



volume 29: number 3: 2012

Research, Policy and Planning

The Journal of the Social Services Research Group

www.ssr.org.uk

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Publication

Research, Policy and Planning is usually published three times a year - by the SSRG, and distributed free to members.

Reviews

Books etc, for review should be sent to:
Paul Dolan, 15 Amherst Avenue, Handsworth Wood,
Birmingham, B20 2LH
Email: pfdolan@hotmail.com
Tel: 0121 554 1220 / 07553 788 456

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Editorial Address

Shelley Nix
Faculty of Education, Health and Sciences
University of Derby
Britannia Mill
Mackworth Road
Derby
DE22 3BL

Email: S.Nix@derby.ac.uk

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Welcome to the third and final edition of volume 29 of *Research, Policy and Planning*, and best wishes from the editorial team for the New Year in 2013.

Last year saw the 40th anniversary of RPP's parent organisation, the Social Services Research Group, and three of the four papers in this edition of the Journal are based on conference presentations made by speakers at the *SSRG 40th Anniversary Annual Workshop* in March 2012.

The first of these, from **Martin Knapp and Ann Richardson**, is a short, reflective paper primarily focused on the impact of social care research on social care researchers. The paper offers a reminder to research active readers, should one be needed, about why social care research can offer both enormous satisfactions and dissatisfactions in equal measure. The paper also offers a series of useful practical suggestions for improving the impact of research, for researchers, research commissioners and policy makers.

John Clarke's paper is the first of three that offer a critical and dissenting assessment of current social care policy and policy direction. Historical amnesia – the term he uses to describe his theme – is not new. The phrase 'Those who cannot remember the past are condemned to repeat it' - or something like it – has been variously attributed to Burke, Marx or Santayana. More recently, the Czech writer Milan Kundera also suggested that 'The struggle of man (*sic.*) against power is the struggle of memory against forgetting'. Clarke reminds us, *once again*, that looking back as well as forward is usually a worthwhile activity in the field of contemporary social policy generally, and in relation to social care specifically. At the core of his paper is a critical challenge: 'If we forget the history of policy, the history of its effects, the history of the accumulation of evidence and varieties of knowledge – how can we hope to make new and better policy?' Clarke illustrates this in relation to two big policy ideas from the present government – the 'Big Society' and the concept of 'austerity'. Clarke adroitly summarises the way key events and policies are overlooked or forgotten as these policy themes are developed.

The third paper to emerge from the 40th *SSRG Annual Workshop* – and the second critical commentary on an aspect of social care policy – comes from **Colin Slasberg, Peter Beresford and Peter Schofield** who take issue with the idea that self directed support is achieving success in delivering personal budgets and personalisation. The authors offer a critical review of the impact of the implementation of self directed support and personal budgets on the personalisation of social care, arguing that the 'indicative budget' stage of the process of self directed support (held by advocates of self directed support to be a key stage in the self directed support process) is undermined by subsequent panel decisions that change the indicative allocation. They go on to argue that the implementation of new arrangements, far from reducing infrastructure costs, as has been claimed, in fact increases bureaucracy and that any savings that may have been made may be due to changes in the proportions of qualified to unqualified staff involved in assessment and budget planning processes. The authors call for a new eligibility framework to support local authority decision-making and a right to holistic assessment in order to reconstruct the relationship between service users and local authorities from 'empowered consumer' to partnership.

The fourth paper, by **Guy Daly**, is focused on the promotion of choice in adult social care. The extension of choice in public sector services has been a major policy objective of successive governments over the last two decades and commands wide, but often uncritical support from politicians, policy makers and the public. Daly's paper reminds us that choice may also bring negative consequences. Referring to the work of T.H. Marshall, Daly persuasively argues that the extension of 'market rights' into adult social care – a concomitant, if enhanced choice is to

occur – may diminish the ‘social rights’ of citizens, and calls for proper funding of social care to have precedence over the extension of choice.

Additionally, this edition of the Journal contains a review by **Paul Dolan**, our Reviews Editor, in collaboration with **Martin Stevens**, SSRG's Chair, of the 12 published *Methods Reviews* commissioned by the School for Social Care Research (all available on their website at <http://www.sscr.nihr.ac.uk/methodsreviews.php>). As well as providing a succinct summary of these methods reviews, Dolan and Stevens draw attention to remaining gaps in these reviews and to the way that some of the authors draw on literature from other disciplines rather than social work or social care – reflecting continuing gaps in evidence. Although the creation of research governance arrangements for social care, SCIE and the School for Social Care Research in the last couple of decades are all evidence of a continuing commitment to social work and social care research, the review is a reminder that there is still much to do.

John Woolham

Research Fellow

Some reflections on social care research: joys, tribulations and aspirations

Martin Knapp^{1,2} and Ann Richardson¹

¹ Personal Social Services Research Unit (PSSRU), London School of Economics and Political Science

² NIHR School for Social Care Research

Abstract

Social care researchers, like their colleagues in other fields, are generally too busy investigating the needs and concerns of others to turn the spotlight around to consider their own activity. But it is a useful exercise, from time to time, to reflect on the impact of the research task on researchers themselves and on others involved in the research process. This paper does not pretend to offer any new evidence on these issues, but it may help those working in social care research to take stock and gain some insight into paths they might usefully explore.

Keywords: Social care, research, methods, research funding, School for Social Care Research

The joys

To begin on a positive note, social care researchers have much of which they can feel proud. Over the years, they have sought to respond to the enormous, complex and increasingly prevalent needs of individuals and their families, as well as wider communities. In a world where the news in social care is often bleak, with great pressure on resources and growing expectations on all sides, the role of research has proved highly important, and potentially of greater influence than ever before. New policies or practices have been introduced in some areas, creating a need for evidence on their actual impact. In addition, for some user groups, there are growing numbers of people needing care, for instance of older people with personal care needs or cognitive impairment, necessitating research attention on how best to meet such needs. The results of countless studies have enabled governments of every hue to develop policies more wisely and in ways that reflect the genuine needs of those seeking care. The numbers in need, the specific nature of the needs of both service users and those who care for them, the efficient and effective use of resources have all been highlighted through the efforts of both quantitative and qualitative social care researchers.

From the perspective of researchers themselves, doing social research is often stimulating, even fun. This is not a frequently noted aspect of the research endeavour, but should not be forgotten. Researchers may enter this field seeking a challenge, and in the social care world they are rarely disappointed, for there are few easy research questions or simple policy or practice solutions. The skills needed to undertake research are considerable – from the ability to obtain information (whether by in-depth interview, focus group or in other ways to generate primary data, or by seeking out sources of extant knowledge), analyse such evidence and then write it up in a readable style for dissemination. In short, the process of undertaking research involves a great deal of day-to-day learning, not always transferable from one study to another. Often working with colleagues in the same or other disciplines, there is also the satisfaction of finding agreed understandings. And there is also a special pleasure from doing research into problems which are genuinely important to people's lives.

The tribulations

But research is not always a bed of roses. First, many social care researchers experience real problems arising from the nature of their

job. Their status within their employing organisation often tends to be low. Many work alone and have few people to whom they can go when they need advice or help. Even those working in an ostensible team may have full responsibility for one aspect of a joint task, so that little expert assistance is readily available. Deadlines can be a constant worry, especially when there is slippage in earlier aspects of the planned activity arising from causes outside the researcher's control. And, of course, the jobs of many researchers are insecure, dependent on short-term contracts, so that many experience ongoing anxieties about their own professional or financial future.

In addition, every social care researcher also knows that many obstacles are – unwittingly or otherwise – put in their way in the course of trying to do their work. They often work in a context of considerable misunderstanding of the nature of the research process. Regrettably, those who commission such research are sometimes naïve about its inevitable limitations. They tend to want results quickly (often ‘yesterday’) and therefore to resort to funding short-term projects which researchers themselves know cannot reflect the complexity of the issues addressed, or adequately answer the important questions. Some research commissioners think that the answers to their questions are already known if only researchers would trawl existing findings or, worse, reinterpret such findings in ways inappropriate to the nature or location or service user group. More worryingly still, some policy-makers may be tempted to seek research merely to confirm decisions already taken, viewing the process of research more as buttress than beacon.

It can be difficult for researchers to stand up to these demands – or seek to explain why they are inappropriate – when they are dependent on these same individuals or organisations for their future contracts and therefore their employment. This is a particular challenge for a researcher employed in a setting such as a university

where independence, transparency and freedom of expression are viewed as paramount. Many senior researchers know they could double their salaries overnight by setting up the kind of consultancy that gives the customer exactly the results needed to support their business interests or policy aims. Indeed, the research task calls on political skills in which many researchers were never trained and which they may not be keen to exercise.

Social care researchers also face challenges from other sources. People working at the front line of services, who are often asked to assist the research process, can also create obstacles for the researcher. Some local practitioners do not understand the complexities of research design, such as the processes of piloting or randomisation, arguing that it is unethical to include some of the people they support and not others, or do not appreciate that some evidence-gathering approaches such as focus groups are necessarily time-consuming. They may be reluctant to include particular individuals or families in a study on the grounds they are not ‘typical’ or, alternatively, because they are not felt to be ‘up to participation’. In some cases, this may even be from a fear that such people will reflect badly on local provision. With the best of intentions, people working in services may want to alter the wording of questions on well-validated questionnaires, arguing that the wording of long-established, validated tools is inappropriate to a particular service user group or context. Some even continue to question the benefits of asking the opinions of those who use services or their carers altogether. (This does not mean that the researcher is always right, and there are plenty of instances of researchers being deaf to helpful suggestions of field staff, for example, but the process of negotiating a research study can sometimes be enormously time-consuming and frustrating for everyone concerned.)

We cannot discuss the tribulations of undertaking research without mentioning the need for ethical and governance approval.

Each is an essential element for successful research, but each can cause difficulties for the researcher. Indeed, whatever the very reasonable premise underlying current requirements, virtually every researcher has at one time or another been seriously frustrated by the processes. In the social care area, tricky questions can arise over issues such as mental capacity, and it is beholden on the researcher to prepare properly by gaining a clear understanding of the legal framework and how it plays out in a particular empirical study. Where researchers often feel that the right balance might *not* have been struck is when ethics committees or governance leads probe into the planned methods in ways that appear to go beyond their remit or skills. But then those committee members or leads might counter that poorly designed, hard-to-implement research wastes the time of individuals and organisations when it cannot answer the questions it purports to address.

Of course, once research has been commissioned and undertaken, problems can arise with the use, dissemination and take-up of the results. Many a researcher presenting quantitative evidence has been told that 'each individual is different' and it is therefore inappropriate to reduce life's 'rich tapestry' to a set of generalised numbers. Conversely, those presenting qualitative data are often confronted with the view that such information is not based on sufficiently large numbers or is in other ways not representative or robust. Or some of the potential users of a study might challenge the underlying motives of the researchers, for example seeing work that is funded by government as politically motivated. Some people involved in policy or practice seem to be reluctant to use research results at all, and research reports often lie unread by those for whom they were intended. (It might be added that this is sometimes because they are written in verbose, impenetrable style. Researchers also need to remember that busy decision-makers do not have the time to search for journal articles to keep up with the latest findings. Many academic journals are also accessible only to subscribers.) The emphasis being

given today to better access to research findings is very welcome in this respect, although the economics of open access publishing remain challenging.

Equally harmful, the evidence from research reports may be used selectively. Reports may be read, but only to seek out evidence that supports particular policy positions. Carefully worded prose that sets out the methodological limitations of a study may be ignored, whether by accident or for reasons of time or political convenience, with only the headline findings passed on to political masters or wielded in some media release to support a particular argument. As a result, the caveats so commonly necessary to describe and define the robustness of findings are lost. Researchers can end up with ideas or evidence ascribed to them which were never intended or, indeed, written.

Social care researchers can also be met with a blanket distrust of all research, making it difficult to argue from their carefully collected evidence. Some sceptics argue that most such research is undertaken solely for political reasons, such as when an economic evaluation is seen to be simply a means to argue for the reduction of public expenditure. It therefore follows, it is argued, that it would be better not to fund research at all. Some implicitly suggest that research is an alternative to action and, given an inevitable shortage of resources, it is much more important to fund frontline services than 'waste' resources on studies.

There is also a prejudice arising from poorly conducted studies undertaken by those outside their profession. A great deal of quasi-research is carried out by auditors, inspectors, task forces and the like who do not usually refer to themselves as 'researchers' but who nonetheless carry out work that is, to all intents and purposes, identical to that which occupies people who are referred to by that term. Their investigations can frequently be intrusive, poorly designed and poorly analysed. They are often undertaken with absolutely no

ethical approval or independent peer review. (Indeed, some reports from such bodies only cite other reports by similar bodies – or themselves – seemingly oblivious to an evidence base from more robustly conducted research. And yes, it is also true that researchers can be terribly, even pathologically, ‘precious’ about methods and processes, and are often poor communicators of what they have found.) Similar problems can arise with student projects, sadly sometimes undertaken without adequate or skilled supervision – and still sometimes undertaken without adequate ethical review. All such activity, although carried out for well-intentioned reasons, can end up reflecting badly on social care research more broadly.

Aspirations

Given these challenges, what can be proposed to improve the dissemination and, more importantly, the *impact* of social care research? Although much could be done on a variety of fronts, we focus here on actions that can be taken by researchers themselves or by their broader professional organisations.

First, social care researchers need to be alert to the practical benefits that can arise from their investigations and ensure that others – particularly research commissioners, users of research findings in provider or commissioner bodies – are aware of these as well. Whatever the temptation to embark on ‘blue skies’ research with no immediate or obvious practical value (‘because it is interesting’), researchers will find few supporters of such a course, especially in the current economic climate. Research proposals should – and normally do – seek to identify the likely practical outcomes, and research reports and other outputs should, of course, strive to find and communicate them.

Although this sounds obvious, researchers should ensure that the methods they employ are suitable to the topic or issue, and that their studies are carried out with appropriate rigour. This is the case whether they are

undertaking large quantitative investigations, small qualitative studies or other sorts of research. This is not to argue that most social care research is *not* rigorous, but it is disappointing still to see poorly designed and implemented studies. One of the aims of the NIHR School for Social Care Research is to improve research capacity in social care, and among the mechanisms we are using in pursuit of this aim is the commissioning of methods reviews. Another is the organisation of events that help to spread knowledge and skills. For example, we want to explore how far social care research could gain from contacts with researchers in other fields, such as health care and housing research.

Researchers need to take lead responsibility for dissemination of their findings. They cannot assume that others will do the job for them. As knowledge transfer experts repeatedly remind us, communication of results needs to be planned at a study’s inception, not when writing the last paragraph of the final report. Many researchers will (rightly) complain that they have not been given sufficient time or resources in their project to fully disseminate their findings, having to write the proposal for their next study at precisely the time they are trying to finish their current work. Research commissioning bodies are often culpable and sometimes (irrationally) unsympathetic. But if researchers were to plan their dissemination or knowledge transfer strategy at the outset, there might be less risk of them expending time writing heavy reports that no-one will read or crafting articles for arcane academic journals that few people have heard of, and even fewer will ever access. Some findings may be of most interest to people who use services and their carers, so that an appropriate vehicle for dissemination might be general mainstream media or weekly magazines. Indeed, there is a need to raise the media profile of social care in general and of social care research. An avalanche of blogs and the chirruping of Tweets might not be to everyone’s taste, but these can be useful ways to make a wide range of people aware of new evidence.

Some research commissioning bodies – and the Joseph Rowntree Foundation is one that comes to mind – have sponsored training in dissemination methods, and generally there is much better appreciation today of how, when and where to be aiming to transfer knowledge from research to those communities that might be able to use it. In the School for Social Care Research we are working with a number of organisations and individuals to suggest ‘pathways to impact’: a set of suggestions and experiences that might help to improve the translation of research evidence into practice. There is a need for exchange: for research providers and research users to better understand and trust each other and to appreciate the pressures under which each works.

Another set of aspirations is for research to be more proportionate, timely and pragmatic. Not every study needs a systematic literature review before it can get into the field. Nor does every project need to start with a survey of local authorities or provider organisations, especially since many of these bodies are feeling bombarded with requests for information and experiencing budget cuts. For quantitative studies, there are usually ways to work out what size sample is needed, yet many social care researchers seem unaware of such possibilities. There is rarely a need nowadays to develop a completely new tool for measuring needs or outcomes, given that we already have some excellent such instruments in most areas of social care. Perhaps most importantly, whatever the focus and whatever the methods, there is no justification for collecting evidence that will not actually be used.

Finally, research really does need to be participative, with greater involvement of people who use services and carers from the very outset. More attention is now being paid to the need for user-controlled research, which offers numerous advantages but also practical and conceptual challenges.

Onward and upward

Compared to even just a few years ago, social care research is in a much better place than it used to be. Research methods *are* more robust and improving on both the qualitative and quantitative fronts. There *is* much greater involvement of people who use services or provide care and support. There *is* better communication of findings. But in a paper that might already be heavy on truisms, here is one more: the need to guard against perfection becoming the enemy of the merely ‘good’. Austere times demand imaginative responses.

Notes on Contributors

Martin Knapp is Director of PSSRU at LSE, Director of the NIHR School for Social Care Research and Professor of Social Policy. He is also based at King’s College London in the Centre for the Economics of Mental and Physical Health. His research interests are primarily in social care, mental health and intellectual disability

Ann Richardson is a Visiting Fellow at PSSRU at the London School of Economics. She has been a qualitative researcher for over 40 years and has written extensively in the fields of health and social care. Her most recent book is *Life in a Hospice: Reflections on Caring for the Dying*, Radcliffe Publishing.

Address for Correspondence

Martin Knapp
PSSRU
London School of Economics and Political
Science
Houghton Street
London
WC2A 2AE

Email: M.Knapp@lse.ac.uk

Historical amnesia: linking past, present and future in politics and policy

John Clarke

The Open University

Abstract

This article explores the problem of historical amnesia in politics and policy. It suggests that forgetfulness about past experience, past policies and past knowledge is a dangerous condition. Drawing on several recent examples, it explores the implications of this form of amnesia and its relationship to another disorder of the politics of policy making: the fetishization of certain objects such as community. Taking up the issue of the contemporary politics and policy of austerity, the paper points to the importance of learning lessons from the past and not surrendering policy making to the proclaimed urgency of the present and future. It concludes that such forms of 'telling the time' are critical political devices.

Keywords: Amnesia, fetishism, knowledge, poverty, community, austerity

In celebrating the 40th anniversary of the Social Services Research Group, I was preparing to talk about the shifting ways in which knowledge has been produced, used and valued over the last forty years since I walked out of the doors of Aston University (just up the road from here) clutching my undergraduate degree. This seemed an appropriate topic for such an occasion, but several things I heard in the course of the day made me abandon my original intention and turn instead to problems of how we think about the connections between past, present and future in the field of policy (and in the politics of policy). Let me just sketch the things that provoked me to change my mind. First, there was an injunction to turn our attention to the future, rather than focusing on the past. Second, there was a claim that, in thinking about social care, 'austerity is the new real'. Third – and here my blood pressure began to reach dangerous levels – was the claim that where we had all criticised Sir Keith Joseph's ideas about a cycle of deprivation when he publicised them in the 1980s, now we all used the idea as a matter of course.

