

This is the first edition of Volume 28 of *Research, Policy and Planning* and is published at a time of widespread concern about the future of social welfare across Europe and no little interest in the plans of the new coalition government in the UK. It is fitting, therefore, that we open with a paper by Sylvia Godden and Allyson Pollock offering their view on the future of social care in the UK (given the fast-changing policy landscape, it is worth noting that the paper was accepted in May 2010). In charting the development of the welfare state, the authors demonstrate how successive administrations have contributed to the shift from collective to individual responsibility and conclude that social care will continue to command low priority, be paid for by private contributions and with private insurance playing a part (it will be interesting to see how the greater emphasis on public provision in Wales and Scotland fares as financial stringencies increase). Robin Jackson's article focuses this theme in an exploration of how the economic recession may adversely affect the quality of services for people with intellectual disabilities. Key factors contributing to the predicted deterioration include the commercialisation of social care, uncertainties about regulation and a decline in the power and influence of advocacy services.

As finances bite and the demands of the workplace intensify, the pressure to recruit the most able trainees and to provide the highest quality preparation for practice is only likely to increase over the next few years. Jo Moriarty *et al.*'s article is, therefore, especially timely. The article draws on data from the Department of Health-funded evaluation of the social work degree qualification in England to identify possible improvements in qualifying education. The authors argue that a concentration on applicant performance at A-level may result in insufficient attention being paid to non-academic qualities, much-needed in adult and children's services. Improved partnership between employers and universities is called for, including more opportunity for involvement in selection and teaching.

Janet Warren's article adds to the growing literature concerning the participation of children and young people in social work research. Specifically, it seeks to further the emerging debate about involving young service users in the development of research proposals. The author employed a series of workshops to involve nine young carers in planning a funding application to undertake participative research of young carers' assessments. It is concluded that, although time-consuming, such participation in the early phases can result in more robust and relevant research.

Against the backcloth of apprehension about and anticipated decline in social care services, Dominique Rawlings' research report serves as a useful reminder of how local activities and groups can have a positive effect on people's lives. The report is based on an evaluation of the 'Proud2B' groups set up in Hampshire for people with a learning disability from minority ethnic backgrounds. The author highlights how difficult expressing cultural choices and needs can be for someone with a learning disability, especially in areas where diversity is low. The groups are intended to celebrate and explore members' and other cultures and the research concludes that participation can have a positive effect on members' lives in terms of enhancing self-confidence and self-advocacy skills.

The issue is completed by five book reviews, spanning a broad range of topics of interest to the readership – critical practice in social work, social work with people with learning difficulties, parenting the adopted child, anti-social behaviour, and kinship foster care. It is always satisfying to be able to publish a review penned by a doctoral student and Cecilia Love is to be congratulated for her contribution to this issue's compilation. If you would like to review a book for a future issue of the Journal, please contact Peter Scourfield, Book Reviews Editor.

With best wishes from the editorial team: Sue Harrington, Greg Mantle, Andy Pithouse and Peter Scourfield.

The future of social care in the UK

Sylvia Godden and Allyson M Pollock
Centre for International Public Health, University of Edinburgh

Abstract

Labour's white paper 'Building the National Care Service' published shortly before the 2010 general election announced plans for major reform of the funding and future of social care in England. In so doing it reopened longstanding debates about the principles on which such care should be based, taking into account acknowledged inequities in the current system. The new government coalition of Conservatives and Liberal Democrats raises questions as to the direction of travel for social care.

This paper charts developments since the inception of the welfare state to the present time. It shows how, regardless of political party, each successive administration has played its role in the move away from care delivered on a universal collective responsibility to increasing individual responsibility where risk and costs of care are held at the individual level. The current promotion of personal budgets and direct payments is described along with the risks for providers and users. Finally, the future of social care is considered in light of the plans of the new Conservative/Liberal Democrat coalition. We conclude that social care will continue to be a personal and not a collective responsibility, paid for by private contributions and where private insurers play a role, despite evidence to the contrary. All governments relegate social care to low priority status and this is likely to continue.

