as this was an integral component of the course.

Discussion

This was a small pilot study comparing an e-learning group with a classroom equivalent. The small number of practitioners involved in this study means that our results can only be taken as indicative of how an e-learning group may perform. Further, as there was no random assignment to e-learning or classroom tuition, selection bias cannot be ruled out. It is possible that the e-learners were more motivated as they had the opportunity to learn via a novel method and they were not distracted by coursework from other modules unlike the classroom group. However, it is equally possible that the classroom group had a greater investment in succeeding as they were enrolled on a Masters programme costing them a significant amount of time and money.

Table 3 Perceived helpfulness of teaching methods to e-learners and classroom group

e-Learning group (n=6)		Classroom group (n=12)	
Position	Teaching method(s)	Position	Teaching method(s)
1	Individual tutorials	1	Reading materials
2	Other tutor contact	2	Lectures / seminars
3	Induction session	3	Other tutor contact
=4	Learning modules	4	Protocol presentation session
	Reading materials / online links	5	Individual tutorials
	Protocol presentation session	6	e-Learning materials
7	Online lectures		
8	Asynchronous discussion forum		

Bearing in mind these limitations, this evaluation suggests that e-learning appears to be as effective as classroom based teaching as a pedagogical method for training experienced social workers in research protocol writing. The practitioners' confidence and ability in writing a research protocol increased significantly as a result of studying the course. e-Learning appears to be an acceptable method of learning, the volunteers appeared highly satisfied with the quality of education they received and the e-learners met the learning outcomes to the same extent as those studying the course in the classroom. Additionally, the e-learners found the flexibility and autonomy of this method beneficial.

An interesting finding of this pilot study was that e-learners valued personal contact more highly than the online learning materials. Online discussion fora were used to facilitate contact online, but these were not highly used or valued by the e-learners. Communicating with a tutor face-to-face or by telephone was important to the e-learners, suggesting that a blend of online and 'traditional' methods best facilitates learning. This is supported by an emerging evidence-base for blended learning in social work education (e.g. McPherson & Barnett, 2006; Cooner & Hickman, 2008; Cooner, 2010). Further investigation of blended learning in post-qualifying social work education in general, and research training in particular, is required.

Our non-completion rate of 45% for the e-learners was, although higher than we would have hoped for, consistent with other e-learning courses which varies from 20-50% at the lower end to 70-80% at the upper end (Tyler-Smith, 2006). Whilst e-learning is flexible and fits around other commitments, it still requires a considerable investment of time.

The e-learners had very little confidence in their understanding of research methods prior to the course, most having previously had little or no formal research training. This lack of confidence is indicative of the wider

problem of poor research literacy amongst social work practitioners (Orme & Powell, 2008). The research protocol writing e-learning course appeared to provide a steep learning curve for the volunteers. In a short space of time they had to become familiar with academic study (a challenge for most who hadn't studied for many years), using online learning, searching bibliographic databases and understanding research methods and basic statistics before they could start to write their own research protocols.

The e-learners achieved the same grades as the classroom group in the course assignment. However, none of the e-learners were able to undertake their research projects on completion of the course because of a lack of support from their agencies and employers. In contrast, the entire classroom group (except one who deferred entering the second year for personal reasons) went on to undertake their research projects in the context of the advanced-level PQ programme. This suggests that the 'circle of resistance' (Orme & Powell, 2008) to developing research capacity can only be broken in the context of advanced-level PQ programmes. Anecdotal evidence from a local authority which sponsors two practitioners on the MSc programme each year suggests that this may be the case: community mental health teams with graduates of the programme in leadership positions appear significantly more willing to engage in research projects than those with none.

The Social Work Task Force (2009) has initiated a series of reforms to introduce a more coherent and effective national framework for the continuing professional development (CPD) of social workers. Ongoing learning and development of professional practice will become the norm, rather than the exception: currently only a very small proportion of social workers enrol on advanced-level PQ programmes (General Social Care Council, 2009), and few receive financial or other support from their employer to do so. The Task Force (2009) argued that organisations must develop strong learning

cultures to free up staff for courses, including e-learning, and support them to access and conduct research to inform their practice. The introduction of a research pathway into the new CPD framework may help to develop practitioner research capacity, possibly by e-learning, but it will only contribute to breaking the 'circle of resistance' if it receives full employer support.

The Coalition Government has confirmed its commitment to implementing the recommendations of the Social Work Reform Board (Loughton, 2010). However, significant reductions in public spending to reduce the budget deficit will make the transformation of social work agencies into effective learning organisations a challenging prospect.

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Notes on Contributors

Martin Webber has social work experience with people with mental health problems and currently runs an advanced level post-qualifying programme for social workers at the Institute of Psychiatry, King's College London. His research interests are in mental

health social work, social capital and social inclusion.