At this point I should apologise to the person who was then sitting in front of me. When that last claim was made, I confess that I

shouted – probably a little too loudly – 'Oh no, we don't'. I certainly don't count myself as part of a 'we' that now uses such ideas unproblematically, and I rather resent being spoken for in such a manner. It was probably this issue – and the manner of assembling this 'we' that now trails in Sir Keith's wake – that was at the core of my decision to talk differently and, in particular, to address the problem of historical amnesia. By historical amnesia, I mean the disposition to omit, forget or delete aspects of history that are, at least, inconvenient for the politics and policies of the present. Such amnesia occludes aspects of past policy making, past politics and – crucially for this setting – past knowledge that might interrupt the future being projected in the contemporary politics and policies. It is, I will suggest, an unfortunate and potentially dangerous disposition.

I will work my way backwards through these provocations about the past, present and future and add some others as I go. That should enable me to end with the problem of the injunction to think about the future, rather than being obsessed with the past: an injunction that I think misrepresents the role of time and knowledge in the policy making process – with unfortunate (and potentially

dangerous) consequences. But speaking of unfortunate consequences, let me turn my attention to the strange revival of Sir Keith Joseph. It is certainly true that I, like many others, criticised his idea of cycles of deprivation as an account of poverty and inequality in the 1980s. It was itself a rather impoverished version of not very convincing American scholarship addressed to the culture of poverty (Lewis, 1969). This cluster of explanations was consistently attacked for ‘blaming the victim’ (Ryan, 1971). That is to say, they located the causes of poverty and immiseration among the poor themselves rather than in the economic, social and political conditions that distributed inequality in advanced Western societies. Such critiques were well established by the time that Joseph floated his version and I don’t intend to rehearse them here.

However, I am troubled by the notion that we all use those ideas now. I am troubled in part because it seems to me to be an unwarranted slur on the audience (Do we? Do we all?) but also because it implies there has been a sort of gentle cultural shift in world of policy and practice in which ‘we’ have all come to terms with things we once found either wrong or offensive (or perhaps both). Upsetting though that idea is (and I have never knowingly used the idea of cycles of deprivation as a way of thinking about inequality), it is still not quite the problem of *historical amnesia* about politics and policy. Historical amnesia here involves forgetting what government politics and policy have done about cycles of deprivation. If we must talk about cycles of deprivation, then we should pay attention to what governments have done to create them. From the governments that included Sir Keith Joseph in the 1980s, through to the present coalition of austerity, we have seen the pursuit of economic and social policies whose effects have systematically marginalised some places and some people – leaving them structurally outside the various ‘economic miracles’ of the free market, and increasingly poorly supported by what used to be a welfare state. If we do now have cycles of deprivation – involving the reproduction of

marginalization and immiseration across generations – we must look to government policy as the agent that has made Sir Keith’s bleak vision come true.

Here is the core of my trouble with historical amnesia. If we forget the history of policy, the history of its effects, the history of the accumulation of evidence and varieties of knowledge – how can we hope to make new and better policy? Unless we know something about how we got here, how will we escape? Historical amnesia seems to me to stand at the intersection of two rather different pressures. The first is the drive to newness and innovation – such that what some have called ‘policy hyperactivity’ dominates, driven by the desire of governments to be seen to be doing something. The second is the rather more wilful (re)writing of history to edit out inconvenient elements. This is *selective amnesia* and is perhaps best exemplified by one of David Cameron’s accounts of the need for a Big Society. I offer a fairly lengthy extract to give a clear sense of how this selective amnesia works:

For centuries, the state expanded in order to help achieve a fairer society. This expansion took many forms. There was the passing of legislation - like the Poor Laws and Factory Acts. There was the introduction of financial help - like sickness benefits. There was the empowerment of institutions - such as local authorities being charged with clearing sums. And in one particularly progressive moment, there was the marshalling of the whole power of the state to abolish slavery. All this meant that by the eve of World War Two, central authorities were involved in setting minimum wages as well as controlling rents and helped provide unemployment insurance, pensions, and public housing.

And in the immediate post-war period we saw the creation of the welfare state. Both main political parties backed a comprehensive system of social security that included universal healthcare and

education, and unemployment and pensions benefits.

What was the effect of this state expansion? It is difficult to be completely certain because for much of the twentieth century, research on poverty levels used inconsistent measures. But from the evidence we have, we can say with some confidence that up until the 1930s poverty fell compared to the years before.

Understandably, in the immediate aftermath of the Great Depression, poverty did begin to rise. But during the 1940s there was a fall in poverty of between ten and twenty percent compared to the 1930s. By the 1960s we are on firmer ground, as consistent statistics on household income began to be produced for the first time. And this data shows that between 1961 and 1968, the number of people living in severe poverty fell by 900,000 and the gap between the richest and poorest fell.

So the evidence suggests that up until the late 1960s, the expansion of the state to advance social justice was not only well-intentioned and compassionate, but generally successful. However, even in this period, it's important to look at the complete picture. Some state extensions helped tackle poverty, others were less effective. Some did so while encouraging responsibility and local pride at the same time others undermined these virtues.

SINCE 1997

But since the immediate post-war period, the most significant extension of the state has taken place under the current Labour government. In 1997, government spending as a proportion of GDP was 38.2 percent. Next year, it is forecast to rise above fifty percent.

... So did it work? Did the rapid expansion of the state since 1997 succeed in tackling poverty? Did it reduce inequality? Well, it would be churlish to deny that some progress has been made.

Indeed it would be rather amazing if there had been no progress. In the past decade, public spending has doubled. Health spending has almost trebled.

Since 1997 the Government has spent £473 billion on welfare payments alone - that's as big as our whole economy in 1988. Much of this has been channelled through tax credits and income transfers and as a result, there has been a measure of success in lifting those just below the poverty line to just above it.

But, quite apart from the fact that it turns out much of this has been paid for on account, creating debts that will have to be paid back by future generations; a more complete assessment of the evidence shows something different - that as the state continued to expand under Labour, our society became more, not less unfair.

In the past decade, the gap between the richest and the poorest got wider. Indeed, inequality is now at a record high. The very poorest in our society got poorer - and there are more of them. The incomes of the bottom ten percent actually fell by £6 per week between 2002 and 2008 before housing costs, and £9 per week after housing costs. The number of people living in severe poverty has actually risen - not fallen, risen - by 900,000 in the past ten years. (Cameron, 2009)

This is an impressive story and one that, for a Conservative, is relatively generous about a history of state involvement and investment. But - oddly - a large chunk of recent political history goes missing. 'Up to the late 60s', he observes, the expansion of the state was generally successful... but 'since 1997' inequality rose and society became more unfair. In the process, however, the 1970s, 1980s and most of the 1990s disappear... almost as if nothing of interest happened. And while I am sympathetic to the pressures of editing speeches to length, it is strange to omit the longest period of post-Second World War Conservative rule: the Thatcher and Major governments of 1979-1997.

Of course, it is true that this period would interrupt the story that Cameron wished to tell about the continuing, unchecked and eventually counter-productive growth of the state. It is also true that it would complicate the story about deepening inequality and unfairness a little, since this was a process inaugurated and intensified during the 1980s and 1990s by the economic and social policies pursued by Conservative governments. And, of course, it is true that including the eighteen years of Conservative rule would call into the question the proposition that deepening inequality is linked to the excessive growth of the state. So, let me repeat my earlier claims: if we do not know how we got here, how can we hope to escape? More precisely, how can we even hope to identify the problems that policy is supposed to address?

I want to stick with the Big Society for a moment, not just to insist that a history of the state and inequality in this country would have to tackle the missing eighteen years and the intentional, systematic encouragement of inequality as an objective of economic and social policy. Nor would it be merely to raise the question of how the shifting role of the state towards providing corporate, rather than individual or household, welfare might be understood. Rather it is that the Big Society involves the most recent return of the most desired object in British social policy: the community. The community combines two psychological disorders in one: it is the focus of both historical amnesia and policy fetishism. In what appears to be a recurring cycle (albeit one that is perhaps increasingly speeded up), community is endlessly rediscovered as the holy grail of UK social policy. Community is simultaneously the object and subject of policy innovation – it is what government should create, enable or empower and it is the form in which we will all govern ourselves (better). Each time community is rediscovered, it appears to have no history. It is announced as though no government has ever addressed the idea before; as though no policies have ever been implemented; as though no research on their

effects has been undertaken – and indeed as though no-one has ever thought or written about the problems of attempting to govern through community (by way of contrast, see Creed, 2006; and Mooney & Neal, 2008).

I do not mean this as a complaint: that no-one listens to academics (of course they don't, and I long ago came to terms with that). The problem is that no-one appears to remember earlier policies and politics. As David Cameron announces the centrality of the community to the project of the Big Society (and promises to train thousands of community activists), can he not hear the echoes of New Labour's enthusiasm for 'community cohesion'? Or the previous enthusiasm for 'community safety'? Can he not remember the recurring Conservative belief of the 1980s and 1990s that communities could be the basis of values, care and regeneration? Can he (or his policy makers or speech writers) not remember the ill-fated Community Development Programme launched in the 1970s? Time after time, community is summoned up as if it has been newly discovered. This is the combination of amnesia and fetishism that make community such a keyword in the politics of policy – it is hard to think of anything else that possesses the same kind of magical or totemic quality.

Let me turn to another contemporary fetish: the idea of austerity (and the claim that 'austerity is the new real'). My long-standing interest in words and the ways in which they are used makes me want to interrupt when I hear such sentences: what is being claimed here? Who is making the claim? For what purposes are they making it? In particular, I am prone to be suspicious when people use the word real or its derivatives, such as 'in reality'. Laying claim to the real is a powerful rhetorical device, and one that attempts to dismiss alternatives by implying their unreal, fantastic, or ivory tower quality. However, it is only a claim and one that should be treated with suspicion – both in general and in this particular case. Austerity is only one version of the new real – in both policy and political

terms. In the UK and elsewhere, ‘austerity’ names a particular set of political and policy responses to the economic crisis induced by the financial sector in 2007-8 (see the special issue of *Critical Social Policy* on Austerity, 2012). This set of responses rests on the rather magical transmutation of an economic crisis (in which private corporations were rescued by public intervention – and very large amounts of public funds) into a fiscal crisis (in which public debt and public spending are the ‘problem’). In the UK, the Coalition government has been an enthusiastic ‘early adopter’ of austerity, presenting it (as I have argued elsewhere, Clarke, 2012) as a paradoxical position of ‘virtuous necessity’: a necessity because (as Margaret Thatcher used to remind us) ‘There Is No Alternative’, but virtuous because it is a political choice (that others in the Eurozone, for example, have failed to make).

The last five years have been awash with such puzzling paradoxes, delicate ironies and glaring contradictions and I do not propose to explore them all here. But, in passing, I do want to celebrate the overturning of two of the foundational New Right/neo-liberal/neo-conservative views of public welfare. Since 1979 (approximately), ‘we’ have known that ‘we can no longer afford welfare’. It turns out that this was not exactly true: we can afford *corporate* welfare, but not welfare for citizens (who must be independent, and especially independent of the state). Since about the same moment, we have known that giving people money when they are in need is counterproductive – it induces dependence, saps moral fibre and leads to moral decay. Again, this basic neo-conservative truth needs to be qualified: such consequences happen if we give money to ordinary people, but extraordinary people (bankers, in brief) are strong enough to resist those social and moral effects, so it is OK to give them large amounts of money without worrying.

This probably sounds a little bitter – and it reflects the experience of having to hear these ‘truths’ repeated time and time again in the demolition of public welfare; and the speed

with which such truths could be abandoned when cases of ‘genuine need’ suddenly appeared in the financial sector. But I should return to the main business of the present – the enthusiasm for austerity as the route to restoring ‘economic confidence’. It should be clear that, in political terms, austerity is not the ‘new real’: other strategies exist and continue to haunt the spiraling failures of austerity (in the UK and elsewhere).

Jamie Peck (2010) has described the characteristic tendency of neo-liberalism as ‘failing and flailing forwards’ – since the fantasy of a free market solution never works and needs state action to correct its failure. But the fantasy continually drives failure forwards – what is needed is more neo-liberalism, since it was imperfectly implemented last time. It will work, it must work – if only we try harder. The Stanford professor (and Kaiser Permanente healthcare corporation advisor) Alain Enthoven’s relationship to the NHS perfectly captures this tendency. As one of the original advisors on marketizing NHS reform he promoted the internal market (1985). He later carried out a return visit to review progress and was rather disappointed (1999). However, he attributed the failures to not taking market reforms far enough... more could and should be done. I confess that I view this approach to policy as most closely resembling the mediaeval medical enthusiasm for bloodletting: if letting blood doesn’t work, then let some more flow, and some more until the miracle is achieved (or not...).

The same tendency towards historical amnesia, it should be noted, is true of ‘austerity’: we have been here before (and not just in the post war British sense, see Kynaston, 2010). Austerity is not just not the new *real*, it is not even *new*. Latin American and African nations were subjected to International Monetary Fund driven ‘austerity’ measures (aka structural adjustment) during the 1970s and 1980s with desperate economic, social and political consequences. A recent study by Ponticelli and Voth has traced the relationship between

fiscal austerity measures and social and political disorder in Europe over the twentieth century with interesting results. They argue that a ‘general pattern of association between unrest and budget cuts holds in Europe for the period 1919-2009. It can be found in almost all sub-periods, and for all types of unrest’ (Ponticelli & Voth, 2011, p.26). They conclude that ‘[t]he frequency of demonstrations, assassinations, and general strikes rises monotonically with the scale of cuts. Only in the case of riots is there a small decline for the biggest cut-backs. In the case of demonstrations, the frequency of incidents appears to rise particularly fast as expenditure cuts pass the 3% threshold’ (*op cit.*, 3).

Let me return to the general point: amnesia is not a good foundation for policy-making. If we forget what we already know about austerity and its effects, we risk making the policies and suffering the same consequences. If we forget what we already know – about marketization, about the uses and limits of community, about anti-poverty programmes that target the failings of the poor – then we risk repeating both the mistakes and the effects that they produce. As I noted earlier, I don’t underestimate the pressures – in an intensely mediatized and politicized world – to come up with new, glossy and innovative policies to address contemporary problems or to dramatize them in spectacular ways, for example by making them subject to the rule of a Tsar (and there’s another unfortunate piece of historical amnesia...). I also recognize the ways in which policy-making is framed, contained or trapped within shifting conventions of what is knowable, thinkable and sayable: such as, you can’t solve problems by throwing money at them; don’t make people dependent; we can no longer afford X or Y; the individual/ family/ community is the foundation of society (delete as appropriate – it is possible to believe all three, apparently). But we also need to treat amnesia as a significant contributor to policy and the politics of policy (for a fuller discussion of the problematic relationship between time, public policy and public management, see Pollitt, 2008).

In an article about New Labour and public service reform, I argued that one of the critical pieces of political-cultural work they engaged in was ‘telling the time’. This emerged from a specific puzzle about time: research that we had conducted (in 2003 and 2004) about people’s view of themselves of users of public services suggested they rarely thought of themselves as ‘customers’ or ‘consumers’ (those foundational identities so beloved of modernizers and marketizers). But everywhere I spoke about this work and the popular reluctance to identify with these ‘modern’ identities, I was told that the research was already out of date, or that we had mistakenly studied the wrong sort of people: people who were ‘old’ or at least ‘old-fashioned’ in their thinking. I argued that in such comments:

A particular sort of time is being told... The time at stake in these comments is constructed around characteristic temporal imaginaries that seem to play a potent role in New Labour and neo-liberal discourses. Distinctions between old and new, or between traditional and modern, work on constructing a flow of time between Past and Future. In these distinctions, the Past appears as the location of our troubles, mistakes and misfortunes. In contrast, the Future holds out the promise of overcoming such conditions. The present tends to be less discussed – merely a staging point on the necessary, inevitable and desired trajectory towards the Future. But in the present, the work of political discourse is to distribute people, orientations and political imaginaries to either the Past or the Future. Strange collectivist orientations, conceptions of publics, communities and categories of membership are – in this view – merely residual. They are the left-overs of older formations: the detritus of collectivism, welfarism, or social democracy. And such detritus will inexorably be washed away by the river of time.

(Clarke, 2007, p.245)

So, to return to the beginning of this presentation, I am put on my guard when told that we should turn our attention to the future, rather than think about the past. 'Telling the time' is always a politically charged process in which the groundwork for policy is being constructed. This is not to deny the problems of the present, nor the challenges of the future. But we might be better prepared to confront both of them if we build on the knowledge that we have developed about the past rather than denying its relevance. Historical amnesia, I have suggested, is a dangerous disorder and a shaky basis for policy making.

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Notes on Contributor

John Clarke is Professor of Social Policy at the Open University, where he has worked for more than 30 years on the political and cultural struggles involved in remaking the relationships between welfare, states and nations. He has a particular interest in the ways in which managerialism and consumerism have been involved in reconstructing publics and public services. He is currently working with an international group on a project called Disputing Citizenship. His books include *Changing Welfare*, *Changing States* (Sage, 2004); *Creating Citizen-Consumers* (with Janet Newman and others, Sage, 2007) and *Publics, Politics and Power: remaking the public in public services* (with Janet Newman, Sage, 2009).

Address for Correspondence

John Clarke
Professor of Social Policy
Faculty of Social Sciences
The Open University
Walton Hall
Milton Keynes
MK7 3DB

Email: john.clarke@open.ac.uk

Tel: +44 (0)1908 654 542

How self directed support is failing to deliver personal budgets and personalisation

Colin Slasberg¹, Peter Beresford² and Peter Schofield³

¹ Harlow, Essex

² Brunel University, Uxbridge

³ King's College London

Abstract

Over the past five years, social care has been experiencing a period of change described as 'transformational'. It has largely been based on a model initiated by the organisation 'In Control' (Poll et al., 2006), variously called 'personalisation', 'personal budgets' and 'self directed support'. The drive to create personalised services through self directed support and personal budgets was implemented before the model was fully tested. Indeed, its implementation was announced before completion of a national evaluation set up by the Government. One advantage of such speedy, widespread implementation is that we are now beginning to have substantial evidence regarding its efficacy. At the same time, we are on the cusp of new legislation likely to shape social care for the foreseeable future. It is essential that legislation takes on board what the evidence says about this model – its strengths and weaknesses. The following discussion shows why the underpinning notion of self directed support seems to have failed in its ambitions. However, the concepts of personalisation and personal budgets associated with it may retain value if interpreted in an appropriate way, delivered through an appropriate strategy. Then even so long as resources fall short of needs, they are likely to ensure the best possible outcomes for service users are secured. If and when adequate levels of funding are also provided, there may be the real prospect of enabling all to live their lives on the same terms as others who do not need social care support.