Keywords: Social care, funding, long-term care

Plans for reform: 2009-March 2010

In 1997, New Labour inaugurated its first term of office with a Royal Commission on Long Term Care (1999) but, having comprehensively rejected the Commission's core recommendation that care should be a universal right funded from taxation, the policy was resurrected ten years later in the government's dying months before the May 2010 election. Labour articulated a wish to reform the funding and future of social care and argued for a new National Care Service (NCS) to rival that of the NHS for England. In so doing, it reopened the debate about the principles on which social care is based and acknowledged inequities in the current system. A white paper *Building the National Care Service* published shortly before the general election described a new social care service to be implemented in three stages (HM Government, 2010).

The inequities and inadequacy of current policy on social care is well argued in the comprehensive and critical report of the House of Commons Health Committee (House of Commons, 2010). The government held a public consultation (HM Government, 2009) on three funding options:

1. Partnership - a proportion of basic care and support costs paid by the state according to means, based on a model by Wanless (2006) but without his proposal that the state would match individuals' contributions on top of a basic state contribution;
2. Insurance - state support as in the previous option but with additional costs covered through either a private or state run insurance scheme;

3. Comprehensive - everyone over retirement age able to do so to pay into a state insurance scheme, then those qualifying would get all basic care free.

Two further options were ruled out; no state support or a fully tax-funded system as for healthcare, discounted on the basis that it placed too heavy a burden on the working population.

All funding options apply only to 'care and support' and not to accommodation (hotel) costs such as food and lodging. 'Care and support' refers to; *personal care* to assist with the tasks for daily living; *home care* which includes care such as help with cleaning and shopping; *community care* such as meals on wheels and day centres; and *residential care*. It is estimated that, currently, around 20% of people will need care costing more than £50,000 and, for over 5%, this will cost more than £100,000. Long-term care can cost people around £12,000 per year (HM Government, 2010). The white paper announced that the result of the public consultation was that the Comprehensive option was most favoured and that, "it is time to build a comprehensive National Care Service that is universal and free when people need it" (p.12).

However, the means of funding such a service was left to a new Commission, yet to be appointed, whose recommendations if approved would not be implemented until 2015. It remains to be seen if, when and how the Conservative and Liberal Democrat coalition will take forward these policies. Long-term care may prove to be the dividing line in the coalition. The Conservative manifesto commits to increased personalisation, privatisation of responsibility through even greater use of direct payments and individual budgets. For older people they propose a voluntary 'home protection scheme' which would involve pensioners paying a one-off £8,000

fee into a privately run insurance scheme that would ensure that all their residential care costs are covered, the evidence for which is far from sound. Indeed the US experience shows this is an unworkable policy. The Liberal Democrats do not support this policy, not least because two thirds of pensioners' chief assets are their homes, i.e. they are asset rich but income poor.

Developments in social care from its inception until the current day

The debate on funding takes place at a time of major economic downturn and recession and after a long period of incremental privatisation of public services. We describe here the key developments that have impacted on social care since its inception so as to better understand the current situation. A chronology of significant policy developments is outlined in the Appendix.

Long-term care

Whilst health care is organised and funded on collective principles, older people carry the main responsibility for funding their care themselves until too poor to do so. Long-term care has been virtually eliminated from NHS and local authority provision and is now largely under the control of the mainly for-profit independent sector. In England, 4,000 private care agencies provide home care, with 14,000 private care homes, whilst third sector organisations have over 500 home care agencies and run more than 3,000 homes (HM Government, 2010). Many people depend on unpaid help. There were 5.2 million carers in England and Wales according to the 2001 national census, with over a million providing more than 50 hours care a week of whom over 225,000 were not in good health themselves (ONS, 2001). Most carers are of working age, with women more likely to work part-time.

The divide between health and social care

Many of the current inequities in social care date back to the inception of the NHS. The immediate post-war period promised better and fairer treatment for sick, older people, with the reviled Poor Laws abolished. Two welfare reform acts passed, the 1946 National Health Service Act and the 1948 National Assistance Act, promised that the state would provide universal health care for all as a right, irrespective of age or ability to pay. However, these acts established two parallel systems. Whilst the NHS provided universal health care free at the point of delivery, under the National Assistance Act local authorities would provide a subsidiary system for those in need of other 'care and attention', primarily frail older people. Unlike healthcare, this was means-tested and subject to statutory charges, providing a safety net rather than a universal service on the assumption that care would be mainly provided by family and voluntary carers.