Laura Currin Salter completed her PhD at the Institute of Psychiatry, King's College London and has recently qualified in medicine. She is the e-tutor for the two e-learning short courses for social workers within the university.

Address for Correspondence

Dr. Martin Webber
Lecturer in Social Work
Health Service & Population Research
Department
Institute of Psychiatry
King's College London
De Crespigny Park
London
SE5 8AF

Email: martin.webber@kcl.ac.uk

Telephone: 020 7848 5096

History and hindrance: the impact of change and churn on integrating health and social care

Ray Jones

Kingston University and St. George's, University of London

Abstract

Governments over the past 40 years have sought to close the divide, begun in the 1940s at the time the welfare state was being created, between health and social care services. Various mechanisms have been introduced from the 1970s onwards to get services to work better together. In the late 1990s and early 2000s, there were moves to integrate the services organisationally. But, in 2010, this still remains a largely unachieved ambition shared across all the main political parties. But government-demanded, frequent NHS and local government reorganisations have, in themselves, been major hurdles, disrupting local commitment to bring services together. The lessons of centrally-imposed organisational change undermining local health and social care integration have still to be learnt.

Keywords: Health, social care, integration, organisational change, impact

Introduction

It has long been government policy (see, for example, Department of Health and Social Security, 1973; Department of Health, 1998, 2006) that health and social care services be brought together. While the joining up of health services with social care services is argued to generate greater economy, efficiency, and effectiveness, ensuring that combined resources are better used and that there are improved outcomes for service users (Frost, 2005; Glasby, 2007), it is also not without its difficulties (Cameron & Lart, 2003; Peck & Dickinson, 2008; NHS Confederation, 2010).

The coalition government of 2010 reiterated its commitment to the integration of health and social care services. The white paper 'Equity and Excellence: Liberating the NHS' (Department of Health, 2010) proposed a major restructuring of the NHS. The responsibility to commission services would be devolved to consortia of GPs and GP practice teams, with more choice of provider to be given to patients but, importantly in the context of this paper, it was stated that 'local authorities will promote the joining up of

local NHS services, social care and health improvement' (Department of Health, 2010, p.4) and 'to achieve greater alignment with local government responsibilities, the Government will transfer PCT (NHS Primary Care Trust) health improvement functions to local authorities and abolish PCTs. Local Directors of Public Health will be appointed by local authorities and the Public Health Service' (Department of Health, 2010, p.34). New 'health and wellbeing boards' will be established to, amongst other responsibilities, 'promote integration across health and adult social care, children's services, including safeguarding, and the wider local authority agenda' (Department of Health, 2010, p.34). All this from a new coalition government where the parties previously promised no top-down major change for the NHS.

This was not the promise of the outgoing Labour government in 2010 where the then Secretary of State for Health, Andy Burnham, stated that "the next few years require more NHS reform than ever before" (Lister, 2009). There was, however, cross party political agreement about the importance of bringing health and social care together in local areas. The previous government's commitment to

bring health and social care services together, albeit with the means less radical but still with a leadership role for local councils (DCLG, 2006a; DCLG, 2006b), was emphasised in the care and support green paper 'Shaping the Future of Care Together' (Department of Health, 2009). It noted the intention that 'people receive more appropriate care in the right setting, reducing costs, improving outcomes and ensuring that services work together to keep people healthy and active wherever possible' (p.11). A 'ministerial group for the integration of health and social care' was established and 'will identify barriers to integrated working which government will need to remove' (p.12). This paper focuses on one such barrier - policy and organisational turmoil - which is created by government itself. It is a barrier about to be raised again, and even higher, by the considerable organisational upheaval promised for the NHS.

History

The divide between health and social care was extended in the post-war welfare state reforms (see Kynaston, 2008; Means & Smith, 1998; Timmins, 1996) with the National Health Service Act 1946 establishing a health service which removed from local government many of its previous health responsibilities, such as the running of local hospitals, but also left with local government - through the National Assistance Act 1948 - responsibilities to care for disabled and older people, primarily at that time in residential care homes which were part of the replacement for the Poor Law workhouses.

The divide was widened in the early 1970s when the Local Authority Personal Social Services Act 1970 established social services departments within local government. These new departments had within their remit welfare responsibilities for disabled and older people, which were previously often under the control of medical officers of health in local councils, and community mental health services. At the same time, the Chronically

Sick and Disabled Persons Act 1970 gave local councils the lead responsibility for identifying and then providing for disabled people. However, the National Health Service Reorganisation Act 1973 took from local government its public health lead responsibilities (which the 2010 coalition intends forty years later to return to local councils) and placed these within the NHS whilst transferring from the NHS to local councils the responsibility for hospital social work services.