Keywords: Personalisation, government strategy, evidence of worth, outcomes

Introduction

It is possible to discern three core elements of the Westminster Government's transformation strategy for social care, first heralded in the document *Putting People First* (Department of Health, 2007). These are *personalisation*, *personal budgets* and *self directed support*. These reforms were first proposed for England, but have since been extended in slightly different ways throughout the UK. These three elements are often merged into one, with any of the three terms being used to describe the whole. This creates the impression that they are mutually dependent, and no single element can exist without the other two. In this discussion we set out why it is not only possible to distinguish them, but necessary to do so if the vision for

transformation is to be achieved. These three elements are:

- The over-arching ambition to create '*personalisation*' of support, a radical alternative to what has come to be called the '*one size fits all*' service culture, whereby people have to fit into pre-existing services, to give people greater control over their lives.
- A '*personal budget*' to enable purchase of the supports and services most appropriate to the individual.
- The *personal budget* arrived at through a process called '*self directed support*', whereby the personal budget is given 'up-front' so the individual can enter the social care market as an 'empowered consumer'. This can be arrived at

through a resource allocation system (RAS) - a points based formula that measures a person's level of dependency and awards money accordingly, a 'ready reckoner' whereby the practitioner estimates a cost based on what the person might have received using traditional services, or an off the shelf IT system (Think Local Act Personal, 2011, *Minimum Process Framework*).

There is wide support for *personalisation* of services and support as defined above and indeed it can be seen to be a thread in thinking throughout the history of social work and social care. It is a concept at the heart of the White Paper *Caring for Our Future* which expresses the need to:

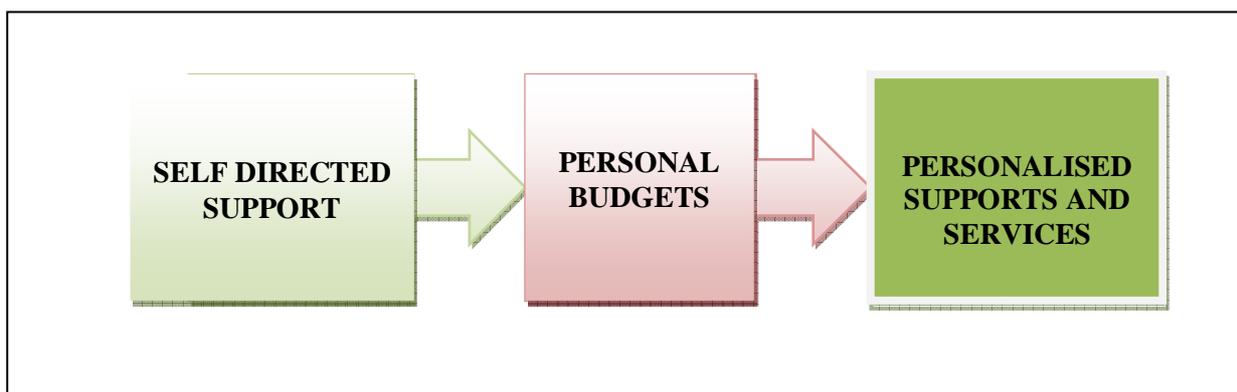
... empower individuals and their carers to make the choices that are right for them.
(Department of Health, 2012, p.3)

For service users, the benefits of having a support system that is responsive to them in their own unique context are self evident. From a council perspective, it is reasonable to hope that replacing a system where most of their budget is spent at the beginning of the year on services into which people have to fit with a system that allows choice of the service that is right for each person, will result in much greater value for money, measured through the balance between costs and outcomes. However, this is not to repeat claims that personalisation through personal budgets will result in major cost savings.

Personal budgets are likely to be at their most effective when used as an opportunity to create a unique support system outside the mainstream, traditional market of commissioned and regulated services. This, in turn, most usually calls for the budget to be taken as a direct payment. This has been seen in a number of studies including the national survey of some 2,000 personal budget holders (Hatton, 2011). However, the evidence, set out later in this paper, is that only a small number of people will make use of this. For the majority, personalisation will come not through choice of which service to purchase, but through a range of choices in relation to how mainstream providers deliver their support. Nonetheless, it should not be assumed which service users will want to create their own support system and which will not. The opportunity to purchase services outside of the mainstream should be available to all. Indeed, by requiring all service users to have a personal budget the *Draft Care and Support Bill*, (Department of Health, 2012, section 25) which proposes a new legislative framework for social care, pre-empts the need for debate should this pass into legislation.

Self directed support has been the most contentious element of the three. The evidence included in this paper suggests that not only is it failing to deliver its intended function, it is having a seriously deleterious effect on social care field work services. There is no reason to believe this will be different in the future.

Figure 1. The route to personalisation through self directed support



Context

The current formal definition of what constitutes a personal budget is owed to the vision of In Control's '7 step model' (Poll *et al.*, 2006, p.25):

1. *The person (or their representative) has been informed about a clear, upfront allocation of funding, enabling them to plan their support arrangements.*
2. *There is an agreed support plan making clear what outcomes are to be achieved with the money.*
3. *The person (or their representative) can use the money in ways and at times of their choosing.* (NHS Information Centre, 2008)

This has been the definition used for performance management since 2009/10 (NHS Information Centre, (2008), National Indicator 130) and has been the basis of a target of all to have a personal budget by Spring 2013 (changed in October 2012 to 70% by the current Minister for Social Care, the Rt. Hon. Norman Lamb). It fundamentally describes the self directed support process.

However, the situation has not been as straightforward as the above definition implies. An early concern was that an upfront allocation - necessarily carried out before knowing the actual cost of meeting a person's needs - would lead to allocations too low to enable eligible needs to be met. This was ostensibly addressed by making the upfront allocation indicative only. The actual budget was to be determined after support planning.

Calculating what resources should be made available to individuals should not detract from a council's duty to determine eligibility following assessment and to meet eligible needs. Rather a RAS should be applied as a means of giving an approximate indication of what it may reasonably cost to meet a person's particular needs according to their individual circumstances. (Department of Health, 2010, p.40)

Attempts have been made to clarify this somewhat mixed message by seeking to minimise both the importance of and work required to address the post support planning decision. Formal guidance published by Think Local Act Personal, the formal initiative and grouping entrusted with steering the transformation says:

The indicative allocation amount should be as close as possible to the final approved budget – if it is not then there is a high risk of wasted process as well as frustrated staff and customers. (Think Local Act Personal, 2011, p.8)

Two critical questions arise from this advice:

1. How close are the indicative and actual allocations in practice? The answer will inform a view about whether or not 'up-front' allocations are driving the size of personal budgets.
2. What has been the impact on the field work process - has there indeed been 'wasted process'?

What is the evidence for proximity of indicative and actual allocations

In Control carried out an analysis of the progress of self directed support in Hartlepool, seen as an exemplar authority for self directed support, in 2009/10. As part of the analysis, they compared the indicative and actual allocations of over 500 cases and reported:

The average approved allocation (actual budget) was £8,457 - slightly lower than the average adjusted allocation (indicative budget) £9167. (Tyson, 2009, p.40)

If the relationship between indicative and actual budgets is expressed as a ratio - where 1 would represent them being the same - the ratio would be 1.08, which may be regarded as reasonably close. However, presenting the data in this way has the effect of concealing the impact that arises from the reality that sometimes the actual budget is lower than the

indicative budget and sometimes higher. A Freedom of Information Act request made to Hartlepool Council in April 2012 for the two sets of data for each of the cases showed this was indeed the case. Of 512 cases, in 381, the actual budget was less than the indicative amount and in 120, it was more. On only 11 occasions was it the same.

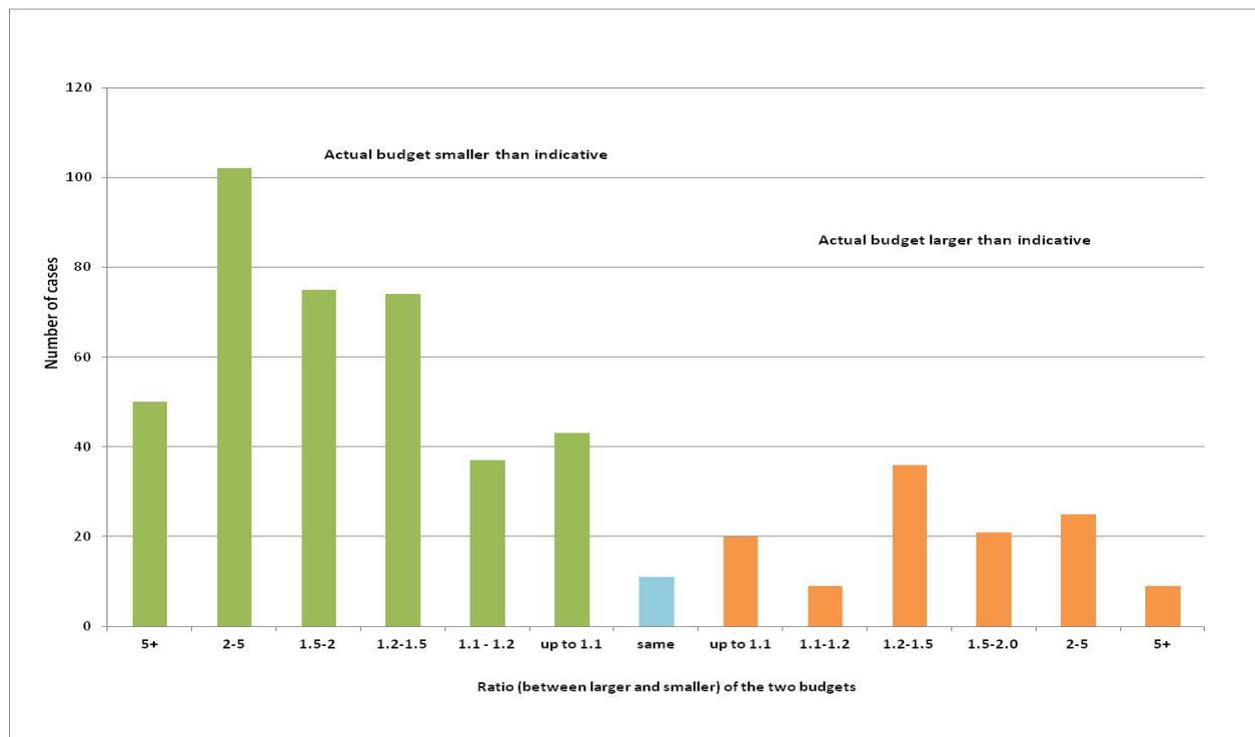
Figure 2 shows how many cases fell into each of the following groups:

- Ratio of 1, where the indicative and actual allocations are the same.
- Ratio of 1.1, where in effect one is within 10% of the other. It may be that this range could be considered to be 'close'.
- Ratio of 1.2 to 1.5, where one is up to one and half times bigger than the other.
- Ratio of 1.5 to 2, where one is up to twice the size of the other.
- Ratio 2 to 5, where one is up to five times the other.
- Ratio over 5, where one is more than five times the other.

Cases to the left of the mid-point (the mean) represent occasions where the actual budget is *smaller* than the indicative and cases to the right where the actual budget is *larger* than the indicative. Taking into account all cases, and no longer allowing cases either side of the mean to cancel one another out in the way the In Control report did, the average difference between indicative and actual budgets varied by a factor of **3.84**. This is very substantially different to the 1.08 suggested by In Control. It represents a truer picture of the real relationship between indicative and actual allocations.

This shows a quite different scenario to the one presented by In Control. It suggests that the 'sign off' of the budget appears to be not so much a quick check on whether the figure created by the up-front allocation is enough but an entirely separate decision that stands alone from the up-front process. It points to Hartlepool, despite being regarded as strong supporter of self directed support strategy, not trusting its own up-front allocation system.

Figure 2. Ratios* by which the indicative and actual budgets differ, Hartlepool



* ratio (r) = IB / AB where IB is greater than AB
and r = AB / IB where AB is greater than IB

No data that compares the two figures is collected nationally to test whether this pattern is being repeated. However, councils are expected to keep such records for internal use. The Association of Directors of Adult Social Services (ADASS) issued guidance in 2010 called *Making Resource Allocation Work in a Financial Environment*. It said that the RAS formula should be recalibrated at least every twelve months. To do so, key data should be:

... collected and collated in one place for easy reference.

The data should include:

... the indicative budget, the final personal budget and reasons for any difference.
(ADASS, 2010, p.22)

A Freedom of Information request was made between July and September 2012 to 9 councils for the two sets of data for all new service users for the year 2011/12. Six of the

councils were not able to provide the data requested. The absence of routine data collection - which would have made it easy for a council to respond to the request - raises questions about how seriously these councils are managing the up-front allocation process.

The three councils who could provide the data did so for over 5,000 cases between them. Figure 3 shows where cases fell into the groups above for each council. The overall average ratio of comparing the larger with the smaller of the two budgets was:

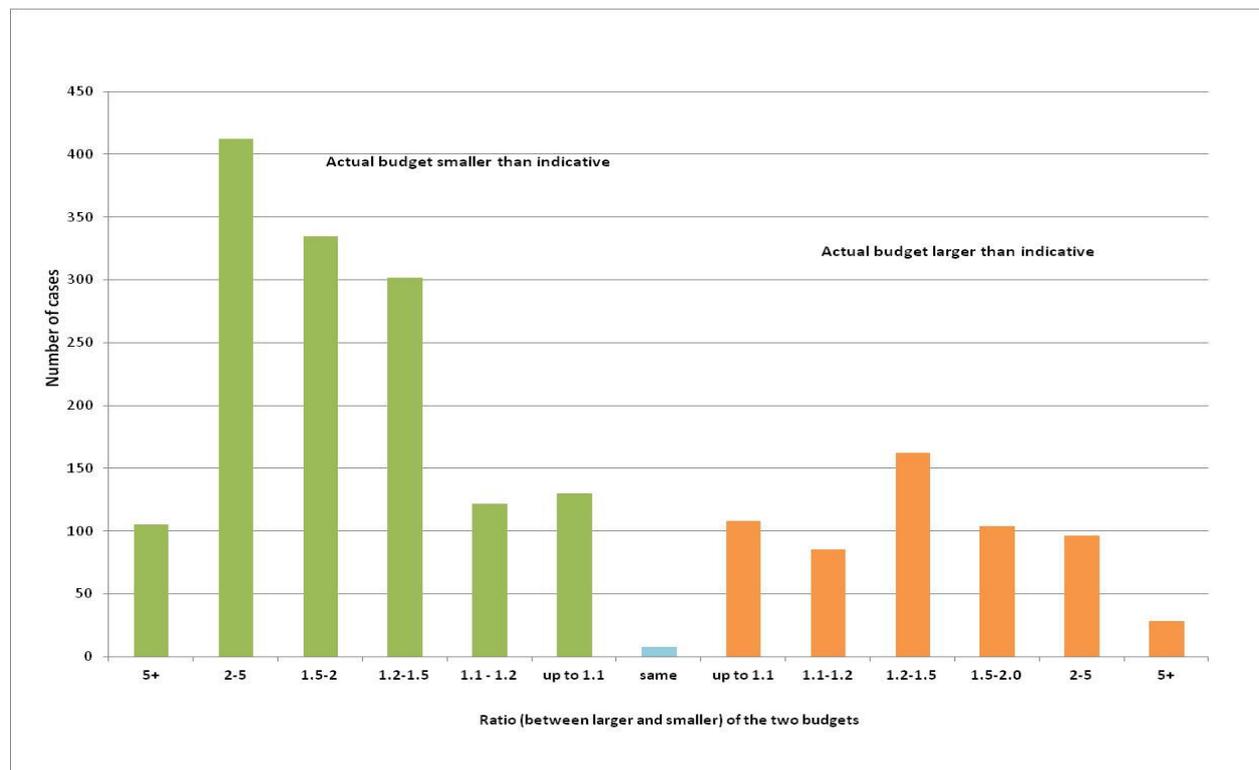
- Council One - 2.45
- Council Two - 2.59
- Council Three - 2.81

Between them, on average, the indicative and actual budgets varied by between two and three times as much as each other.

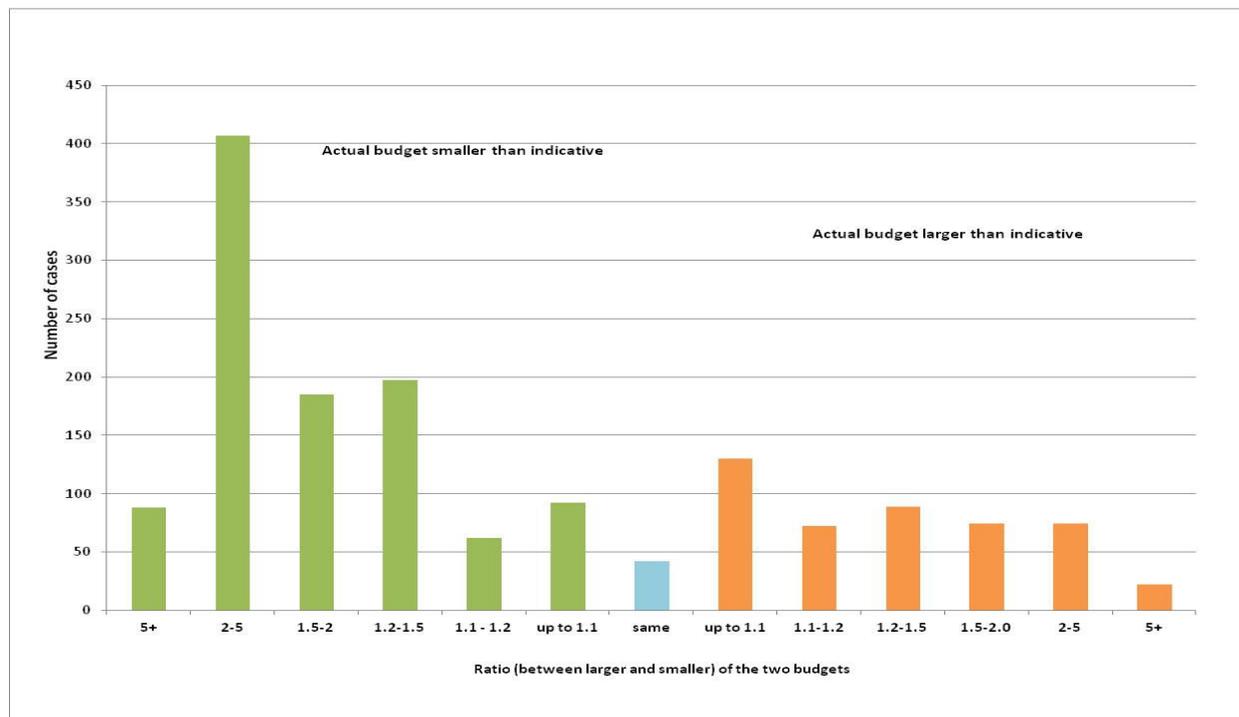
The broad pattern seen in Hartlepool is replicated by these councils.