This distinction, introduced by Bevan, created a fault line between the 'sick' and those needing 'care and attention'; the latter of which has been expanded to include a range of chronic illnesses and diseases. This was never the intention; it had not been anticipated that the National Assistance Act would be applied to those with considerable health care needs. The post-war Labour government had envisaged the construction of high quality residential care homes relying, in the meantime, on voluntary 'third' sector organisations such as the Salvation Army, Darby and Joan homes, church organisations and others. But, despite its major role, this third sector was neither large nor co-ordinated enough to assume responsibility for domiciliary services, so legislation in the late 1960s enabled local authorities to provide such services, with the state becoming the main provider until the end of the 1990s. Local authorities also assumed responsibility for older people who became ill, so came to look after more heavily dependent older

people in care homes within a means-tested system where charges could be levied.

Private sector involvement in care for older people

To the incoming 1979 Conservative administration, social services provided good potential for increased private sector involvement and promotion of a market. This sat with the belief that families and charities should bear the primary responsibility for care. As income from cash-strapped local authorities reduced, voluntary organisations responded by lobbying government and so local Department of Social Security offices (DSS) started to pay supplementary benefits to meet care home fees, a policy that was formalised in 1983 with the result that the care home sector became largely subsidised by DSS benefits. As the DSS would only fund people in voluntary or private homes, councils cut back their own provision. Unlike local authority homes there was no assessment of need for services and, as it cost councils nothing to place people in a home, many ended up in institutions rather than receiving services to remain independent. As intended, new corporate providers were attracted to the market with the result that policy had the effect of replacing state with private sector provision almost overnight. In effect, the government had established a voucher system for the public funding of private and voluntary care homes, with fees paid from the social security budget to the benefit of private providers.

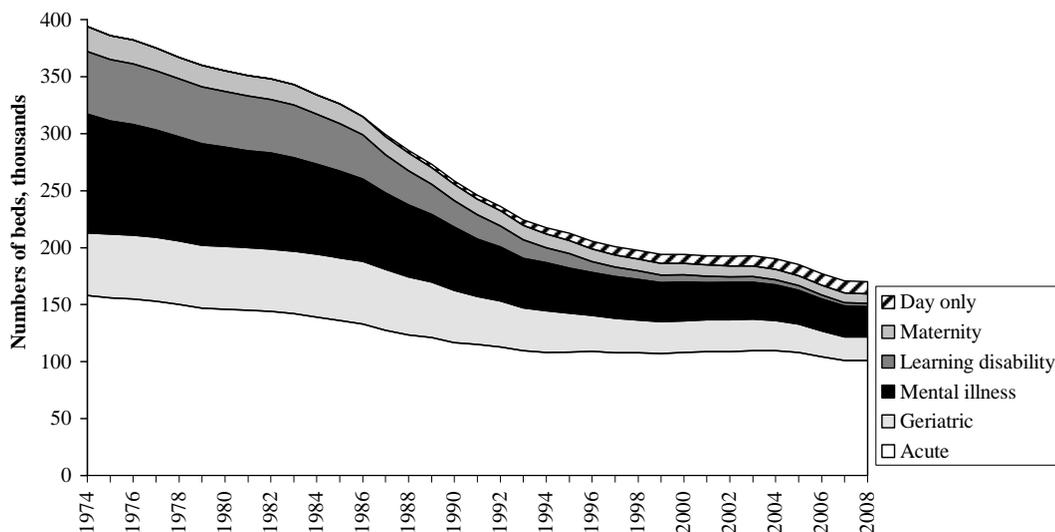
Following concerns over the rising social security bill, the government under Margaret Thatcher asked Sir Roy Griffiths to review the funding of community care. Subsequently, the 1988 Griffiths Report and the 1990 NHS and Community Care Act accelerated developments, recommending that local authorities should move away from directly providing care to become purchasers within a mixed economy.

After 1993, local authorities had to fund all community care from the Personal Services allocation in the block grant they received from central government, but the impact was softened by a Special Transition Grant (STG), of which 85% had to be spent in the independent sector, thereby forcing councils to contract out. The Community Care Act also required them to take over the funding of nursing home care, so contracts with the independent sector became the main way of delivering services. Councils received a further incentive to use the private sector by allowing them to recoup part of their residents' Income Support benefit (residential allowance), but only for those in private homes. Not surprisingly, many councils transferred or sold their own care homes in a major, under-reported sell-off to the independent and voluntary sector often at knock-down prices, i.e. some residential homes in Scotland were disposed of for a pound (Accounts Commission, 2000). Not only had the state guaranteed private providers an income stream, it had also transferred to them substantial assets, that

had been publicly paid for, at little or no cost.