Then, as now, it is sometimes difficult to track the motivators and intentions of national policy, which may be influenced by vested political, professional and organisational interests (see, for example, Klein, 1995, on political and professional considerations and the development of the NHS, and Hall, 1976, and Cooper, 1983, on the debates and discussions leading to the social services and health reforms of 1970 and 1974) as much as by clear, coherent and consistent planning. The consequence can be overly complicated, and sometimes conflicting, allocations of responsibilities requiring considerable time to overcome the complexities created.

Such was the position in the late 1970s, with the NHS Reorganisation Act 1973 introducing a range of national mechanisms to promote joint working across the health and social care divide. Joint Consultative Committees, Joint Care Planning Teams and Joint Finance were introduced to stimulate service planning and development between health and social care. Essentially, these were mechanisms and manoeuvres to span across and to simplify some of the chasms and complexities which had been created.

The intention was to have health and social care services working better together but the failure to achieve better joint working and improved shared performance of health and social care services, despite thirty years of prompting, planning and procedures (see, for example, Jones, 1995, on joint commissioning), led to a change of political script. No longer was the text about joint

working. It was now about joining up by building integrated services.

This was a change in political script which was tracking, rather than leading, what was already happening on the ground in many areas. But, it is not unusual for national legislation and government policy to respond to, rather than create, change. For example, the Community Care (Direct Payments) Act 1996 was a response to the argument made by disabled people since the early 1980s that they should be given the cash to allow them choice and control over how they received the assistance they needed, with an increasing number of local councils then creating the means (trust funds; third party payment schemes) to get around the then restrictive legislation which made it illegal for councils to give cash to disabled people.

It was in the late 1990s that the argument about integrating health and social care services started to gain momentum. In 1997, the House of Commons Health Select Committee considered whether and how health and social care services might be brought together and one of the submissions argued for the creation of 'community health and social care trusts' (Jones, 1997). Subsequently, some of the legal hindrances to bringing health and social care services together were addressed in the Health Act 1999 which introduced the legal powers to allow pooled budgets, lead commissioning and purchasing agreements, and integrated service providers.

It was in 2000 (Department of Health, 2000) when the then Secretary of State (Alan Milburn) and the then Minister of State for Health who was leading on social care (John Hutton) started to promote 'care trusts' as the mainstream future. Integration was starting to be seen not as an option but as the predetermined way forward. 'Care trusts' were to be located within the NHS but would provide both health and social care services, with funding transferred from local councils and councils contracting with the care trusts,

to deliver the council's social service responsibilities.

The problem was that no governance framework was created which balanced the responsibilities of care trusts between the NHS and local government. Care trusts were to be NHS bodies, accountable to the NHS nationally and centrally. Even if councillors were appointed to care trust boards as non-executive directors their first responsibility and accountability was then to the NHS. This dilemma was never addressed, maybe because the political champions for care trusts moved on and the new national health and social care political leaders had their own interests to follow, new imperatives to address (such as tackling increasing NHS overspends) and their own marks to make.

More recently, in 2005-2006, despite a continuing rhetoric about integrating health and social care, the politically-determined imperative that within one year the overspending NHS should achieve financial balance was having a significant impact. This led to rapid local NHS reorganisations and managerial and service changes. This undermined commitments to bring NHS and local government social care together and led to a significant cost-shunt from the NHS to local government (ADSS, 2006; Golding, 2006). In areas which had been at the forefront of establishing integrated health and social care services but where there were significant NHS financial deficits, such as Barking and Dagenham (Wistow & Waddington, 2006) and Wiltshire (Brindle, 2006; Chorley, 2006; Glasby, 2006a; Thistlethwaite, 2006), there was an unravelling of established integrated arrangements.

Lessons for building and sustaining integrated health and social care services

So what are the lessons for building and maintaining integrated health and social care services? The main lesson is that it requires at least some stability within the NHS and local government. This was recognized by

Gill Morgan, the then chief executive of the NHS Confederation and now a principal civil servant, who commented that:

A starting point for improvement must be honest discussion of shared problems, responsibilities and solutions, as well as the alignment of planning cycles ... It also requires a period of stability from reorganisation, as delivering imaginative solutions depends on trust and long-term relationships. (Morgan, 2006, p.10)

Shared agendas, commitments and trust take time to build but little time to undermine. For example, in a national review of the partnership flexibilities enshrined in the Health Act 1999, it was noted that ‘the fine-grained relationships which have to be built at local level need to be better understood and supported’ (Glendinning *et al.*, 2002, p.10) and, in a review of research on partnership working, Balloch (2007) concluded that ‘the trust that has to be built between individuals in a community of practice takes time to establish and requires a degree of stability in the workforce’ (p.74). This is reinforced by Cameron and Lart (2003) in their systematic review of the evidence about joint working which found that a history of good partnership working is, maybe not surprisingly, an indicator of likely future success. There is also a requirement for continuity and stability so that attention is given to detail when health and social care services are brought together. For example, Hudson (2006) has commented (based on the experience in Sedgefield in the north of England) on the fine tuning of processes and procedures which may need to be introduced to support front-line practice integration.