Figure 3. Ratios by which the indicative and actual budgets differ

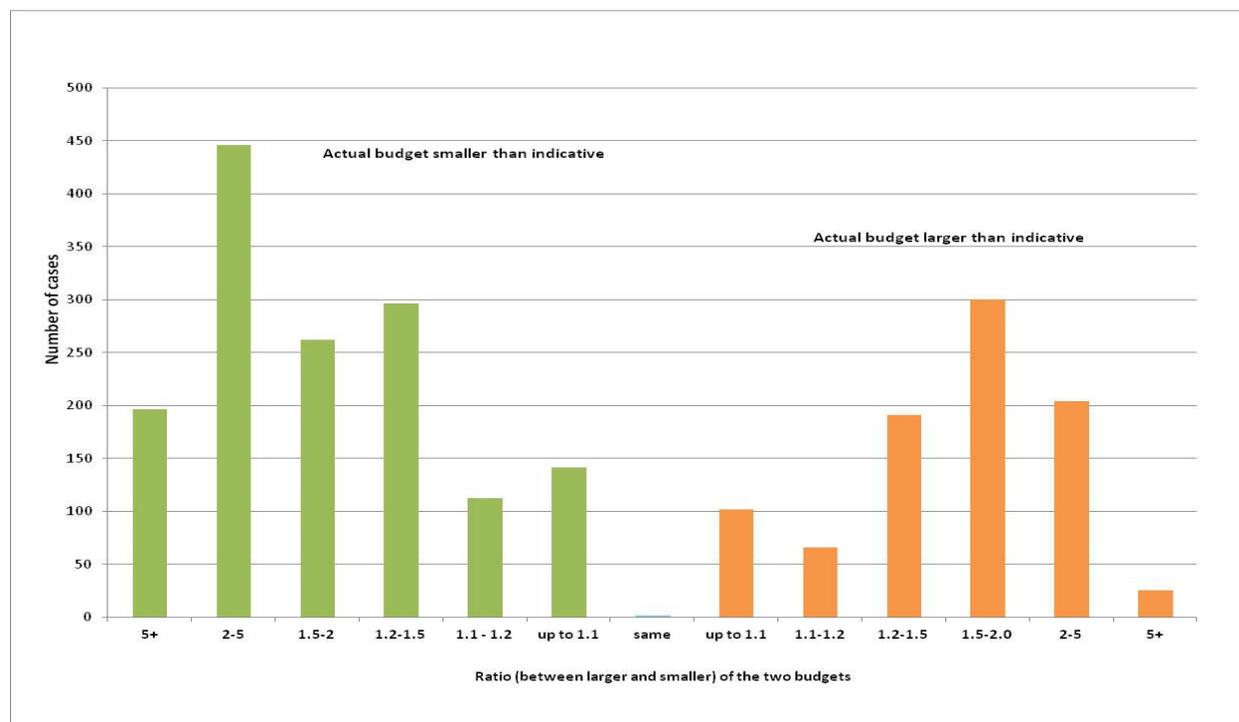
Council One



Council Two



Council Three



One of the six councils - Council Four - though not able to provide data for the whole year did provide the data they had used to test a sample of cases (173) to recalibrate their formulae. They provided the original indicative budget, the actual allocation and the adjusted indicative budget:

- The total of *original indicative allocations* was **£2.1M**.
- The aggregate of the differences between each indicative allocation and the respective actual allocation was **£881K**.

- The *adjusted indicative allocations* were very different to the *original indicative allocation*. The *aggregate difference* between the two sets of figures was **£667K**.
- However, this actually made the situation worse in that the new aggregate difference between the indicative and actual allocations went up from **£881K to £1.02M**.

This council has followed guidance in attempting to establish a more accurate RAS through recalibration, but the evidence suggests that it is unlikely to have any more confidence in the revised formula than the original.

The number of councils included above is small, although it includes a council regarded as an exemplar of self directed support, and the rest show a similar pattern. None of the councils has been able to demonstrate it has developed a RAS in which it appears to have confidence. It may be that there are councils whose indicative calculations are driving their actual allocations. However, any such councils will have to address how they are managing both their legal and financial obligations. Case law has made it clear that the decision about resource allocation must take place following support planning. The Supreme Court ruled in the case of *KM v Cambridgeshire* (Supreme Court, 2012, paragraph 28) that:

What is crucial is that, once the starting point (or indicative sum) has finally been identified, the requisite services in the particular case should be costed in a reasonable degree of detail so that a judgement can be made whether the indicative sum is too high, too low or about right.

Councils will also need to know the priority of the various needs being met by such resources. If a council is allowing the indicative allocation to be the basis of the actual budget, one of two scenarios applies. The first is that they are finding their

indicative allocation is matching the requirements set out by the above. If this is the case, it is reasonable to ask what function the up-front allocation is actually fulfilling. The second is that they are flying in the face of their legal obligations, either by not knowing what needs are to be met, or the cost of doing so, or by not paying attention to them if the cost would vary from the indicative allocation more than they are willing to allow.

If up-front allocations are to drive allocations of resource in the way In Control's 7 step model envisioned, the analysis above suggests the law will have to change, removing the legal right to have a minimum level of need met. Without a change to the law councils will have to know the actual, assessed needs being met and the cost of doing so, rendering the up-front allocation virtually meaningless. This problem is exacerbated by the huge differences between the allocations being arrived at before the information generated by support planning compared with the allocations arrived at once such information is known. Funding for social care would have to sit alongside all other cash based welfare entitlements. However, neither the *Draft Care and Support Bill* or White Paper shows any intention of taking this route.

The impact of self directed support on field work

The original claim of advocates of self directed support was that it would significantly reduce infrastructure costs:

A large share of the social care budget goes on devising and administering care plans, but self directed services cut out much of this bureaucracy, and savings mean that more money can be spent on people with less critical needs. (Leadbeater, 2008, p.6)

Community Care carried out a survey in 2012 into the 'State of Personalisation' (Community Care, 2012). It showed that 82% of social

workers agreed with the statement that the strategy had increased bureaucracy, with 60% agreeing 'strongly'. This resonates with responses from the National Personal Budget survey (Hatton, 2011) which noted that in the case of those from amongst the 2,000 survey respondents who made additional comments on the personal budget process:

... the vast majority of comments were negative and covered most aspects of the personal budget process. (Hatton, 2011, p.19)

Whilst such findings paint a powerful picture of the subjective experience of practitioners and service users, it is also important to test what is happening against the hard data that is available. The following data is available in relation to all councils (National Adult Social Care Information Service (NASCIS) website):

- Spending on the field work service through an annual return, EX1, completed by all councils with social services responsibilities.
- The number of staff employed within field work offices through another NASCIS annual return, SSD001, which reports on numbers of staff employed.
- The number of assessments for new service users, NASCIS report A6.
- The number of reviews for existing service users, NASCIS report A1.
- The number of people who receive 'professional support', NASCIS report P2f.

This set of data can offer an insight into the productivity of the service. Comparing the year before formal introduction of self directed support, 2007/8 and 2010/11, provides information about impact over a four year period.

- In 2007/8, the gross spend on field work was £1.82BN and in 2010/11 £1.97BN. In order to take inflation into account to measure the change in spending power more accurately, it is perhaps important

to acknowledge that the major component of spend is public sector wages. They have risen at a pace below general price inflation given the impact of pay restraint during this period. An analysis of pay inflation in the health and social care sector (Curtis, 2012, p.241) shows that, cumulatively, pay rose by 11.9% between 2007 and 2011. Applying this figure, there has been a reduction in spending power of 3.3%.

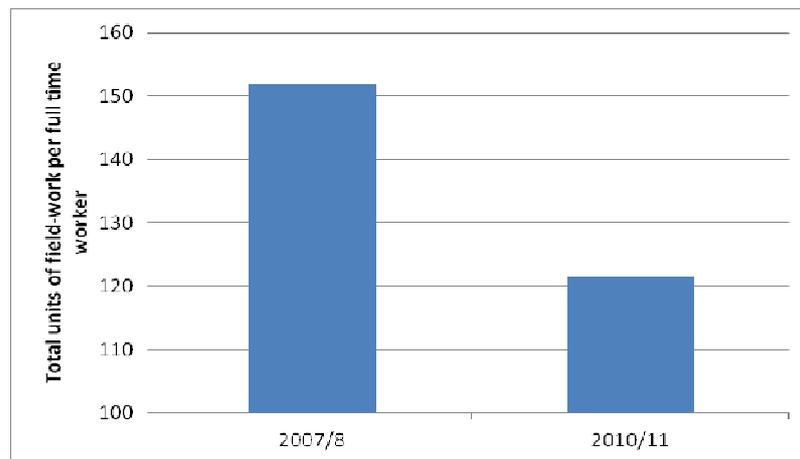
- However, the number of whole time equivalent field work staff employed by councils increased from 16,540 to 17,970, which is 8.6%. (This, in fact, under-reports the increase as this period saw a number of councils outsource some field work services, mostly at the initial contact stage of the assessment process for people referred to or referring themselves for local authority social care. These staff were not counted in the return used for this figure). Lower spending and higher staff numbers have also been noted by the Audit Commission:

Since 2005/06 the rate of change in spending has slowed substantially and numbers of staff have increased faster than spending. (Audit Commission, 2012, p.13).

The Commission's explanation for this is that it reflects a changing skill mix from qualified to less costly unqualified staff.

By contrast, however:

- In 2007/8, there were 660,895 new assessments and in 2010/11, 660,530. Therefore, the volume of new assessments remained virtually unchanged.
- In 2007/8 there were 1,343,165 reviews, and in 2010/11 1,150,725. This represents a reduction of 14.3%.
- In 2007/8, 506,720 people received professional support. In 2010/11, this had fallen to 371,910: a reduction of 27%.

Figure 4. Change in field work productivity

It can be expected that demand for new assessments will continue to be prioritised. The numbers completed have remained relatively stable. However, there have been major reductions in reviews and people getting professional support despite increases in staff numbers.

In order to offer a single quantitative measure of the changes in productivity, although simplifying what is a more complex scenario, if each of the three elements of work - assessment, review and professional support - are treated as taking the same amount of time on average, productivity can be measured as the volume of work delivered by each whole time equivalent worker. Figure 4 sets out the comparison between the two years.

This suggests a reduction in productivity of some 20%, with more staff delivering less work.

There is further confirmation that implementation of self directed support is responsible for the decline in productivity by comparing spend against loss of outputs amongst the councils that made the most progress in implementing with those that made the least. The latter can be measured by performance in relation to the target of the numbers of people said to have a personal budget as a percentage of all service users. The top six averaged 60% with a personal

budget in 2010/11. The bottom six averaged just 8.9%.

Table 1 shows that the bottom six happened to reduce their spending on field work services much more than the top six, but at the same time suffered a much lower loss of activity.

These findings are supported by Jacobs *et al.* (2011) who surveyed 249 practitioners and compared the time spent on cases involving personal budgets and cases that did not. This study concluded that:

... on most measures there were no differences in working patterns between care managers with and without IB holders on their caseload. However, the results do show that - contrary to expectations - more time was spent assessing needs and that more time generally was required to conduct support planning activities. (Jacobs et al., 2011, p.2).

If assessments are taking longer when personal budgets are involved, and, if assessments of new service users are given priority, we can expect that pressure will be created on other field work activities with reductions in outputs. The pressure will increase as more assessments involve the personal budget process.

Table 1. Comparison of change in productivity between 2007 and 2011 of the six councils with most and the six councils with the least service users with self directed support

	Spend on Assessment and Care Management*	Assessments and Reviews	Professional Support
Councils with least amount of SDS	-12.2%	-5.5%	-14.5%
Councils with most amount of SDS	-3.8%	-12.4%	-49.9%

* Assumes 11.9% inflation

Summary

Available evidence presented above points to the likelihood of a significant increase in bureaucratisation since self directed support was formally introduced resulting in major losses of efficiency, directly contradicting the predictions of its advocates.

The evidence strongly suggests that far from the up-front allocation process replacing existing processes, it has simply added to them. Councils are claiming that large numbers of service users now have a personal budget based on providing people with a 'clear, up-front' allocation. However, there is a serious question as to whether personal budgets, as they are defined, exist at all. Whilst the up-front allocation process may be allowing councils to claim they are achieving required performance targets they are not playing any part in driving resource allocations. They are not creating personal budgets as envisioned, or indeed, in any meaningful sense at all.

Does self directed support improve outcomes?

There might be a view that the problems set out above may be justified if there was an accompanying improvement in outcomes. Government retains the view that they do. However, a paper by the authors, 'Can personal budgets really deliver better outcomes for all at no cost' (Slasberg et al., 2012), highlighted the following:

- The surveys that are held to demonstrate better outcomes as a result of personal budgets consistently demonstrate that it is largely only people with direct payments that enjoy the better outcomes. An impression is created that this success attaches only to personal budgets more generally by packing survey samples with direct payment recipients. The largest of such surveys, the National Personal Budget Survey (Hatton & Waters, 2011) had 2,000 respondents. Nearly 90% of them had a form of direct payment. At the time of the survey, only 7.7% of all service users actually had a direct payment (NASCIS, P2f).
- The survey concluded that improved outcomes would be achieved for all by ensuring the proper personal budget process was universally applied. This is despite the fact that amongst their respondents who chose to make further comments, those who commented on the personal budget process were overwhelmingly negative.
- Far from process being the cause of better outcomes, it is more probable that, in addition to the advantages of being able to manage their own support system, having adequate resources - while not necessarily by itself sufficient nor a guarantee of better outcomes - is nonetheless a key condition for the better outcomes achieved by people with a direct payment. In the year of the survey, 2009/10, while only 7.7% of

service users had a direct payment, 13.7% (NASCIS, EX1) of the spend on community support went on direct payments.

Overall, there is no evidence that personal budgets necessarily improve outcomes. Indeed, on the contrary, there is evidence that they do not, along with the process being disliked by service users and practitioners alike.

Woolham & Benton (2012) arrived at some similar findings in a study of a Shire County that measured costs and benefits of personal budgets. They looked at a large number of personal budget holders all of whom had a direct payment, with a comparator group that did not.

- The average value of support packages was 44% greater for people with a direct payment than the control group (p.10).
- They found evidence of improved outcomes, significantly greater for working age people, albeit only marginally for older people (p.14).

Why has self directed support failed?

An imperative for councils is to spend within their cash limited budget. The decisions about how much resource to give to each individual are the most significant spending decisions in determining whether they succeed. Councils have traditionally relied upon on a case-by-case decision-making process, following support planning, and managed by budget holders. By and large, it has worked for them, with councils generally spending within their budgets. Relinquishing this approach, and trusting to either a formula, professional 'guesstimate' or what the computer says, represents major, and very possibly, intolerable risks.

- If the up-front allocation gives less than is required to meet eligible needs, this is unacceptable. Councils have a clear legal obligation to provide the resources

required so that all needs are deemed to be eligible.

- If the up-front allocation gives more than is required to meet eligible needs the council will face a financial risk. It makes no financial sense to spend more than is required. Also it will mean some service users will have a greater range of needs met than others, although this may be randomly determined if resource allocation decisions are not consistently applied. This is contrary to policy objectives of sharing resources fairly.

The evidence set out in this paper leads us to suggest that up-front allocations may often result in very different sums of money being identified for service users to what may actually be required once the cost of each person's support needs are known.

Is it possible for up-front allocations to work?

Advocates of self directed support suggest it is still early days and more time is needed to get it right. They argue that the problem lies with councils through the processes they put in place, rather than following formal guidance that is the problem. Martin Routledge, then Programme Manager for Think Local Act Personal noted how "unhelpful bureaucracy and process" (<http://www.communitycare.co.uk/the-state-of-personalisation-2012/>) was at play, but without any acknowledgement of how self directed support is contributing to that. Similarly, the National Personal Budget Survey noted that councils:

... clearly have a major impact on outcomes through the processes they put in place. (Hatton & Waters, 2011, p.3)

However, we contend that the prevailing model of self directed support is fundamentally flawed and there is little reason to believe there will be any improvement.

Up-front allocations rely on the theory that it is possible to:

- a) standardise and measure needs, and,
- b) attach a standard monetary value to them.

This was not tested before implementation. It is important to recall that the Government embarked on its policy of personalisation before the results of the evaluation of the pilots (Glendinning *et al.*, 2008), which it had commissioned, were known. A benefit of what may be described as such hasty implementation is that we now have substantial information about what it means in practice. As we have seen, the thinking and assertions of the early advocates of personal budgets have been found seriously wanting, with up-front allocations wildly different from the actual cost of meeting needs. Even a complete recalibration, as seen by Council Four above, may fail to get close to the cost of meeting actual needs. This reinforces the view social care needs are unique to individuals, as are the costs of meeting them. Indeed, this is arguably the view that underpins the Department of Health's policy in relation to resource allocation:

Calculating what resources should be made available to individuals should not detract from a council's duty to determine eligibility following assessment and to meet eligible needs. (Department of Health, 2010, p.42)

We have now not only had four years of national implementation of up-front allocations, but before that a number of years of development work by In Control. However, there is as yet no formula that inspires confidence nationally, despite the early promises of its advocates.

The idea of the 'ready reckoner' approach to replace the formulaic approach to Resource Allocation Systems as the solution to the problem of bureaucratisation is not sustainable. The RAS at least offered a theoretical promise of enabling councils to

spend within their budget by being able to adjust the monetary value of each point awarded to individuals so that the sum of personal budgets could match the overall budget. This cannot happen at all with a system based on a series of individual 'guesstimates'.

Is it possible to have personal budgets and personalisation without self directed support?

The *Draft Care and Support Bill* defines a personal budget (paragraph 25) as:

... a statement which specifies...the amount which the local authority assesses as the cost of meeting those of the adult needs which it is required or decides to meet...
(Department of Health, 2012, p.18)

It makes no mention of when this should be decided. Is it possible to make meaningful the concept of a personal budget without the up-front allocation?

The concept of self directed support rests upon the assumption, also asserted, that it is essential for people to be given an amount of money with which to plan their support in order to be able to choose services appropriate to their needs. However, whilst it may be an advantage (if a reliable figure could be established), there is no logic to say it is essential. Indeed, evidence that an up-front allocation is not essential to plan support without reference to the pre-purchased menu lies in the fact that people had been doing exactly that through direct payments since the mid 1990s. The importance given to it by the In Control model perhaps stems from looking for ways to make the concept of choice work in an environment where councils spend most of their money in advance putting a menu of services into place. Giving people money, not services, would enable them to 'escape' the pre-purchased menu of services. It is, therefore, a policy that assumes a two-tier service, with only the top tier expected to enjoy the real benefits of choice of service. If

the objective is for all service users to have choice of service - notwithstanding the evidence clearly showing that the majority of service users will exercise their choice by opting for mainstream, regulated services - then the only condition that is truly essential is that councils cease the practice of spending most of their money in advance. The budget will then be freed up. People will know that they can start with a blank piece of paper upon which to plan. Decisions about how much of the plan is affordable can follow.

There are fears that freeing up the resource base in this way would threaten market stability. However, there are strong reasons to believe that the demand for mainstream, commissioned services will not diminish. Pressure to increase the numbers with a direct payment has increased in the context of the Government's personal budget strategy. Think Local Act Personal (October 2011, p.2) has asserted that direct payments are: '... likely to benefit the majority'. The Coalition Government in its Vision for Adult Social Care stated the aim that:

Personal budgets, preferably as direct payments, are provided to all eligible people. (Department of Health, 2010, p.15)

However, while the numbers of people with a direct payment have increased, they do not appear to be moving away from mainstream services. There is good reason to believe that a new tranche of people with a direct payment has been created. Unlike the original tranche, they may not necessarily want to purchase and manage their own support systems (mostly done through employing Personal Assistants). They are more likely to continue to purchase mainstream, commissioned services.

- Spending through direct payments increased as a percentage of total spending on community based services between 2007/8 and 2010/11 from 7.8% to 13.3% (NASCIS website, EX1).

- At the same time, the volume of regulated home care purchased also increased, from 188 million hours to 200.3 million. (NHS Information Centre, 2010/11, p.42)

This links to evidence that the choices that are actually important to the majority of people are not about which service to purchase, but about how services are delivered. This was acknowledged by the Association of Directors of Social Services in their report, the Case for Tomorrow:

For many older people the choices they want are not so much about who provides, but what is available, when and whether they feel they have a rapport and relationship with that particular care worker. (ADASS, 2012, p.51)

There is little evidence that service users supposedly empowered by being the purchaser - whether using their own money as 'self funders' or public finance - achieve better outcomes or value for money or have any greater choice and control when they purchase mainstream services. Indeed, the opposite may be the case. People who use their own money - 'self funders' - often pay more for the same service as those funded by the State. The Office of Fair Trading noted concerns that residents of care homes who self fund were being charged a higher rate in order to make good the shortfall in prices paid for publicly funded residents (Office of Fair Trading, 2004). Self funders are also particularly likely to enter institutional care. While it is possible for institutions to offer personalised services, there is a widely held view that most people prefer support at home to ensure their best possible quality of life.

... self funders, lacking appropriate advice, information, support and advocacy are ending up inappropriately in disproportionate numbers in residential institutions. (Beresford et al., 2011, p.95)

Conclusion

The evidence in this paper of the failures of the Government's self directed support strategy can be seen as the unhappy fruition of early warnings discernible from the evaluation of the individual budget pilots (Glendinning *et al.*, 2008).

The finding that individual budgets (the term that preceded personal budgets when the idea included the notion of including several funding streams) could improve outcomes was far from unequivocal. This is despite the fact that whilst the sample of cases was meant to be random, over six times as many people in the pilots had a direct payment than was the case nationally (26% of service users in the pilots (p.38) against 4.4% nationally (NASCIS, P2f)).

It found a major increase in the time taken for assessment and support planning. The cost for people with an individual budget was £18 a week compared with £11 a week for traditional practice. This is early evidence of a growth in bureaucratic process.

The authors believe successful delivery of personal budgets and personalisation is not only possible, but remains the basis for a future of authentic promise. This is to ensure that resources are used to the best possible advantage of service users in their search to meet their reasonable expectations of well being and independence. However, an effective system of personal budgets and the goals of personalisation are not being delivered through the prevailing model of self directed support. There is no reason to believe that will change.

The authors believe that a core barrier remains the need to successfully address the relationship between needs and resources. Until and unless society offers disabled and older people an absolute right to the resources required to live on as equal terms as possible to non-disabled people, achieving personalisation and an effective system of

personal budgets will require a new policy environment with the following elements:

- A right to a *holistic assessment* that makes clear all the needs that the State should meet if reasonable expectations of wellbeing, measured against the experience of wellbeing for the majority of the population, are to be achieved.
- A new *eligibility framework* that supports councils to make decisions that are both sensible and fair about which needs they can afford to meet and which they cannot.
- These two measures will call for a relationship between councils and service users characterised not by enabling service users to become *empowered consumers*, but by *partnership* to agree needs, outcomes and the best ways of meeting them. This calls for effective *person-centred* practice. This will need to work hand in hand with moving away from a culture characterised by paternalism and institutionalisation to one rooted in independent living and the social model of disability. It will also signal a shift away from the focus on seeking to achieve a culture based on consumerism that has underpinned the approach to personal budgets hitherto. In its place there would need to be a new approach to working in partnership between the State and service users to ensure their authentic inclusion. Although the current strategy aimed to achieve similar cultural change, there is no evidence that it has.

We also believe the personalisation will require a new strategic partnership between councils in their commissioning role and mainstream providers that enables providers to deliver the flexible and responsive services that personalisation calls for. Such mainstream providers will need to be extended to include on equal terms user led organisations (ULOs) and community based organisations which are particularly valued as service providers by service users (Barnes &

Mercer, 2006). It will also call for outcomes to replace outputs as the currency for commissioning to allow providers to be fully responsive to their service users' specific needs and shared rights. We take such outcomes as meaning working to ensure the support that service users value to achieve their goals as fully as possible (Shaping Our Lives, 2003) This goes beyond the current passive 'market facilitation' role for councils that has become closely associated with the self directed support model. It is also a major change agenda in itself. Paley *et al.* (2008) set out the range and scale of challenges and how they were tackled from experience in developing outcome based commissioning over a five year period in a unitary council. With most people likely to continue to want mainstream services, and these being increasingly diversified, it is the approach likely to bring the highest level of personalisation.

Figure 1 would thus be replaced with Figure 5 as the route to personalisation.

Whilst the above are the ingredients of a culture and best practice that will make the best possible use of available resources, full achievement of the reasonable expectations of wellbeing for all those who need State support will require adequate levels of resource. Achieving adequate levels of resources will require an invigoration of the political budget setting process at both national and local levels by making available information about the range of needs councils are not able to meet within their cash limits.

This package of reforms could offer a realistic and feasible way of taking forward political commitments to meaningful personalisation for a growing number of people with diverse needs for the immediate future.

Acknowledgement

The authors would like to acknowledge the help of Professor Paul McCrone, Health Economist at King's College London, in how to address the presentation of key elements of the data.

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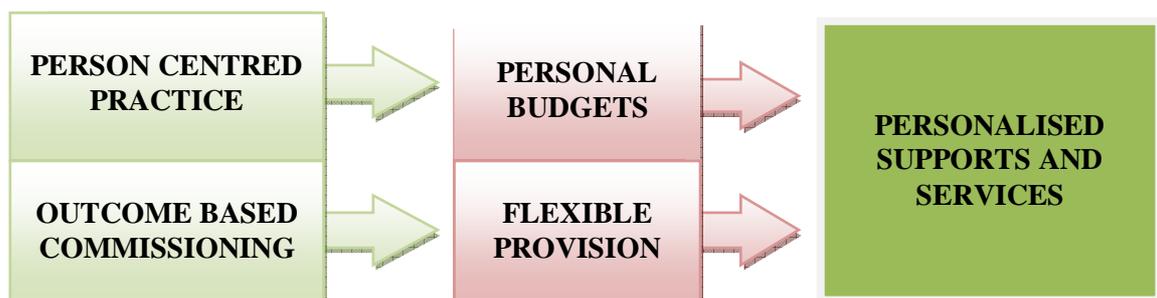
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Figure 5. The route to personalisation through partnerships between councils, service users and providers



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Notes on Contributors

Colin Slasberg is a qualified Social Worker and has worked for over thirty years in shire and unitary councils as a practitioner, team manager, area manager, strategic planner, Assistant Director of Resources and independent consultant. He led a programme of transformation over a five year period in a unitary council built around the concept of outcome based commissioning. This changed the way strategic commissioning was delivered, the way providers delivered care and support, and the way assessment and support planning was delivered. Colin has had an enduring interest in addressing the issues of eligibility and priority of need

dating back to the Community Care reforms of the early 1990s.

Peter Beresford, OBE, is Professor of Social Policy and Director of the Centre for Citizen Participation at Brunel University. He is Chair of Shaping Our Lives, the national user controlled organisation and network of service users and disabled people. He has a background as a long-term user of mental health services and has had a longstanding involvement in issues of participation as activist, writer, researcher and educator.

Peter Schofield is a Research Associate with interests in mixed method approaches. He has worked on a wide range of primary care related projects applying advanced statistical techniques. He is a statistical advisor on the board of the *British Journal of General Practice*.

Address for Correspondence

Professor Peter Beresford
Director of Centre for Citizen Participation
Mary Seacole Building
Brunel University
Uxbridge
UB8 3PH

Email: peter.beresford@brunel.ac.uk

Citizenship, choice and care: an examination of the promotion of choice in the provision of adult social care

Guy Daly

University of Derby

Abstract

Choice for service users in social care and public services more generally in the UK has been promoted by all Westminster governments over the last thirty years. However, there has been insufficient reflection on how this impacts on service users and citizens as a whole. When choice in social care is examined from economic, psychological and socio-political perspectives, doubts arise as to the extent it has empowered service users, promoted the rights of citizens and improved service delivery. Social care needs to be (re)constructed less as solely a market or civil right and more as a social right since markets can be ineffective in coordinating the production, distribution and governance of social care. In addition, the promotion of choice in social care can have deleterious socio-political, psychological and economic consequences. The paper argues, therefore, that rather than concentrating on choice, a more appropriate way forward in the provision of social care and in the meeting of citizens' rights to care would be to conceptualise choice as a 'second order' concern at most and, instead, to concentrate on establishing adequately funded, high quality universal social care services across the whole of the UK.

Keywords: Choice, citizenship, social care, adult care, public services, rights, service users

Introduction

Over the last thirty years UK social policy has been shaped by the neo-liberal informed Conservative governments under Margaret Thatcher (1979-1990) and John Major (1990-1997), Tony Blair's (1997-2007) and Gordon Brown's (2007-2010) *Third Way* New Labour administrations and, since 2010, the Conservative and Liberal Democrat Coalition Government (see, for example, Ferguson *et al.*, 2002; Clarke, 2004; Grimshaw & Rubery, 2011; in relation to social care, see Stevens *et al.*, 2011). During this time, we have observed the championing of 'choice' in social care policy discourse and more widely, but arguably with insufficient reflection on how this impacts on service users and citizens as a whole. Choice has been promoted across the public services in health, housing, social care and education. Social care users have, similarly to other public service users, been reconstructed increasingly as 'heroic citizen consumers' making choices over their care arrangements within a mixed economy of

public, private and third sector providers. However, when we examine choice in relation to social care and more widely from economic, psychological and socio-political perspectives, doubts arise as to the extent that its promotion has empowered service users, promoted the rights of citizens and improved service delivery. This paper therefore explores the phenomenon of choice as it relates to social care provision, firstly by drawing on T.H. Marshall's work (1950) on citizenship and citizens' social and market rights, followed by briefly examining current social care policy developments, and then by examining the promotion of choice in relation to economic, psychological and socio-political analyses. The paper then briefly examines some of the evidence on the effectiveness of the promotion of choice in social care before moving on to recommend that rather than concentrating on choice, a more appropriate way forward in the provision of social care and in the meeting of citizens' rights to care would be to cease being distracted by a focus on choice and

instead to concentrate on establishing adequately funded, high quality universal social care services.

Citizenship

In trying to understand developments in UK social care policy and their relationship to citizenship, it is useful to refer to the work of T.H. Marshall (1950). Marshall's analysis of citizenship is regarded by many as seminal (Roche, 1992). Marshall described the evolution of citizenship within modernity from the eighteenth to the twentieth century. He argued that citizenship had developed over these three centuries during which time citizens acquired civil or market rights (in the eighteenth century), then political rights (in the eighteenth and nineteenth century with the advent of modern parliamentary democracy) and latterly social rights (in the first half of the twentieth century, in which citizens acquired the right to social entitlements, institutionalised in the post war settlement and the creation of the modern British welfare state) (see Bulmer & Rees, 1996; Timmins, 1996; Gladstone, 1999). Whilst not part of Marshall's analysis, one also needs to note that as part of the welfare state settlement, whilst some social rights would be met universally and would be free at the point of use (e.g. NHS provided health care; education), others would be either targeted and/or means tested (e.g. social housing, unemployment benefit and welfare benefits more generally). Social care was an interesting case in that, unlike health care – free at the point of use, irrespective of means – social care was to be means tested and non-universal. This was as a result of healthcare being constructed, via the NHS Act 1946, as free at the point of delivery whilst social care, via the National Assistance Act 1948, was to be the responsibility of local authorities and, as such, subject to means testing and local variance. This 'anomalous' position of social care entitlement has remained throughout the subsequent seventy years and is, therefore, still being grappled with by Government today, as can be seen with the Dilnot Commission of last year (Dilnot Commission, 2011).

Marshall's work is not simply a helpful historical analysis but is also useful in explaining what has happened in the refashioning of citizenship over the last thirty years, that is since the advancement of the influence of neo-liberalism in UK social policy. Over this period, one has seen the promotion of notions of the citizen as a customer of public services (whereby there is an emphasis on 'consumer citizens' with civil or market rights). Whether it be in relation to choice (and personalisation) or just more generally, public service users, including social care users but also patients, housing tenants, pupils and students, are all constructed to a greater or lesser extent as customers and consumers. Public services have therefore been reshaped, rhetorically at least, as ones that promote the citizen customer or citizen consumer who is able to exercise choice. This promotion of choice in current social care policy is what will be explored next.

The continued promotion of choice within social care policy development

Under the Coalition Government there has been a continuation of the promotion of the choice discourse that was witnessed under previous governments over the last thirty years (DH, 1998, 2001, 2003, 2005, 2006, 2007, 2008; HMG, 2007, 2008). In both *A Vision for Adult Social Care: Capable Communities and Active Citizens* (DH, 2011) and the White Paper *Caring for Our Future: Reforming Care and Support* (HMG, 2012), the Coalition has expressed its commitment to social care services' users having choice, not least through the 'greater rollout of personal budgets to give people and their carers more control and purchasing power' (DH, 2011, p.8). In addition, the Coalition established the Dilnot Commission in 2010 into the funding of social care and support in England. This reported its findings in July 2011 with a set of proposals that would cost just under £2 billion a year in order to implement a more universal care service. However, the Coalition has yet to respond fully to the Dilnot Commission's proposals

other than to publish its own social care White Paper (HMG, 2012) mentioned above.

When one examines the extent to which social care users have actually been provided with choice, an ambiguous picture emerges (see Netten, 2005; Scourfield, 2007; Beresford 2008, 2009; Daly & Roebuck, 2008; Glendinning *et al.*, 2008; Ali, 2009; Institute of Public Care, 2009; Woolham, 2009; Orellana, 2010; Needham, 2011; ADASS, 2012; Beresford *et al.*, 2012; Glasby, 2012; Woolham & Benton, 2012). On the one hand, over the last thirty years, a mixed economy of social care providers and social care markets has slowly developed. This has included a substantial shift to independent sector provision of services as well as a shift to domiciliary or home based care. Another change has been that it is increasingly only those social care users with the highest levels of need who are deemed eligible for state funded support. However, these 'eligible' service users are then, paradoxically, provided with more intensive care packages. Consequently, those with lower levels of need increasingly have to purchase care services independently ('self-funders'), if they can afford to do so. If one is judged to be in need of social care support, one may be provided with both a greater voice and greater choice over provision. However, this is arguably at the expense of the numbers deemed not entitled to receive adult social care. It is as if those social care users who are provided with public support have seen their (Marshallian) civil or market rights increase, whilst the vast majority of citizens who may be viewed as in need of some sort of social care support have seen their (social) rights reduced. As a consequence, running alongside or even counter to the promotion of choice and personalisation in social care, there is a concern that the inequities or contradictions within current state supported care need to be resolved, whether that be in relation to the vagaries of the 'postcode lottery' of local authority eligibility criteria and charging policies or that increasingly it is only those individuals with the highest levels of need

who are provided with social care and support (and then only if they meet increasingly strict means testing criteria). Within this context, a focus on choice is arguably a second order matter. And, whilst personalisation in social care does seem to have gained widespread support (Glasby & Littlechild, 2009; Needham, 2011) there has been some degree of critiquing, that is not accepting the supremacy of 'choice' at face value or unquestioningly (see, for example, Beresford 2008, 2009; Daly & Roebuck, 2008; Ali, 2009; Woolham, 2009; Beresford *et al.*, 2012; Woolham & Benton, 2012). It is to this critiquing of the promotion of choice that the paper now turns.

Examining the general consequences of promoting choice

In this section of the paper, a number of critiques are presented of choice as a mechanism for delivering goods and services, not least public services, including social care. These include economic, psychological and socio-political critiques of the consequences of choice.

'Economic choices'

For liberal economists, sovereign and rational individuals exercising their freedom of choice results in the most efficient production and distribution of society's goods. Adam Smith's (1776) 'invisible hand' ensures that supply will meet demand in the market and that price will keep this in balance. However, some of the problems with the market include: the need for perfect information; how to resolve the challenges of distributing scarce goods and merit and public goods; and, thirdly, problems of inelasticity of supply. Each of these will now be explored briefly with reference to social care where appropriate.

Rational economic men and women are supposed to be able to make appropriate choices because they have perfect information and are likely to behave rationally. This is, obviously, problematic when an individual does not have sufficient information, is unable to interpret it, and/or

chooses to make ‘irrational’ choices. Decisions over the provision of social care helps to illustrate these difficulties (Daly, 2008). Even in the Wikipedia and Google-age, we are not necessarily sufficiently well placed as social care users or carers to exercise choice; notwithstanding that one needs to recognise the expertise of service users or experts by experience. Do social care users or carers have all the information they require about their social care needs, the care options available, the competence of the social care providers, the efficacy of the various options available to them? Evidence from research on individual budgets (Glendinning *et al.*, 2008) and self directed support (Woolham, 2009; Woolham & Benton, 2012) would suggest that older social care users for one are not necessarily wanting to take on the role of rational economic decision makers in the social care market place.

Second, there is the problem of how to distribute scarce items. Obviously, where supply cannot meet demand, or those in need cannot afford the cost of supply, the price mechanism might not be the most appropriate mechanism for distributing such goods and services. This leads us on to considering whether certain goods or services are, therefore, too important to be left to the market to provide, that is ‘public’ goods or services, because the appropriate distribution and consumption of them is in the interest of wider society. Public health and education would be examples of this as would, arguably, social care services for vulnerable individuals and groups. Where ‘social care goods’ are too expensive for most individuals, other than the most wealthy of ‘self-funders’, we may collectively decide to choose to ‘pool the risk’ and to distribute social care via means other than the market.

The psychology of choice

Choice is also not entirely helpful as a mechanism for distributing goods and services, including social care, when one considers it from a more psychological standpoint. In this section, choice will be

considered in terms of: quantities and quality of choice; the ‘tyranny’ of individual decisions; opportunity costs and choice; whether having less choice is more effective; whether choice promotes anxiety; notions of satisficing rather than maximising; and, whether choice can make us unhappy. In exploring each of these in relation to social care, reference is made to the ‘paradoxes of choice’ as presented by Schwartz (2004). Schwartz argues that more choice does not necessarily equate to greater choice, let alone greater liberty. For social care users and carers when faced with the possible choices open to them (similarly to when one visits a supermarket to be confronted by the array of different types and brands of baked beans), may feel disempowered by the choices they have to make. The use of a broker or care manager is often required to support a user and/or carer to design an appropriate care package.