Conversely, frequent organisational, senior management and policy churns are the antithesis of planned and well-managed change and development. Even the brightest and most sensible ideas need time to be followed through. There is a demonstrable need for ‘completer-finishers’ as well as ‘shapers’ (Belbin, 1991) and the shapers must not be given a total free rein. The building of

integrated services takes time, as noted by Rosen and Ham (2008) and Dudman (2009), and is easily disrupted and derailed by disturbing relationships and shared commitments. The impact in 2006 has been commented upon by Hugh Taylor, then acting permanent secretary at the Department of Health:

The financial shocks in the NHS, the reactions to those shocks, the restructuring of the NHS: all of these have inhibited partnership working in some places. We’ve seen good initiatives held back and I know how frustrating that’s been. (Gainsbury, 2006, p.11)

One implication of the NHS “financial shocks” was a cost-shunt of pressures to local authorities (and also to the voluntary sector), destroying trust as well as previously shared strategic intentions. This danger was anticipated by Plumridge:

Other potential sources of money [for the NHS] lie close at hand in pooling arrangements with social care budgets. When sharing a picnic, beware of the guest with a big appetite and recently reduced income. We might see attempts to raid pooled budgets or, less blatantly, to shift the burden of cost to social care organisations. (Plumridge, 2006, p.28)

But, it is not only organisational change within the NHS which may disrupt the integration of health and social care services. Local government boundary changes in 1974 destabilised the health and social care partnerships which were being established following the creation of social services departments in 1970 (Rivett, 1998). A similar disruption to local relationships and shared commitments occurred in the late 1990s following local government reform (Craig & Manthorpe, 1999; 2000). More recently, in 2009, the further move to unitary local government, building on the changes of the mid 1990s, has led in six large county areas in England to local government reorganisation, and this was noted to be

disruptive to building and maintaining local joined-up health and social care agendas (Puffett, 2009).

Progressing integrated health and social care also needs a greater balance in the attention which is given nationally within health and social care. In an, albeit small, survey of sixty seven social care managers who were asked if the Department of Health was focusing enough attention on social care, 98% 'thought social care was neglected' and 80% stated that 'social care priorities would become subordinate to health as adult social care integrates with health services' (LGC, 2005).

Integration is not a sensible aspiration if it is built on an overwhelming focus on the needs of only one partner with, for example, social care used to provide solutions to NHS difficulties such as pressures on acute hospital bed occupancy (Department of Health, 2002; Jones, 2004a) and overspends (Glasby, 2006b; Jones, 2006; Shifrin, 2006). As the Audit Commission (2006, and see also Audit Commission, 2009) pointed out within its broad review of partnerships, it may be necessary to take hard decisions to scale down involvement in partnerships if the costs outweigh the benefits or if the added risks cannot be managed properly.

There is also the danger that when there is an imbalance in the performance of partners the likelihood is that the trend in performance will be towards the lowest common denominator. For example, in 2006, the two largest of Wiltshire's three PCTs were both rated by the Healthcare Commission as 'weak' on 'quality of services' and also on 'use of resources', placing them amongst the poorest performers nationally (see Laurance, 2006). At this time, Wiltshire County Council's Social Services rating went from one of the best in England and Wales (Audit Commission/Social Services Inspectorate, 2000) and from being a top-rated three stars in 2005 to two stars and then to one star because its future prospects were 'uncertain' (CSCI, 2006).

However, bringing health and social care together locally still makes considerable sense. In Wiltshire, for example, it gave easier access to services, a quicker response to patients/service users and carers, and with some evidence of a wider range of assistance being provided (Brown *et al.*, 2002; 2003). It also improved communication and understanding between health and social care workers (Tucker & Brown, 1997).

But the lesson that needs to be learnt is that it does require a stable political policy platform and a continuing management commitment from all organisations. It takes time and is undermined by turmoil. This is the lesson of history over the past forty years and one which was emphasized in the past decade. With further rapid and radical, politically-determined change ahead for the NHS (Department of Health, 2010) it is also a lesson for the future.

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Notes on Contributor

Ray Jones is Professor of Social Work at Kingston University and St. George's, University of London, and, from 1992 to 2006, was director of social services and then director of adult social services in Wiltshire.

Address for Correspondence

Professor Ray Jones
School of Social Work
Kingston Hill Campus
Kingston University
Surrey
KT2 7LB

Email: R.L.Jones@sgul.kingston.ac.uk

Book Reviews

Knowledge-in-Practice in the Caring Professions: Multidisciplinary Perspectives

D’Cruz, H., Jacobs, S. & Schoo, A. (eds.)
Surrey: Ashgate Publishing Limited, 2009,
pp. 256,
ISBN: 978-0-754672-84-5, £19.99 (pbk.)