Also, our individual decisions about our care arrangements may have unintended long term consequences (sometimes described as the tyranny of small decisions). As individual social care users or carers, we may make our own individual (*sic.*) decisions, believing them to be in our best interest. However, the aggregate consequence of these may not be what we would have wanted in the longer term. For example, as more and more social care users set up their own, individualised care arrangements, they and society as a whole may not appreciate that their withdrawal from supporting the collective provision results in that provision being withdrawn altogether (even though these same social care users might have thought it would be there for them to fall back on when they needed it). Examples of this can be seen in the withdrawing or closing of day care provision as it becomes unviable due to insufficient ‘demand’; what Ali (2009) has described as the withering away of ‘bog standard’ provision.

The opportunity costs associated with weighing up different choices is also something worthy of consideration and reflection. Schwartz argues that spending

time researching for the best product or service creates opportunity costs, for example in reducing the time we spend on other important activities. This may partly explain why older people, for example, have been reluctant to take up the option of Individual Budgets or Personal Budgets (Glendinning *et al.*, 2008). Indeed, making choices can simply result in disappointment. When presented with an array of choices, and having made one's decision, one may often feel regret ('what if') over missed opportunities, raised expectations, awareness of inadequacy in comparison to other options available. Social care users and carers are often faced with these anxieties when deciding whether or not to enter residential care. Is going into residential care the right choice; is the chosen care home the best one available; what if it is the 'wrong choice', will it be possible to switch to another provider or an alternative type of care arrangement?

For Schwartz, we need to decide when we need to behave as choice perfectionists (maximizers) and when we should be content with being pragmatic choosers (satisficers). He argues that for most choices in life, we are probably better off being a satisficer. However, one could go even further with this argument and suggest that on the occasions when a choice is so important one needs to behave as a maximizer (for example, whether to have a particular medical treatment or whether to sell one's property in order to go into residential care), one would probably be better off finding someone else to help you make the choice (in the manner of co-production) or even to 'abdicate' the decision to them if they are the expert.

One final aspect of the consideration of the psychology of choice is that choice can actually make us unhappy. Myers (2000) and Lane (2001) both suggest too much choice may lead to feelings of unhappiness or even depression and feelings of isolation. They argue that consumption can make us unhappy and the commodification of social interactions and exchanges may lead to isolation and a breakdown in communal or

social connectivity. When one considers examples of the commodification of social care in which home care workers are only permitted to undertake pre-prescribed tasks, often within a particular timeframe, one can see the possibilities of marketisation of social care potentially creating feelings of alienation of social care users from their organised care providers. The consumption of care becomes increasingly a marketised or commodified transaction rather than a professional or social interaction. This latter point relates to some of the insights gained from socio-political analysis to which the paper turns next.

Before that, it is hopefully useful to draw some conclusions from this admittedly brief and limited exploration of the psychology of choice: having more choices does not necessarily mean better choice(s); sometimes less choice is better; our own individual choices may, alongside others' choices, aggregate into something we had not thought would happen and we would rather did not happen; our agonising over choices can sometimes be at the cost of pursuing other opportunities and/or result in feelings of anxiety, inadequacy and alienation; and, overall, one needs to think about which aspects of our lives we wish to choose such that, for other parts of our lives, we should be pragmatic choosers or (if it is a significant decision) get advice or ask someone else to (help to) make the decision. Overall, therefore, social care users' and carers' psychological well-being is not necessarily best served by the pursuit of choice.

Socio-political analyses of choice

Socio-political analyses of choice also offer some helpful insights into the problematic nature of the promotion or reification of choice. In examining social care and choice, the work of Le Grand and Clarke are particularly relevant, in my view, not least in relation to: the development of quasi-markets in public services; the impact of privatisation and 'individualisation'; the need to consider choice in terms of who, what, where, when, how and whether; and, finally, the extent to which choice may exacerbate inequality.

Over the last thirty years we have seen the development and incorporation of quasi-markets (with the split between the supplier and the purchaser) in the provision of public services. However, quasi-markets are problematic not least because, unlike in a 'pure' market, the purchaser is not the direct consumer or user. For example, the social care user may 'consume' publicly funded social care, but does not necessarily directly purchase it (unless they are a self-funder or are in receipt of an individual or personal budget). Rather, the care manager purchases or puts together the package of care on the user's behalf. With the advent of individual and personal budgets, the service user may choose how to have their needs met, but it is still typically the case that the care manager or social worker will have assessed what the service user's needs are and then played a significant part in determining from whom to purchase the social care provision. What is also interesting about the advent of quasi-markets is that this purchaser-provider split has arguably changed the behaviour of welfare purchasers and providers. Le Grand (1998) described this in terms of 'knights' and 'knaves', whereby before the development of quasi-markets, both purchasers and providers arguably behaved in more benign (or 'knightly' ways), constructing welfare (including social care) recipients as people to serve and to have their needs met (however naïve this may sound, today). With the advent of markets and quasi-markets, purchasers and providers behave more 'knaveily', for example taking great care (as a purchaser or provider) when determining the level of social care support users are entitled to and what the budgetary implications of this are.

UK governments over the last thirty years have also sought to privatise welfare not just in terms of handing provision over to private or quasi-private organisations, but also in terms of relocating parts of it (including social care) back into the private realm, that is with individuals, families and communities. Therefore, responsibility has been privatised, by making individuals, families and

communities responsible for meeting their own welfare needs (Clarke & Newman, 1997).

Another complication in the promotion of choice in welfare provision is the need to be clear over what aspects of choice are being considered. In their text, *The Consumer in Public Services*, Simmons *et al.* (2009) adapted the work of Le Grand to depict the types of choices a public service consumer might make, including social care users. Social care users are increasingly faced with choices about *who* should provide their care, *where* to have that care provided, *what* care tasks should be provided, *when* that care should be provided and *how* the care should be provided. Over the last thirty years we have seen developments in choices over *who* provides (for example, with the promotion of private and voluntary sector providers of social care), *what* is provided (for example, IBs and PBs in social care), *when* it is provided (again, IBs and PBs are examples of this), and *how* it is provided. However, social care users are, arguably, more concerned with being provided with good care services and less concerned by the 'who' and, possibly, the 'where'. The 'what', 'when' and 'how' are worries in that social care users do want to be able to determine, for example, *what* the care assistant might provide as well as *when* and *how*. One that is not identified by Simmons *et al.* (2009) but that needs considering is the *whether*, that is whether to take up the option of choice (and whether there is an option to opt out of making choices) (Daly & Woolham, 2010). Again, the results from the IBSEN review (Glendinning *et al.*, 2008) of IBs suggest that some service users were less interested in taking up the choice option.

If markets are about suppliers responding to the demands of consumers, then not only do we have to contend with the limitations of rational economic humans, explored earlier, but also with the fact that some people are in a better position to demand or choose than others. For Clarke *et al.* (2005), choice may, therefore, exacerbate inequalities rather than reduce them; not least because access to

welfare services is shaped by economic and social capital and social inequalities more generally. It is, perhaps, partly because of some of these uncertainties that social policy analysts of choice, as well as social care advocates, have suggested that rather than focusing on choice, we should be promoting co-production, personalisation, voice and so forth. Indeed, Simmons *et al.* (2009) suggest that *choice is not the only fruit* and that co-production might be a better fruit to cultivate. Through co-production, social care and other public services ‘can be brought under user control in very different ways: the key questions concern putting which consumers in what driving seat’ (Simmons *et al.*, 2009, p.265). To paraphrase Clarke, consuming welfare and public services ‘is not [straightforwardly] like shopping’.

To conclude this section, socio-political analyses have identified a number of problems with the reification of choice. These encompass: the imperfections of quasi-markets and how their promotion of choice can lead to purchasers and providers being knaves rather than knights; that privatisation has led to shifting the responsibility back to families and individuals (which some would see as regressive); that when one contemplates the promotion of choice, one needs clarity over which aspect(s) one is promoting (choice over where, who, what, when, how and whether); and, finally, that the promotion of choice may add to existing inequalities.

What of choice and social care?

Having explored the implications and consequences economically, psychologically and socio-politically of promoting choice, the paper will now turn briefly to some of the evidence of how effective the promotion of choice in social care has actually been, by reference to research into the development of individual budgets (IBs) and personal budgets (PBs) as well as self directed support (SDS), the main vehicles through which choice in adult social care have been promoted. Indeed, these remain central to government social care policy (DH, 2011; HMG, 2012). Whilst

some researchers have remained generally positive of PBs/IBs/SDS (see for example, Glasby, 2012), others have questioned their efficacy (see, for example, Beresford, 2008, 2009; Ali, 2009; Beresford *et al.*, 2012; Woolham & Benton, 2012). Research findings suggest that: whilst aspects of choice have been developed via IBs, PBs and SDS, older people have found their promotion less beneficial (Glendinning *et al.*, 2008; Orellana, 2010), psychological well-being is not necessarily improved for some groups (Glendinning *et al.*, 2008), and that for people with mental health problems, while experiencing potentially significant benefits, there are still major barriers to increased take up (Glendinning *et al.*, 2008). In addition, social care markets remain insufficiently flexible and responsive and still need to be developed fully (Institute of Public Care, 2009; DH, 2012), the supply of good care staff is still not adequate, social care users are still insufficiently skilled to take on the responsibilities of being IB or PD holders, and that there remains a need for effective advocacy services to be developed (Daly & Roebuck, 2008; Orellana, 2010; DH, 2012). As well as this, doubts have been raised as to whether PBs/IBs/SDS are really being implemented or whether councils with social care responsibilities (CSSRs) are simply labelling care arrangements as personalisation by attaching a notional cost to those care arrangements, whether PBs/IBs/SDS are more expensive because of the transactional costs associated with them, that there is a concern we might see a withering away of collective provision, and that one should be less occupied about who provides and more occupied about the what and when of social care provision (see Beresford 2008, 2009; Ali, 2009; Woolham, 2009; ADASS, 2012; Beresford, *et al.*, 2012; Woolham & Benton, 2012). Indeed, vis-à-vis older people, the ADASS (2012) has recognised this last point:

For many older people the choices they want are not so much about who provides, but what is available [and] when [as well as]... whether they feel they have a rapport and relationship with that

particular care worker. (ADASS, 2012, p.23)

In the meantime, recipients of publicly funded adult social care remain some of the most vulnerable and most in need. Most people who might benefit from public social care support are deemed either to be not in sufficient need and/or as having sufficient means to support themselves. Therefore, the choices (or market rights) afforded to some citizens are in sharp relief to the lack of the social right to care for the majority of citizens. Rather than Government fetishising or reifying choice in social care, perhaps what is required is an adjustment to the social contract such that older people can be provided with the care that they need. The Dilnot Commission (2011) maps out a way to do that and, whilst it may cost £1.7billion, that is 0.25 per cent of GDP. We can concentrate on ensuring care is personalised once we have the funding sorted. However, this doesn't mean continuing to reify choice. Rather it means we will need to ensure social care is right 'first time', provided by well run and regulated providers, with the expertise to know what is required and the skills to facilitate the assessment of an individual's care needs and then meeting those needs in a timely, personalised and effective manner (the what and when of choice).

Conclusions

The purpose of this paper has been to demonstrate that the promotion of choice is problematic. One of the consequences of the reification of choice is that over the last three decades there has been a shift in the balance of citizen rights, with an emphasis on market or civil rights sometimes, to the detriment of citizens' social rights, not least in the provision of social care. However, when one examines choice from an economic, psychological or social-political perspective, doubts are raised as to the benefits of its promotion. Therefore, in the provision of welfare and public services, choice in and of itself is either not sufficient or, at times, not appropriate. It may be better to consider

choice a 'second order' concern in that it is useful at a micro level, for example in the provision of adult social care where some (but only some) service user groups have found it empowering, not least disabled people and people with long term conditions. It is also useful at the macro level in terms of providing opportunities to service users and carers to shape provision. However, one should be mindful that the promotion of choice can also be counter-productive, not least in destabilising provision (Ali, 2009) and exacerbating inequalities (Clarke *et al.*, 2005; Stevens *et al.*, 2011).

One needs to recognise that social care is as much a social right as it is a market or civil right and that markets can be ineffective in coordinating the production, distribution and governance of social care (and other welfare and public service) provision. The promotion of choice in social care can have deleterious socio-political, psychological and economic consequences. In addition, the promotion of choice distracts from the need for appropriately funded social care (Dilnott, 2011) in order that adequate levels of care can be made available for all who need it, and not just to those with the highest need for social care support. Choice over 'what', 'where', 'when', 'how' and even, for some, 'by whom' and 'whether' are important considerations in the provision of social care but they are, arguably, only second order ones when considering how to meet citizens' social rights to care.

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Notes on Contributor

Guy Daly is Professor and Dean of the Faculty of Education, Health and Sciences at the University of Derby. His research

interests include UK social care policy, local governance and government, housing and health policy. He has researched the relationship between citizenship and social care provision and is currently involved in an NIHR funded research project investigating older people and personal budgets being led by Dr John Woolham.

Address for Correspondence

Professor Guy Daly
Dean of the Faculty of Education, Health and Sciences
University of Derby
Kedleston Road
Derby
DE22 1GB

Email: g.daly@derby.ac.uk
Tel: +44 (0)1332 591850

Reviews

Children's Needs - Parenting Capacity Child Abuse: Parental Mental Illness, Learning Disability, Substance Misuse and Domestic Violence

Cleaver, H., Unell, I. & Aldgate, J.

London: The Stationery Office, 2011, pp.273

ISBN: 978-0-11-706365-5, £25.00 (pbk.)

Also available as a download from
<https://www.education.gov.uk>

This second edition updates the authors' original exploration of policy developments and research literature, and now includes material on parental learning disabilities. The format followed this time largely mirrors that of the 1999 (pp.138) publication, but is considerably more detailed with almost double the number of pages. The focus remains firmly on how parental factors and behaviour *may* have an impact on a child's wellbeing. From the outset there is clear recognition that the extent to which, and the ways in which, a child may be affected will depend upon a range of factors – these are helpfully set out and summarised throughout the text. Research findings are considered for each age group in line with the conceptual framework introduced over a decade ago (Department of Health, 2000) and updated by the Department for Children, Schools and Families in the Integrated Children's System (2010) designed to assess and measure outcomes for children in need. The three domains of the framework are: the child's developmental needs, parenting capacity and family and environmental factors.

In the *Introduction* the authors acknowledge the limitations of the available research, such as pointing out that studies have predominantly focused on a single specific issue whereas co-morbidity is commonly found in practice. For example on page 2 they cite Munro (2011, p.30) who noted that more than one third of families experiencing multiple problems had children subject to child protection procedures. I would also add that Masson *et al.* (2008, p.2) had previously

identified that 'nearly all' the children in their care profiling study came from families that had multiple difficulties, leading to chaotic lifestyles and very inadequate care for children. Cleaver *et al.* highlight that many of the research studies included in their book have focused on problems rather than taking a more holistic approach whereby resilience-promoting strategies are identified. In contrast they, in their own words, seek to apply 'a holistic and developmental model' (p.18) throughout.

The book is structured in three parts: Part I (Chapters 1-3) provides an overview and context, broadly exploring each issue in terms of prevalence and the impact on parenting; Part II (Chapters 4-6) delves into specific impacts by age and stage of development; whilst in Part III two chapters highlight key findings and conclusions before considering implications for policy and practice.

Since the publication of the first edition there has been a growing awareness of the significance of attachment, partly based on increased knowledge of early brain development. Neurological research has shown that early exposure to fear and chronic anxiety can have lifelong consequences by disrupting the developing architecture of the brain (National Scientific Council on the Developing Child, 2010). In the light of this it is invaluable that the revised edition now includes more comprehensive coverage of family and social relationships and notably of early attachment formation. However, in this context and given the authors' desire to apply a holistic and developmental model, I was a little disappointed to see so little discussion of children's sibling relationships and no index reference to them, despite the statement contained in the section on middle childhood that 'siblings can be an enormous support for children when parents have problems. In particular, children identify brothers and sisters as key sources of support and comfort...' (p.151). To some extent the same

point applies in respect of friendships and peer relationships. However, within the text there is general recognition that for individual children the existence of a supportive relationship with one or more family members can be crucial and act as a protective factor.

Throughout the text terms are clearly defined and explained, for example: ‘hazardous drinking; harmful drinking; higher-risk drinking’. Similarly, I appreciated the authors’ inclusion of quotes from children and parents which bring to life service users’ individual perspectives.

Another strength of this publication, as in the first edition, is that each chapter includes one or more summary sections (entitled: ‘To sum up’) where salient ‘bullet’ points are clearly highlighted. This is likely to be especially welcomed by hard-pressed practitioners and first line managers working in Children’s Services. Given the clear, easy to follow and to ‘dip in’ nature of this book, it also looks set to become a useful core text for social work students.

The final chapter considers implications for policy and practice, and in doing so emphasises amongst other issues, the need for joint working and flexible time frames. Whilst the recommendations are sound in principle, a minor criticism is that some are rather obvious, whilst others take little or no account of the resource context in which staff operate. For example, the authors note that outcomes for children might be improved by increased use of foster or residential care as family support. There is already a critical shortage of such placements, such that it is difficult to envisage them being used more flexibly. In contrast, the authors’ focus on enhancing collaborative inter-agency work and better addressing service users’ information needs are likely to prove more fruitful.

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Shelagh Beckett

Independent Consultant

Safeguarding Children Across Services: Messages from Research

Davies, C. & Ward, H.

London: Jessica Kingsley Publishers, 2011, pp.224

ISBN: 978-1-84905-124-8, £19.99 (pbk.)

Also available as a download from the DfE website: <https://www.education.gov.uk>

Recent high profile controversies concerning the abuse of children and young people surrounding Jimmy Savile and about residential care in the 1970s in North Wales have fed into a long-term public narrative that the child protection system is in crisis and that it needs reform. These have raised important issues about public accountability and institutional abuse as well as about more general attitudes toward the safety of children and young people. There is, however, a danger that these issues, which have had far reaching political ramifications, will eclipse the broader and longer-term debate about the efficacy of child protection processes, and where these fit within the child welfare system.

Eileen Munro’s recent review of child protection (Munro, 2011), initiated in the aftermath of the inquiry into the death of Peter Connolly, has been central to this debate. Munro proposed there needs to be a much more fundamental shift in the way that

keeping children safe is understood. She argued that the system has become driven by a managerial-technocratic and risk-averse approach that stymies professional expertise and judgement, and has led to a culture where practitioners' professional activity is dominated by bureaucratic and administrative tasks, as opposed to building helpful and helping relationships with children and their families. The need for reform has been given added urgency as local authorities, who are central to delivering safeguarding services, have to do so with decreasing resources and a significant increase in demand. A recent report by CAFCASS highlights how the rate of care order applications has almost doubled in the last 5 years (CAFCASS, 2012).