This is a very useful and interesting edited text from Australia. As the editors explain in their comprehensive introduction, and revisit in their concluding chapter, the book aims to answer several interrelated questions on knowledge and its place in professional practice, as well as recognising that there are differences within and between the professions. It does this admirably.

The book begins with a useful exploration of epistemology. The editors look at the philosophy of Karl Popper and the theories of knowledge of Polanyi, Ryle and Oakeshott. Thereafter, the main body of the book contains a series of chapters written by experts in particular fields. These cover medical practice, psychiatry, social work, disability, nursing, psychology, midwifery, physiotherapy and addiction studies. Each chapter offers individualised views on the place and types of knowledge in their specific practice areas. The aim is to offer professionals a structure on which to base their practices. For example, the chapter by Lawn and Battersby, from Flinders University Medical Centre in Australia (pp. 161-187), reports on their 2007 investigation into “training and information options to support chronic condition prevention and self-management” (p.162). They write:

Yet, arguably, the needs of service consumers are a common thread through all health service organizations [. . . and . . .] we professionals could do more to come together with the person and one another to know how we each contribute to the larger picture of care for the person. (p.163)

This is the central challenge of the book and one that the book goes a long way to beginning to answer. However, the experiences of service consumers are not really addressed in depth. Chaffey notes in her chapter that “a person with a disability brings their own personal lens [. . .] to the therapeutic encounter” (p.98) and, “[I]t is conceivable that the professional’s and the client’s personal lenses may clash” (p.99).

Later, the editors write:

While a reader from one profession is not expected to learn another profession’s paradigms and concepts, exposure to these differences in texts can serve to replicate the everyday experiences of practitioners working in multidisciplinary teams where each team member’s knowledge base is not fully known or appreciated, or is dismissed as irrelevant and strange. (p.238)

However, it is nowhere acknowledged that such difficulties are magnified for the service consumer. Notwithstanding this omission, this is an important and wide-ranging book. It would have been good to have had a chapter written by service users addressing the role of knowledge-in-practice for them, and their experiences of trying to fathom sometimes what on Earth the professionals are driving at.

Richard L Peacocke

Consultant, Dorset Mental Health Forum

Mental Health Act Manager, Dorset Primary Care Trust

Student, Professional Doctorate, Bournemouth University

Email: rpeacocke@bournemouth.ac.uk

Enriched Care Planning for People with Dementia

May, H., Edwards, P. & Brooker, D.
London: Jessica Kingsley, 2009, pp. 175,
ISBN: 978-1-84310-405-6, £25.00 (pbk.)

The launch by the New Labour Government of the *National Dementia Strategy* in 2009 was specifically designed, amongst other things, to increase awareness of dementia and radically improve the quality of care that people with the condition receive. This both timely and easy to read book, which is part of the Bradford Dementia Group's *Good Practice Guides*, will, in its own way, help the strategy meet these goals.

The book emerges from a profiling approach said to have been piloted over five years in a range of different dementia care settings. It is this approach that is given the name 'enriched care planning'. Enriched care planning, itself, is said to be a "means to an end" (p.15) – which is to deliver person-centred care. 'Person-centred care' is the approach which everyone associated with health and social care claims to adopt without not always necessarily making it clear what processes are involved. It is often easier to adopt the value of person-centred care without being clear what it means in terms of day-to-day practice reality. This book excels at being very clear about exactly what the processes involve and gives suggestions for how they should be undertaken.

The book has twelve chapters which give a good idea of the scope of the book. The titles are: *What is Enriched Care Planning?*; *Life Story*; *Lifestyle and Future Wishes*; *Personality*; *Health*; *Capacity for Doing*; *Cognitive Ability*; *Life at the Moment* and *Implementing and Reviewing the Enriched Care Plan*. The book is then supplemented with a section on useful resources and a range of templates designed to assist with the enriched care planning process.

Chapter One begins by discussing the rationale for making care 'person-centred'. The authors tell us that:

A crucial aspect of being person-centred is helping each person to continue to engage with their world so that their sense of self, of personhood and their inner world is kept intact. (p.16)

suggesting that this is an approach that goes beyond simply 'safeguarding' and 'minimising risk' that informs much current care discourse. The profiling approach promoted by the book is designed to both establish and promote the personhood and individuality of the person with dementia. As much as anything, this is to combat the 'old' (but lingering) culture of dementia care, which the author's caution:

... arises from a one dimensional view of dementia which pre-judges all that the person says and does as a consequence of having a mind that no longer functions properly. (p.18)

However, in this respect, the book provides useful explanations about how the brain works and how the progression of dementia affects its functioning.

These more 'medical' sections, as with the rest of the book, are written in language that anyone - health professional, care assistant or relative - could understand. Each chapter concludes with a summary of the main points covered. As suggested by the different chapter titles, each chapter tends to focus on a different aspect of how dementia might affect someone's ability to live independently. The chapters then provide suggestions on how to engage with the person about that aspect and develop strategies for maximising functioning in that area. The detail into which the authors go reveals both the strengths and the weaknesses of the book. On the positive side, anyone following the approach with someone living with dementia could not fail to gain a better sense of who they were/are and how their holistic well-being might be better promoted. However, the authors themselves explain that "enriched care planning is not a one-off event, it is a process that takes time and care" (p.18). This highlights a weakness

of the book. The authors pay little attention to the real life contexts in which much dementia care takes place – for example, in people’s own homes where paid-for, formal care might be tightly rationed or in care homes which are struggling to maintain national minimum standards. We know that current social care resources are stretched and likely to become more so. There is also a growing reliance on an immigrant work force which brings with it rapid staff turnover. All of these factors suggest that both the time and training required for enriched care planning to take place properly will continue to be significantly constrained.

Therefore, while I completely endorse the approach promoted by the authors, I also have my doubts about the extent to which the full programme might be able to be adopted as suggested in many cases of people requiring care. However, I would be very happy for my doubts on this to prove unfounded.

Peter Scourfield

Senior Lecturer in Social Work
Anglia Ruskin University
Cambridge

**Law and the Social Work Practitioner
(2nd Edition)**

White, R., Broadbent, G. & Brown, K.
Exeter: Learning Matters, 2009, pp. 191,
ISBN: 978-1-84445-264-4, £22.00

Recent years have seen a proliferation of texts aiming to support social workers in understanding, interpreting and applying the legal rules that influence their practice. In addition to generic volumes which act as reliable, comprehensive critical texts (for example, Brammer, 2009), students and practitioners have access to a range of books, from those pitched at introductory level to highly specialist resources in the fields of child care, adult services or mental health. Critical analysis of the legal framework and of its application to practice is well developed (Braye & Preston-Shoot, 2009) and attention has been paid also to the need for learning

resources which assist social work students in what is perceived as a challenging learning task (<http://www.scie.org.uk/publications/elearning/law/index.asp>). The authors of the volume reviewed here have themselves contributed to these developments and we should particularly acknowledge the work of one of the authors, the late Rodger White, in helping to make the legal rules accessible to social work students.

In comparison with other areas of the core prescribed curriculum for initial training (DH, 2002), however, law remains under-resourced in the literature and any new text is to be welcomed. This volume stands out in that, although the first edition was written for students on social work degree programmes, this updated version is explicitly positioned as part of a series to support post-qualifying study. This could be a timely and important step, given we know that law knowledge is not reinforced or extended in some practice settings.

The content of this text is broken down into clearly defined and accessible sections; the pedagogic aims are clearly stated, and readers gain a clear indication of the learning objectives to be achieved. These are supported by practical exercises which stimulate reflection on practice examples to which the material may be applied. From the outset, the authors draw on the work of other commentators to locate law as a topic to be subjected to critical analysis and emphasise the importance of reflecting critically on its roles and functions in society, as well as on the values that it embodies.

The core content is supportive of students’ learning. There is a clear explanation of the principles and components of the English Legal System. The Children Act 1989 is given a high profile, its core mandates laid out in a structured and accessible way, with helpful rubrics to assist students to retain core principles (for example, “the six Ps” and “the three Cs”). Basic information is set out in a useful, tabulated form. Community care law, mental health law, administrative law, youth

justice, adoption, anti-discrimination legislation, domestic violence, housing and homelessness and human rights are all the subject of discrete chapters, following the same accessible style.

There are two concerns, however. The first relates to the depth of coverage and discussion of the issues addressed. Little use is made of case law, despite its importance in extending understanding and interpretation of the legal rules and its importance in guiding practice. The chapter on mental health is a welcome exception here and is the better for it. The coverage of topics is uneven and partial; insufficient attention is paid to the Children Act 2004 and to the development of outcomes-focused work in integrated children's services. In the context of community care, there are errors and omissions (the NHS Act 2006, eligibility criteria and more recent direct payments rules). Mental capacity is given very sketchy treatment, with little attention to best interests' interventions and deprivation of liberty. The English legal system chapter omits policy and practice guidance and codes of practice; whilst these are sometimes mentioned in later chapters on substantive law, there is a missed opportunity here to help students understand their status. Equally, it is difficult to understand why the Human Rights Act 1998 is left to a separate chapter at the end of the book, when it is so central to an understanding of the legal system. Two-page chapters on adoption and youth justice are insufficient.