There are many dimensions to the debate as to how services and practice can be improved, and therefore Davies and Ward's overview of 15 diverse safeguarding studies is particularly welcome. Most of these studies were part of the Government funded *Safeguarding Initiative*, a programme of research commissioned following the death of Victoria Climbié, with the aim of improving the knowledge base that informs service design and practice for those agencies involved in children's safeguarding. The studies cover a wide range of areas but focus on the following four themes:

- Identification and initial response to abuse.
- Effective interventions after abuse (or its likelihood) has been identified.
- Effective inter-agency and inter-disciplinary working to safeguard children.
- A particular focus on emotional abuse and neglect.

Covering such a diverse range of research means the messages that emerge from the studies are similarly diverse and not all sit entirely comfortably alongside each other. For example, the overview highlights the consequences that adversity and in particular neglect can have in later life. Therefore while

some conclusions drawn are that 'robust' steps need to be taken to avoid such damage as early as possible, others highlight the importance of sustained long-term interventions, and a recognition that sometimes it is rather that services are hard to access for parents rather than that the families themselves are hard to help.

The focus on neglect and emotional abuse is particularly helpful. This is an area that practitioners find difficult: as Davies and Ward argue, they are both forms of maltreatment that often do not have a single determining incident as such, and indeed are on the continuum of normative parenting. This is in contrast to physical or sexual abuse, which break the taboos of parenting. Responding to this challenge, Davies and Ward emphasise the importance of practitioners having access to the evidence base, and in particular an understanding of child development. They also emphasise the importance of multi-agency working in this area.

One aspect around neglect that is highlighted in this cohort of studies, particularly in the work of Stein and his colleagues, is the recognition that neglect can occur in adolescence. Several of the other studies equate early intervention with intervening early in the child's life. However Davies and Ward, citing Stein, argue that adolescents can also be neglected; and that the system is not sensitised to safeguarding issues with this group, focusing instead on managing challenging behaviour, including risk-taking behaviour, offending and school non-attendance. They point out that the long-term outcomes are as poor for young people who have been neglected in adolescence as for those neglected earlier in life.

In terms of multi-agency working the overview is positive about the impact that Local Children's Safeguarding Boards have had over the 7 years that they have been established, and suggests they provide a much more robust and coherent forum for coordinating safeguarding work in local

authorities than previous arrangements. However, the one area that remains problematic is the role of general practitioners. Their participation in the child protection system remains erratic and inconsistent. This is of particular concern given the current changes in the NHS that make GPs central to the commissioning and management of health services.

Some of the other messages are challenging in the current difficult budgetary environment. For example, several studies, especially Tunstill's, highlight the importance of agencies providing a continuum of services across the continuum of need. Cutting universal and targeted services may result in opportunities being missed for helping families when problems are less difficult to overcome. However this continuum is not only important in early intervention. Davies and Ward report Brandon's findings that 45% of cases that were the subject of serious case reviews were *not* previously known to children's social care, emphasising the importance of lower tier services to the child protection system.

At the higher levels of need, and in particular regarding social work services, this overview also has important messages. It reports the concerns that some of the studies raise: that cases were often closed too quickly, and that families only received short-term episodic services that did not address long-term need. Also, if social workers are to effectively assess capacity for change, they need not only the skills but also the opportunities to develop relationships with parents and then provide packages of support that can both ameliorate the impact of difficulties on children and effect long-term change.

For those children who do need to live away from their families the overview presents an overall encouraging picture: that care does, in the majority of cases, make a positive difference. However, it identifies the need to develop therapeutic placements for the more vulnerable children and in particular adolescents.

Agencies involved in the child protection system are in a period in which they are attempting to engage in a process of what in many respects is profound reform, especially within social work services. However this is against the backdrop of the biggest cuts in spending for a generation. The studies covered in this overview do not offer easy solutions to this challenge; but they do offer extremely helpful and practical messages, so as to build a system that is both effective and humane.

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James Blewett

Social Care Workforce Research Unit, King's College London
London Coordinator for *Making Research Count*

Supporting Vulnerable Adults: Citizenship, Capacity and Choice

Stewart, A.
Edinburgh: Dunedin Academic Press, 2012, pp.98
ISBN: 978-1-906716-12-7, £15.99 (pbk.)

This book is one of the series of Scottish volumes entitled *Policy and Practice in Health and Social Care* produced by Dunedin Academic press, which a number of readers may already be familiar with. The series aims to produce short practitioner-focused guides that introduce theoretical ideas and relate these to current policy and practice issues. This volume provides a short overview of the issue of adult protection (also known as adult

safeguarding) and is a useful addition to existing literature in this area.

Although society has been aware of issues relating to child abuse and protection for several decades now, and that some women are also exposed to violence from intimate partners (or ex-partners), it is only comparatively recently that there has been an acknowledgement that abuse of 'vulnerable adults' also exists. Although there has been some increase in media attention concerning this area, it is not possible to state at present that adult abuse is always recognised or dealt with appropriately. However there has been increasing recognition in recent years within social care and health about this topic, and a growing acknowledgement that this is an area in need of attention, together with the development of responses and interventions. Scotland introduced legislation covering this area in the form of the Adult Support and Protection (Scotland) Act 2007, so it is therefore useful and timely for this volume to appear as it contains consideration of the Scottish dimensions of this issue as well as discussions about what has taken place elsewhere in the UK.

The book provides a combination of theory and practice and also incorporates guidance on the legal aspects of adult protection (as it is still known in Scotland; in England the term used now is adult safeguarding). The book focuses on the early post-implementation phase of the Act and considers the development of the legislation in relation to theories of citizenship, capacity and choice in relation to the support of adults who may be at risk of harm, whilst also comparing and where necessary contrasting these issues with relevant material from the rest of the UK. This is particularly helpful for those readers from other jurisdictions within the UK. It also includes the results of research undertaken during the first few years following the implementation of the Act (which was funded by the Scottish Government). This provides a helpful backdrop for the main theme of the book, which explores the tension between the issues

of autonomy and independence and those of safety and protection, and clearly links these to the concepts of rights, particularly in relation to citizenship and capacity.

The book is strong in the discussion and exploration of issues of potential discrimination and oppression and the extent of the reach of the State, with a key question: does this legislation (potentially or actually) compromise an individual's freedom of action and choices within decision-making. Some useful practice-related suggestions are included in relation to decision-making, capacity and recording and sharing of information. The use of case studies and findings from a number of enquiries into situations of abuse (at individual and institutional levels) is useful, and particularly helps to locate the theoretical discussion firmly within the realities of practice. These relate to situations that have occurred in both England and Scotland, including the Scottish Borders Inquiry (Scottish Executive, 2004), and are clearly cited for those who might be interested. The discussion of terminology and of vulnerability is also helpful; and relating the concept to the social model (of disability) rather than to individual pathology appears to be an important shift, requiring some additional exploration in future. The consideration of definitional issues and interactions between risk, vulnerability and harm are also helpful to this area.

The need for holistic and socially inclusive approaches towards people with situational vulnerabilities who may experience difficulties relating to abuse, neglect or exploitation is emphasised throughout; and the importance of such approaches is highlighted in the book. The book is thought-provoking in a number of areas, such as the discussions of terminology and reconceptualisation in terms of the social model. Moreover, the common concerns across the UK relating to achieving the correct equilibrium between autonomy and protection are well presented. In a book of less than a hundred pages it is difficult to achieve a balance between theory (and

knowledge) and practice, particularly in this field that covers a wide range of individuals and service user groups: but this volume pretty much attains this. There are a number of useful recommendations relating to the key themes of capacity, choice and citizenship in the later chapters of the book. The discussion of practice issues will be of particular interest to practitioners in this area of work and helps provide a sound basis for the development of evidence-informed practice. As a foundation for further study of this field the book also leaves readers wanting further in-depth consideration of the issues addressed.

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Bridget Penhale

Reader in Mental Health of Older People
School of Nursing Sciences,
University of East Anglia, Norwich

Evaluating in Practice (2nd Edition)

Shaw, I.
Surrey: Ashgate Publishing, 2011, pp.184
ISBN: 978-0-7546-7858-8, £25.00 (pbk.)

'Evaluation and research do not enjoy a good press amongst social workers' (p.8). With this in mind, in *Evaluating in Practice* Shaw sets about opening the eyes of social workers to the value of evaluation by proposing a model which would embed these concepts within their everyday practice. Throughout the book he challenges the model of evaluation which is symbolised by external researchers coming in and carrying out an evaluation of social work practice, after the event. He portrays a vision of reflexive social workers who can undertake their own evaluation of practice in

all aspects of their work. Shaw states his primary audience is practitioners and his secondary audience academics and social scientists, but points out explicitly from the beginning that this is not a skills handbook. Nevertheless, he sets out to explore what knowledge, skills and values social workers must hold in order to adhere to this model of practice.

The book has nine chapters. In the first half Shaw sets out what he means by evaluating in practice and places it within the context of a range of methodological approaches. Chapter 4 is what Shaw calls the 'hinge' of the book in which he outlines the principles of his approach and grapples with the relationship between research and practice, drawing particularly on the work of Schon (1983, cited on p.62) and his thesis of reflective practice. In the remaining chapters Shaw discusses how evaluation can permeate all aspects of assessment, planning, intervention and reviewing outcomes.

This book has international appeal in that much of the literature Shaw quotes is from the USA, some of his practice examples are also from Canada and he refers to the excellent international journal *Qualitative Social Work*. This does not detract from the arguments he is making about the value of evaluating in practice, but I imagine the examples might feel some way from the experiences of social workers employed in statutory agencies in the UK.

Each chapter ends with a section entitled 'Taking It Further' in which Shaw suggests tasks to stimulate reflection, discussion and reinforce the learning from the chapter. I cannot see many readers undertaking these alone and some of them require access to literature most easily accessible in universities. However, some of the exercises will be of great value to practice educators who are supervising social work students on placement, and an excellent resource for social work educators who could usefully incorporate them into classroom activities or reflective assignments.

The book is written entirely in the first person and as such the style has a persuasive quality sometimes lacking in social work texts. For most social worker readers there will be a number of places which make you stop and think, and imagine yourself using these techniques in practice. For me, there were two such moments. First was the value of undertaking a 'cultural review' (McCracken, 1988, cited on p.93), by systematically evoking memories of relevant personal events in one's own life before undertaking complex pieces of work in order to 'demonstrate reflexivity and render explicit what we know and do not know' (p.94). Second was Shaw's reference to Gerhard Reimann's work (2005, cited on p.83) in asking social work students to reflect on and learn from the most mundane of experiences (in this case the arrival at placement on their very first day and the experience of being mistaken for a user of the service) as they begin their careers in social work.

This book is the second edition of a book written in 1996. Shaw has updated the content and reflected on the expanding range of qualitative methods of research available to practitioners, in particular arts and technology inspired techniques, which have developed since the first edition. The text is sometimes a little dense but is certainly worth pursuing for the nuggets of insight and passion which Shaw brings to the subject. I imagine we will see a third edition of this book at some point in the future and that Shaw sees this as a text which will never be complete, so committed is he to the view that 'Evaluating in practice challenges social work to new understandings and new methodologies – and it holds the promise of keeping social work honest' (p. x and p.164).

Rosemary Littlechild

Senior Lecturer
Institute of Applied Social Studies
University of Birmingham

Methods Reviews from the School for Social Care Research

Electronic documents, published as free downloadable pdf files
<http://sscr.nihr.ac.uk/methodsreviews.php> (Last accessed 27/12/12)

The School for Social Care Research (SSCR) remit includes helping to strengthen the evidence base in social care research related to adults. A series of commissioned and peer-reviewed methods reviews is being published, and those numbered 1-12 issued in 2011-12 are considered here. (Others are anticipated and should fill some gaps.) For review they are grouped thematically, as described below.

1. *Qualitative methods overview* (Moriarty, J.) pp. iv, 43.
 2. *LGBT sexualities in social care research* (Price, E.) pp. iv, 34.
 3. *A brief guide to carrying out research about adult social care services for visually impaired people* (Charles, N.) pp. iv, 35.
 4. *Research governance and ethics for adult social care research: procedures, practices and challenges* (Woolham, J.) pp. v, 35.
 5. *The use of 'large scale data sets' in UK social care research* (Hussein, S.) pp. iv, 27.
 6. *Overview of outcome measurement for adults using social care services and support* (Netten, A.) pp. v, 38.
 7. *Mathematical modelling and its application to social care* (Squires, H. & Tappenden, P.) pp. iv, 18.
 8. *Care homes* (Luff, R., Ferreira, Z. & Meyer, J.) pp. v, 40.
 9. *Research with d/Deaf people* (Young, A. & Hunt, R.) pp. iv, 23.
 10. *Structured observational research in services for people with learning disabilities* (Mansell, J.) pp. iv, 27.
 11. *Research with black and ethnic minority people using social care services* (Vickers, T., Craig, G. & Atkin, K.) pp. v, 26.
 12. *End of life care* (Goodman, C., Froggatt, K. & Mathie, E.) pp. vii, 58.
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Purpose and style of the reviews

The intended readership for the reviews is researchers, including experienced researchers new to social care, and students intending to undertake research in adult social care. (Mansell also suggests that the contents will be suitable for students learning about research methodology.) Those commissioning research in social care organisations or reviewing research proposals are not a stated target group.

The reviewers are independent academic experts, and a couple also appear to have experience of working in adult social care settings. The structures of the reviews are similar: a table of contents; an abstract; detailed discussion of the topic around the identified literature; conclusions; recommendations generally and to social care researchers; alphabetical listing of the literature cited, and sometimes glossaries and indications of other web-based sources of further information. The literature sources

cited range in amount from one tenth to just over one quarter of the total text. There are no alphabetical indexes.

The contents range far in time and geography. All sources are in English, but the interested reader would require access to a good library or Athens password, perhaps via their employer or the Social Care Institute for Excellence (SCIE), or otherwise need to be prepared to pay significantly to follow up even a small proportion of the published articles drawn on. Some reviewers indicate whether the material they discuss is from UK-based work, but this is far from standard. There is a link therefore with a fundamental problem, discussed by many reviewers: the fluid definition of 'social care', and to some degree 'adults'. It clearly limited the reviewers' literature searches: from 376 potential sources on mathematical modelling no project was actually found to have met the inclusion criteria. As a result, the cited research is frequently drawn from sources in health care research, as well as from disciplines such as social policy, psychology, and sociology. Publication being required in a journal source, so as to justify citation, seems also to have excluded much research undertaken in or by local authorities; and it is not clear whether all reviewers consulted SCIE Online as a research source, though some did. The range of review topics is wide, suiting the variety of activities that can be subject to research in social care and also raise issues of methods. Some obvious omissions – quantitative research such as surveys, research on aspects of mental health and learning disability, research on non-institutional care for older people, and the use of varied research techniques – might well be rectified in future reviews. (Three more reviews are announced). Such later reviews will also be able to draw on those already published.

Reviews are shorter than a typical monograph – the shortest is 22 pages, the longest 65 pages. They can also be shorter than the typical student text book chapter, where some limited comparisons can be made. For

example, around 80 pages of the recent second edition of a text book on understanding research, for students of social work and social policy, is devoted to qualitative research; and around 60 pages to quantitative research (Becker *et al.*, 2012).

The remainder of this review draws out some different elements from the first 12 reviews. The first to be discussed are the reviews on research techniques, design processes and decision-making; and subsequently those reviews that concentrate on various groups who might be the subject of social care research.

Within the first group are: mathematical modelling (Squires & Tappenden) and use of large data sets (Hussein); measurement of outcomes (Netten); qualitative techniques (Moriarty); and considering ethics and governance issues and processes, and designing projects with these elements and challenges in mind (Woolham).

The remainder can be loosely defined according to the specificity of the groups, with 'methods' being understood in a broad sense. They are: research about adult social care services for visually impaired people (Charles); research with d/Deaf people (Young & Hunt); research on services for people with learning disabilities – using observational techniques (Mansell); care homes for older people (Luff, Ferreira & Meyer); end of life care (Goodman, Froggatt & Mathie); LGBT sexualities in social care research (Price); research with black and ethnic minority people using social care services (Vickers, Craig & Atkin).

Reviews on research techniques, design processes and decision-making

Squires and Tappenden, (7), make the case for techniques of *mathematical modelling in social care research*, especially in cost-effectiveness evaluation. This is based on the analogy with health care evaluation. The definition of mathematical modelling for inclusion in their literature review is:

- the definition of causal relationships between phenomena;
- the use of some form of extrapolation, either the projection of short-term data to longer-term outcomes or the translation from intermediate to final outcomes through defined causal relationship; and
- the synthesis of evidence from multiple sources. (p.1)

As no UK adult social care study met these criteria the review is at a high level of abstraction, and also refers to a forthcoming review in the SSCR series for information on the economic framework within which modelling takes place. Examples used to illustrate modelling relate to clinical trials, for example on the impact of contraceptive advice. Even so, there was the limitation that most of the five clinical trials which did meet some of the above criteria had nevertheless not been the subject of extrapolation from the initial trial data. In reality, as acknowledged, in using data for modelling, corners can also often be cut, owing to time and resource constraints. The authors also acknowledge the limitations of social care concepts methodologically, and make the case for committing resources to undertake mathematical modelling in social care alongside development work on public health modelling – work which is referred to, but not discussed. Doubtless debates will take place within the National Institute for Health and Clinical Excellence (NICE).

Advocates of the rigour of mathematical modelling could do worse than read the review by Hussein, (5), who similarly suggests an expansion of techniques of analysis, this time to engage with available *large data sets*. These are data sets drawn from general population data (from censuses and surveys, including longitudinal studies) and from surveys and administrative data from social care sources – primarily public organisations.

The studies cited include some on nursing care, justified because of the overlap with

social care in the case of residential care – and there is a dearth of UK social care data sets. Hussein illustrates findings and limitations from several analyses of cross-sectional or time-series data on carers in households. Limitations, of course, are set by the original data sources and their definitions; and conclusions drawn can be trite. For example, after adjusting for marital status and household size, it appears that older women are more likely to provide informal care than older men.

Hussein's discussion is well grounded, and she is not afraid to refer to cross-boundary data sources (in children's social services) alongside standard data sources, such as the national user experience surveys conducted over the past decade by local authorities. Her own specialist experience most recently has been in relation to social care workforce data, so there is an informed discussion of resources and possibilities in this area – fraught as it is by definitional issues around social care. Of particular importance in the use of large data sets are the possibilities of sifting various different sets in order to generate hypotheses or findings in relation to a broad research question. Martin Knapp and colleagues are reported by Hussein to have done this in a cited study of the costs of autism. Opportunities have been taken from available data, but the researcher has to be aware of the building blocks in data sources, so as to avoid false inferences. A practical illustration in workforce data coding is of 'missing' data on qualifications as being equivalent to 'no qualifications'. Published articles reviewed by Hussein illustrate her point that studies don't always indicate the sources and limitations of the data on which they were based. Statistical analysis of data is also discussed in the review, albeit briefly and with the minimum of glossing. Prompts given about type 1 and type 2 errors of inference and about logistic regression techniques should at least be enough to remind researchers to review their thinking.