My second concern relates to the level at which the text is pitched. After the early focus on conflicting imperatives in Chapter One, little reference is made to the tensions and conflicts that are inherent within the legal rules themselves, or triggered in their application to practice. This lack of critical analysis is a serious limitation in relation to the book's target market and does not really constitute Post-Qualifying (PQ) level learning. To address the needs of PQ students, many of whom are studying at Master's level, the text would need to support

students in developing their level of critical analysis. Equally, it would be important to ensure that the stated learning outcomes go beyond those of the National Occupational Standards (which are listed) and are mapped to the PQ standards for the various specialist awards that students using this book might be pursuing. Qualified practitioners will wish to build on their core legal knowledge and understanding to develop more sophisticated understandings and engage in development and expansion of themes, issues and debates.

Suzy Braye

Professor of Social Work
University of Sussex

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Values and Ethics in Social Work Practice (2nd Edition)

Parrott, L.

Exeter: Learning Matters, 2010, pp. 173, ISBN: 978-1-84445-370-2, £16.00 (pbk.)

This revised edition of *Values and Ethics in Social Work Practice* sits within Learning Matters' Transforming Social Work Practice series. The series is intended to support students on the social work degree. The introduction to this volume states that it is targeted primarily at first year students but likely to be of use more widely. It is, it says, designed to encourage critical thinking among its readership. The volume, first published in 2006, underwent two reprints in 2007 and is now out in its second edition. It is

obviously catering for a need or demand in the market. The book draws upon a breadth of sources, and ideas, and subjects these to some critical and, at times, insightful thinking, especially regarding the respective impact that managerialist dogma and ideas of risk have on social work practice. Chapter Six also contains some good discussion of advocacy. In that sense it, perhaps, does begin to model the kind of critical thinking it hopes for in its readership.

Against such a backdrop it feels somewhat churlish to record a number of reservations about the book. These are largely to do with its structure. Basically, I struggled to discern what, if anything, holds the book together. It claims as its central theme, “the importance of a commitment to social justice through anti-oppressive practice as the bedrock upon which social work values and ethics are set” (p.xiii). Anti-Oppressive Practice, somewhat uncritically, is claimed to have positively influenced social work practice. This privileging of Anti-Oppressive Practice as foundational in social work values and ethics can have the effect of underplaying the profession’s historical context. Biestek scarcely warrants a mention, far less some of the earlier (or indeed contemporary) religious, political or philosophical thinkers who might claim strands of a tradition of social work values or ethics.

The conflation of values and ethics in the book’s title might, in fact, be problematic. While there is some discussion in Chapter One as to what social work values might be, ethics receives no such treatment. This leads to a failure to differentiate between major ethical theories such as deontology, consequentialism virtue or care ethics and social work mood music such as AOP. Indeed, AOP merits a chapter (Chapter Two) of its own while the aforementioned ethical theories are all dealt with in Chapter Three, ‘Principles and Consequences’. Inevitably, they cannot be done justice in the resultant discussion. Thus, Kant is located within the Enlightenment but the Enlightenment is not then linked with modernity and its quest for

scientific rationality. This makes the introduction of Bauman’s critique of modernist ethics in Chapter Eight feel rather decontextualised.

The other structural problem is one of overcrowding. Too many ideas are thrown together while their associations are rarely developed meaningfully. In Chapter Eight, in his discussion of bureaucracy, the author introduces Kafka, *Catch 22*, Foucault in respect of Bentham’s Panopticon and Bauman. I am not sure how many undergraduate students would manage to make the connections required to make sense of this. Similar conceptual overload is evident in a number of places in the book. The resultant sense of bittiness isn’t helped by the series’ attempt to link texts to National Occupational Standards, the General Social Care Council’s Code of Practice and academic benchmark statements. Attempting to consider ethics within such a framework is, perhaps, particularly troublesome in light of their aporetic nature.

Before concluding, I feel I need to question the book’s suggestion that Alison Taylor, the ‘whistleblower’ at the heart of the North Wales child abuse inquiry, “upheld the highest standards of ethical social work practice” (p.13). An authoritative counter narrative of the North Wales case (Webster, 2005) paints a very different picture of Taylor. Indeed, this example might provide copious food for ethical thought around aspects of consequence or virtue regarding Taylor’s actions. It is at best simplistic and, arguably, exceedingly questionable to accord her such elevated status in the annals of social work ethics.

A final gripe concerns the book’s idiosyncratic indexing. Biestek does not feature, nor does Bauman, whereas Habermas does. So too does Alison Taylor but she is only linked with one page whereas she features again elsewhere later in the book.

So, to conclude, the book may have some merit in providing a Cook’s tour of a range of

ideas influencing contemporary social work but I am not sure if all the discussion could best be thought of as being about values and ethics. As a way into values and ethics, I think it would need to be augmented by some of the other texts on this subject.

Mark Smith

Lecturer in Social Work
University of Edinburgh

Reference

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Death, Dying and Bereavement - Issues for Practice

Watts, J. H.

Scotland: Dunedin Academic Press Ltd, 2010, ISBN: 978-1-906716-08-0, £13.99 (pbk.)

Jacqueline Watts has written this book as part of a series looking at Policy and Practice in Health and Social Care. The book aims to explore issues around death and dying in the UK with an emphasis on what is happening in Scotland.

The first chapter considers death and dying in modern Britain looking at how and where people die, together with how we as a society, view death. There are some interesting statistics given which demonstrate where people would like to die and where they actually die. There are also contrasts between life expectancy in areas of the UK, with Scotland given particular mention. Attitudes towards death and dying are discussed together with the influence of major religions. The chapter finishes by considering what is a 'good death'. Several definitions are explored but I was surprised that patient choice was only alluded to and not discussed more explicitly. Although this book is looking at practices in Scotland, I felt that the *End of Life Strategy* (DH, 2008) could also have been given a mention at this stage.

The second and third chapters look at the philosophy and practice of palliative care, together with the rise of the hospice movement in the UK. The concept of palliative care is explored and the holistic approach to care is recognised and discussed. Ethical principles are defined and the importance of good communication skills in end of life care is addressed. I would have liked a little more about this, especially in relation to advanced care planning which is not mentioned. The challenge of widening access to palliative care is explored, although no mention was made of initiatives that have helped to do this. The author gives a good overview of the history of the hospice movement and day therapy services but I think does not make the distinction between specialist palliative care services and palliative care provided by generalist practitioners. Although patients may die in hospital, they spend much of their last year of life at home supported by community services but this is not acknowledged. What is also not acknowledged is that many patients come into a hospice for short periods of time before going back home but the impression given was that most people come to a hospice in-patient unit to die.

Chapter Four is, in my opinion, one of the best chapters of the book, focusing on spirituality. Definitions of spirituality are offered together with an overview of spiritual care. The author asks the question "whose job is spiritual care?" and, while indicating that it is the job of any health care worker, also acknowledges that time constraints can make this difficult. The author also speculates that while attentive listening to the patient story can be important, is it possible to give spiritual care in relation to their life review if the health professional has only known the patient a short time? In my experience, listening to a patient tell their life story when facing death is one of the most moving experiences I have had as a health professional. I would like to think that I was able to offer a little spiritual support by doing so. The chapter concludes with an overview of spiritual care policy in Scotland but fails to

mention the Spiritual Care Competencies developed by Marie Curie Cancer Care in Scotland.

The fifth and sixth chapters focus on understanding grief and supporting bereaved people. Models of grief are explored and there is also a section on anticipatory grieving which was refreshing as this is often an aspect that is overlooked. I would have liked a little about the factors that influence grieving such as the relationship with the person who died as well as the models of grief. The author argues that, as the experience of grief has become essentially private in Western Society, there is uncertainty about the 'normal' feeling of grief, which has led to the development of "professional skills and services aimed principally at providing reassurance to the bereaved person". While there may well be some truth in this, I am not sure it is quite so straightforward. The demise of the nuclear family and migration from relatives, often leaving people alone and unsupported, may well contribute to people needing support during bereavement. Support for bereaved people is explored in terms of counselling and mutual support groups. Bereavement services in the UK are explored and there is an interesting section on the needs of bereaved children and young adults. However, no mention was made of the work that Julie Stokes and Winston's Wish (the charity for bereaved children) have undertaken which has contributed greatly in terms of understanding the needs of this particular group and providing services to meet those needs - which was surprising.

The last chapter looks at issues for policy and practice. The author touches on issues such as legislation and assisted suicide and

euthanasia. I would have liked the author to have explored this in more depth – especially assisted suicide and euthanasia given the Assisted Dying Bill out for consultation in Scotland. The author then focuses on the report from NHS Scotland (2008) *Living and Dying Well: A National Action Plan for Palliative and End of Life Care in Scotland* and emphasises the importance of a cohesive approach to planning and delivering end of life care. The National End of Life Tools are defined and the action plan is discussed.

Overall, this book gives an interesting overview of death, dying and bereavement although I feel it has missed out on some of the aspects that would have given it a fuller perspective. It is very readable and will have relevance for those working in other parts of the UK as well as Scotland. It provides a stepping stone to more in-depth reading and has a really useful list of references.

Cathy Alban Jones
Head of Education

Arthur Rank House: Specialist palliative care service for people over 18 who have a life-limiting illness,
Cambridge

References

Department of Health (2008) *End of Life Care Strategy - promoting high quality care for all adults at the end of life*, London: Department of Health.

NHS Scotland (2008) *Living and Dying Well: a National Action Plan for Palliative and End of Life Care in Scotland*, Edinburgh: NHS Scotland.