Cost advantages from undertaking analyses of existing data sets are suggested, because of

not having to develop all one's own data collection instruments; and existing data sets might help researchers to generate sub-samples of potential respondents, as with older ethnic minority people who have been subject to abuse (in the cited 2007 UK study of abuse and neglect of older people).

Hussein concludes by pointing to the potential for data sets being linked to generate data for analysis, and to the possibilities for longitudinal analysis in social care, from the present apparent under-use of large scale data sets.

The possibilities for creating better data are not lost on Netten, (6), alongside a strong commitment to relate service *outcome measurement* to the quality of life of service users. A starting point is the concept of social care as primarily compensating for (personal) impairment, and therefore generating ideas about what it is and does (or should do): and then measuring what can be measured. Relating the specific impact of services on quality of life has generated the concept of Social Care Related Quality of Life (SCRQoL) and Netten describes attempts to operationalise this, using large scale survey data drawn from user experience surveys carried out over the last few years by local authorities according to standardised guidance.

Domains of SCRQoL are described and defended from criticism. A strength is that they attempt to be grounded in expressed preferences, with minimal association with national policy nostrums – which have changed over time, and no doubt will continue to do so. Challenges include how far changes or other impacts on the quality of life can be justly attributed to social care services. A conceptual and practical problem – the counterfactual question ‘what would in all probability have happened in the *absence* of social care intervention?’ – is not easily resolved, though the toolkit (Adult Social Outcomes Toolkit – ASCOT) does attempt to help. At a time in adult social care when the development of personal budgets means data

on actual service inputs are increasingly disaggregated or absent, it seems likely that precision of attribution will become even more difficult. Nevertheless ASCOT is used nationally by researchers, and by local authorities, though how systematically and with what results at local level has yet to be established. Issues of applied method, as discussed by Netten are: how provision of information and advice can relate to outcomes; adaptations of service user measures to cover carer outcomes; and objective and subjective elements in wellbeing measures.

In practice, adaptation by service users to their personal expectations, and then actual levels of expectations of service users have made measurement of service impact difficult; and Netten also rightly draws attention to the burden of information-seeking on survey respondents – who tend to be paid rather small amounts (if paid at all) for their time.

A further methodological challenge is the shift from personal functioning to capabilities as a way of conceiving the range of domains that are appropriate in measuring service outcomes. Measurement of morale, psychological wellbeing and ‘happiness’ are briefly discussed in connection with outcome attribution, but understandably Netten sees these as part of a future agenda – not least because of fluid definitions – such as with ‘independence’. Potentially of great interest to those responsible for surveys in councils is Netten's discussion of the ability of people who use services to contribute their views on measurement and on their own quality of life, as it might be measured in relation to social care aspirations and achievements. The whole review, though, repays careful re-reading.

At a more general methodological level, and within its 47 pages, Moriarty's *overview of qualitative methods*, (1), with examples from published social care, health care and other social research reports, would be hard to better. The examples and discussions are chosen from what are suggested as the more

common styles: ethnography; grounded theory; case studies; conversation analysis; life history and narrative approaches. Qualitative methods are reported to be prevalent among social work practitioners, and others have pointed out that they are in many ways opposed to natural scientific approaches, not just the explicit absence of quantification. (See Becker, Bryman & Ferguson *op cit.*, especially pp.274 ff.) Moriarty picks her way clearly through this area of conflict, and tends to describe researchers' actual choices - for example on convenience sampling - rather than be prescriptive. However, a general observation citing an analysis suggesting a contrast with reporting of *quantitative* social care research, is that:

Better standards of reporting could help establish the validity of social care research. Attention to quality of reporting also needs to include consideration of how to make the writing more inviting and accessible to a wider audience. (p.27)

Moriarty calls for an informed debate about methodological quality in much social care research; and 'informed' would include attention to opportunities for, and take-up of, research guidance by those, such as social work educators, practitioners and service users, who might consider themselves as undertaking qualitative research. Attention to methodological plurality and interdisciplinary approaches nevertheless means the present is a time, for Moriarty, that researchers can use for innovation, alongside technological developments, and the expansion of practitioner and user-controlled research.

This reflective overview is admirably complemented in Woolham's, (4), review of *procedures, practices and challenges in research governance and ethics for adult social care*. He carefully delineates procedures (largely non-statutory) and practices, which can be rather variable, especially in different sectors within adult social care. A decade of modest regulation within local authority social care is described,

together with debates questioning the validity or usefulness of prospectively reviewing research projects, whose aims, methods and instruments might not always be available for such external scrutiny. The burden of compliance on researchers is perceived (by researchers) to have grown, alongside, as Woolham suggests, some improvement in the protection of potential research participants from exploitation. Recent good evidence on this from an adult social care perspective is not plentiful, and there has been none from research reviewer processes except some comment in a Social Care Research Ethics Committee (SCREC) annual report; there is a little from children's social care, but more from those involved with NHS care and clinical trials.

Large areas of research in relation to social care are not subject to the recommended governance systems - research in commercial health or social care settings; or governance systems are fragile, loose or inconsistent - as at least until recently within different parts of some universities, or in relation to different levels of research, or in a considerable proportion of local authorities. Woolham's conclusion is that there has been progress in the governance of social care research, perhaps preventing some unethical or methodologically flawed research, and valuably revising other proposals; but it has been 'slow, patchy, and has not yet delivered the five key principles described in the Route-map for Researchers' (p.30).

(These principles are: reciprocity between the three main review systems, in universities, the NHS and local authorities; the avoidance of double-handling in ethics review; proportionality (to risks) in review decisions; independence of judgement of reviewers; review being sought by the principal researcher.)

The only statutory element in research ethics review, in relation to the Mental Capacity Act 2005, and the establishment of a national Social Care Research Ethics Committee, using NHS ethics review procedures,

documentation and practices, is an outcome of conflicts mainly outside social care. As such, it is hard to take issue with Woolham's conclusion that unresolved issues:

... reflect, or are responses to, wider, societal ambivalence towards risk and protection. Solutions are likely to require shifts in power and the sharing of resources, changes to organisational and professional culture, investment in training, and continuing dialogue. (p.31)

Reviews on methods and research practice with specific groups

Expertise in fields associated with disability research is clearly evident in Charles's, (3), advice on *carrying out research about adult social care services with visually impaired people*. The range of literature covered is wide, covering debates about definitions and prevalence of visual impairments. It includes references to statutes, and to administrative documents from the Royal National Institute of Blind People and other third-sector organisations and from government, up to mid 2010. In research discussed in these methods reviews it is unusual to find a longitudinal study: but one exists in the area of visual impairment (Birmingham University's Visual Impairment Centre for Teaching and Research's *Network 1000* and its associated reports are cited for displaying design and questionnaire expertise.)

This is one review where the possibility of cross-reference to other reviews could be considered in future updates. The brief discussions on measuring satisfaction and on qualitative research, for example, appear worthy but not especially relevant to visual impairment. There is, however, a useful reminder of the use of case vignettes as a data collection technique within research on professionals, but as also typically recommended for qualitative research with sensitive groups such as children and drug users. Even more, the practical information provided by Charles on operationalising research consent processes for visually

impaired people has relevance well beyond this group, and his discussion of the social model of disability versus the 'so-called medical model of disability, which constructs disability as entirely inherent to the individual' (p.2) is similarly relevant to other methods reviews.

Young and Hunt's, (9), review on *research with d/Deaf people* is another which has little adult social care research to draw upon. Its emphasis is on definitional factors, such as those reflected in its title, which differentiates between early and later acquired deafness and their distinct implications. The review draws on international research, population estimates and some polemical sources. Definitions are of course crucial to research design and methods, so this emphasis is welcome; and it tries to reflect cultural inclusivity and the varieties of 'deafness', which are carefully spelled out. As Young and Hunt put it:

Thinking carefully about even the most basic labels and categories by which to classify research participants is not a matter of political correctness; it is of vital importance if errors are to be avoided in how samples are described and inferences drawn. (p.6)

Even more basic for researchers is the virtual exclusion of sign language from the academic milieu, as claimed by Young and Hunt. This means, as reported, that basic concepts used in research, such as phenomenology or linear regression, are not yet clearly marked in BSL and have to be finger-spelled.

Ethical aspects of research, such as those involved in gaining consent, are discussed: these aspects are thought not fundamentally different from good practice in processes involving non-d/Deaf people:

Ensuring that data collection matches preferences in language and communication is a vital component of quality research in this field. (p.7)

The process for researchers of gauging communication preferences is nevertheless not straightforward, because of potential assumptions: for example, about lip-reading; or ignoring the distinction between active and passive communication. Accordingly, advice from Young and Hunt is:

Interpretation of data which includes d/Deaf people should be treated with caution unless there is a satisfactory description of how and why the sample is described as it is. (p.7)

Similar care with inferences from data also underpins the review by Mansell, (10), of *structured observational research on people with learning disabilities*. Finding research methods to reflect the experiences of people with severe or profound learning disabilities is a challenge. This review focuses on one such approach (observational), which has been used in the UK, in research on mental health and on older people, but mainly in learning disability research.

The review gives examples of the kinds of questions that the method can address, and clearly distinguishes structured observational methods from open ended *qualitative* observation. Structured, *quantitative* observation, on the other hand, is said to be more useful in providing evidence about such issues as how frequently people behave in certain ways. Examples are given of projects that have used this structured observational method, reporting on engagement in tasks, and on the pattern and content of interactions between staff and people with learning disabilities.

Consent issues for this particular method, and for people with learning disabilities generally, raise practical and ethical problems: and the case example offered in this review antedates the Mental Capacity Act, so is now superseded. At the end of the section about selecting and defining behaviour that is being observed, there is a mention of the need to test and refine new measures, if researchers are not using measures developed previously.

This is a useful reminder, but could, as with the text on consent, be usefully expanded in an update.

Extensive guidance is given on the technical aspects of structured observation: how often to observe, and for how long, and there is a balanced view on the merits of continuous observational techniques and momentary time sampling. Partial-interval and whole-interval sampling are mentioned, but dismissed without a description, as they have been shown (in one American publication) to be unreliable.

The evidence base for the review is broad in time (1970s onwards) and geography, and the result is authoritative within its stated limits. Further, it makes clear the value (despite the financial costs involved) of the observational approaches it analyses in supporting the development of more humane and better services for people with profound learning disabilities: people who are often ignored in research, as it is difficult to gather data on them or from them using other kinds of research methods.

Research on care homes is also fraught ethically and methodologically. The review by Luff, Ferreira and Meyer, (8), invited submissions as well as drawing on an extensive 2007 literature review (cited in the references) led by Meyer. It has larger elements of how-to-do research than the other methods reviews, in the context of care homes for older people, and with practical suggestions for reflexivity on the part of the researcher. It would have been useful to attend to the distinction between practitioners' and researchers' approaches to reflexivity, as this is a good starting point to understand the similarities and differences between practice and research modes. Nevertheless, this is no bad thing as the specific suggestions are based on cited research in care and nursing homes. For example:

... researchers and their managers should ensure that emotional support is available

for research staff should they wish it (for example, access to counselling services). This support, its relevance and importance should be made explicit during planning stages. For example, it could be included in funding applications as an essential requirement to support researchers. (p.7)

Early in the review the distinction between research and development within care homes is elided, and the suggestion seems to be that research towards the development end of the research – development continuum is more likely to be acceptable within homes than more theoretical, exploratory or evaluative research.

Ethical issues around consent are discussed and illustrated. The Mental Capacity Act 2005 is mentioned, (though not the associated Code of Practice issued in 2007), as is Woolham's methods review (4). However, an intended footnote appears to have been lost and the impression is given inadvertently that applications for independent ethics review to research ethics committees or to SCREC incur costs. These points could all be amended in an update, adding perhaps some practical examples of methods to involve care home residents who lack capacity to consent, and explaining the role of consultees and the status of their advice about the participation of people who cannot give consent themselves.

Maintaining confidentiality is particularly important in research using qualitative methods, owing to the amount of data about each individual and the aim of reflecting experience in different ways. More exploration of this issue would have been useful, covering ways of anonymising data and the limits of confidentiality in care homes.

Turning to methods issues *per se.*, the section on quantitative methods starts with a useful discussion about sampling and the difficulties of getting valid sample sizes, due to overestimating likely levels of response. It highlights issues relating to levels of interest

from staff and managers, the complexity of the language of questionnaires administered to staff who might anyway not have English as a first language, and implications of staff turnover. The authors rightly suggest that the wording of some measures, which have been validated on other populations, may need to be changed. However, they do not mention the consequent potentially negative impact on reliability and validity. The review might also have identified a need for more work to develop and standardise versions of research instruments specifically for use in care homes.

Nevertheless this review, by quoting extensively from student and professional researcher reports, gives more than a flavour of the issues arising from the *application* of methods in care homes for older people – issues that researchers can prepare for. Sources of further information (email addresses) are given within the text.

Research on end of life care is touched upon by the care homes review; and in turn this earlier review is cited by the authors of the review of *end of life care*, Goodman, Froggatt and Mathie, (12).

Understandably, much of the cited research is from a nursing perspective, though Froggatt's and Mathie's own research findings are discussed. A request to forums and to 18 researchers in England, Wales, Scotland and Ireland yielded results about research in social care over and above the known literature and SCIE Online. Nevertheless, the crucial investigations and recommendations on outcomes measures in particular are from American sources.

Website resources are cited within the text, though the general data sources cited in a table are unhelpfully broad: Department of Work and Pensions, Audit Commission etc.

The range of data collection methods discussed in the review is wide, with their advantages and disadvantages; but the conclusions report areas of underdevelopment

(in terms of research evidence) even in respect of cost-based evaluations, as well as the relative impact of different interventions, and of hospital-based and social care provision.

In part-recompense, the discussion of innovative arrangements, such as the Liverpool Care Pathway and the Gold Standard Framework, is enough to provide useful leads for prospective researchers.

The review can justifiably claim to be a direct resource for the evidence base that national policy asserts is needed in social care. It concludes, possibly on the basis of Mathie's cited study, that 'people at the end of life often value the opportunity to participate in and find benefit from their involvement in research' (p.41).

The review of *LGBT sexualities in social care research* by Price, (2), suffers from some of the limitations identified in other reviews: a virtual absence of good quality social care research to draw from, with the partial exception of the area of learning disability. From the methods perspective:

... sampling of LGBT populations is difficult as it is a social group that is generally considered to be 'hard to reach', 'resistant to definition' and subject to discrimination and social isolation. (p.14)

Generalisability, from such convenience samples as are typically achieved, is thus limited. Price indicates that her own research for a study of carers, using 'snowballing' recruitment techniques, took four years to recruit 21 gay men and lesbian women. On a larger scale, a 2001 'Gay and Lesbian Census' yielded no published results.

After discussing varied small scale research projects the reviewer concludes:

... whilst qualitative methods have traditionally been the choice for research that explores hidden or particularly vulnerable populations, for LGBT

research, mixed methods have proved a useful way of, first, providing a broad understanding of particular issues and, second, more in-depth analysis of participants' experiences. (p.26)

Research with black and ethnic minority people using social care services, reviewed by Vickers, Craig and Atkin, (11), is acknowledged as drawing from wider sources than social care research described in electronic databases and SCIE Online. Academic networks and conferences were also used, but the reviewers explicitly and to their credit acknowledge this was not a 'systematic review', in the technical academic sense. As with most of the other methods reviews, most examples cited are not in the social care field: here literature on health care in particular has been drawn on. So the occasional apparent slip, such as using 'South Asian' as an ethnic group, or 'impact on the patient', must be derived from this focus.

The wide-ranging discussion on the varieties of ethnic identity is a useful corrective to past naivety among researchers and policy-makers. To explore more fundamental questions about the analytical value of ethnic categorisation is probably beyond a methods review - but references and discussion are broad enough to encourage this. From a methods point of view, the discussion of sampling and booster sampling in surveys is welcome, if brief. Similarly, the discussion on issues about the trialling of research instruments with minority group participants, recruitment, translation and matching of interviewers with participants, informed by a wide range of studies, encourages careful thought at the design stage of research projects.

More than in other methods reviews researchers are challenged politically. Initially this is to justify their proposed research to potential participants, as plausibly likely to benefit them or others; and in analysis 'how to represent the experience of ethnically diverse populations, without recourse to sweeping generalisations which

can essentialise the experience' (p.15). Also caution about the dissemination of research results is general advice, applicable to social care researchers, to avoid 'unintended contributions to racialised stigma' (p.16).

Conclusion

Taken as a group, the methods reviews so far more than meet their brief. There is something of value in each, and a few are outstanding in their range and depth. When the present series is complete (with some obvious gaps like those mentioned above being filled) one hopes for a synoptic index, so that it will be possible to cross-reference terms in all of the reviews, together with some updating of content, so as to maintain the assured authority of the texts. One would like even more to see promotion and then evidence of their use in practice in designing research, in order to strengthen the quality of the social care research evidence base.

As a group, the reviews also display the fact that as yet there is not a great deal of empirical UK research literature on adult social care that can be drawn on so as to illustrate methods issues and good practice. This reflects both local and national funding priorities, and reporting and dissemination sources.

In particular, the reviews highlight the imbalance in terms of the research approaches used. Much adult social care research is qualitative or small-scale as opposed to large-scale and quantitative. This is illustrated by the difficulty mentioned in one or two reviews in finding significant quantitative research examples on which to draw. It seems likely that this does not only reflect researchers' methodological preferences and

expertise, as discussed in the very first review in this series. It also reflects the underlying choices and commitments by strategic commissioners of research and research infrastructure support in the adult social care field.

The published and prospective methods reviews appear likely to focus more on quantitative methods issues (despite the apparent lack of examples from UK adult social care on which to draw). While there is a great deal of qualitative research undertaken, there is arguably scope for improvements in qualitative methods, as applied to varied adult social care subject areas. Consequently, there are additional topics for more qualitatively focused methods reviews that would be of value (interviewing people with learning disability or a degree of dementia, for example). Overall, though the commitment of SSCR in publishing such a range of methods reviews is very welcome: it deserves to be strengthened, and to influence all those making strategic and local adult social care research choices in the long term.

Reference

Becker, S., Bryman, A. & Ferguson, H. (eds.) (2012) *Understanding Research for Social Policy and Social Work: Themes, Methods and Approaches (2nd Edition)*, Bristol: Policy Press.

Paul Dolan

Reviews Editor
Research, Policy and Planning

Martin Stevens

Social Care Workforce Research Unit
King's College London
Contributing text on Methods Reviews 8 and 10

What are SSRG's objectives?

- to provide a network of mutual support and a forum for the exchange of ideas and information on social and health care services;
- to promote high standards in social and health care services research, information, planning and evaluation;
- encourage collaboration in social, housing and health services activities;
- to develop an informed body of opinion on social and health care services activities;
- to provide a channel of communication for the collective views of the Group to central and local government, other professional bodies and the public;
- to sponsor relevant research and identify neglected areas of research;
- to encourage and, where appropriate, sponsor high quality training in research techniques.

Who belongs?

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