The general government interpretation of care *by* the community as opposed to care *in* the community placed an increased financial burden on individuals themselves as cash-strapped local authorities became obliged to ration and charge for care accompanied by large cuts in NHS beds for older people. Figure 1 shows how, since 1979, around 200,000 NHS beds in England have been closed, despite the findings of the 2000 National Beds Inquiry (DH, 2000a) that bed closures had gone too far and the subsequent promise of increasing the number of NHS beds in the NHS Plan (DH, 2000b). Although many geriatric facilities badly needed replacing, eliminating NHS provision transferred costs to individuals on a huge scale. Though impossible to quantify, current levels of ill-health amongst older people in nursing homes suggest that a significant proportion would have received free NHS care in the past.

Figure 1 Average number of NHS beds available daily, England, 1974-2008



Sources: Department of Health form KH03, Hospital Activity Statistics for figures from 1987-88

Acknowledgement to Alison Macfarlane for earlier statistics derived from DHSS and DH statistical bulletins

In 1994, the Department of Health introduced eligibility criteria for free NHS care, ruling that this was only a right for those with complex or multiple healthcare needs requiring continuing and specialist medical or nursing supervision. Local authorities were required to assess needs and financial eligibility for long-term care, with most providing for only the most dependent. Meanwhile, financial pressures encouraged councils to apply user charges for all services including domiciliary care; from the early 1990s, central government made the assumption that 9% of domiciliary care costs would be recovered through charges. Accordingly, by 2000, 94% did so (Audit Commission, 2000). As there is no national means-test, local authorities can set their own policies giving rise to huge variations in charges for people with similar needs. Currently, councils recoup 11.8% on average of homecare costs through charges (House of Commons, 2010). Financial pressures also encouraged councils to try harder to coerce older people to sell their homes to pay for residential care.

Entrance of the Labour administration - the Commission on Long Term Care

When Labour came to power in 1997 there was intense pressure to redress inequities in long-term care. The new government declared this a priority with the Prime Minister stating that he did not want children brought up in a country where the only way older people could get long-term care was by selling their home (Labour Party Annual Conference, 1997). Subsequently in 1999 a Royal Commission was established to “examine the short and longer term options for a sustainable system of funding long-term care for elderly people and to recommend how ... the cost of such care should be apportioned between public funds and individuals” (Royal Commission on Long Term Care, 1999). The main recommendation of the subsequent report was that long-term care costs should be divided between living costs, housing costs

and personal care, the latter of which should be free. However, for two dissenters of the 12 member commission, Joel Joffe and David Lipsey, old age was a time of ‘*rights and responsibilities*’ and they recommended that personal care should continue to be means-tested. The government’s response published in an appendix to the *NHS Plan* (DH, 2000b) sided with this minority view, and declined to make an official commitment to free, comprehensive long-term care as recommended by the Commission.

There were practical problems in distinguishing between nursing and personal care. Criteria varied between local authorities with some care home residents paying for services they were legally entitled to. To address this, free nursing care was introduced in 2001 for residents who paid their own fees categorised according to their level of dependency. However, payments did not necessarily meet the actual cost, leaving a shortfall for residents to pick up. Even those qualifying may have to ‘top-up’ the basic package, sharing costs with the local authority through a legal contract. Also, as payments are made directly to care home owners, the government is not authorised to intervene in this private relationship so cannot prevent increases in fees, eliminating the benefits of the system. Because of this, the Scottish Parliament implemented the Royal Commission’s recommendation in 2002 so that Scottish residents, aged over 65 and in need, receive free personal care.

Intermediate care

Though Labour phased out the residential allowance and the STG requirement, the culture of contracting out was well-established and local authority provision continued to decline as central government cut funds from which councils could borrow to invest in their own homes. Further, under the 1999 *Best Value* policy, councils had to demonstrate that their own services were

cost-effective. The better pay and conditions of staff in state owned homes usually make independent homes appear more economical, thereby ensuring further reductions of in-house services. Though the focus on ‘best value’ has waned with the emergence of the Comprehensive Performance Assessment, much of the regime is still in force.

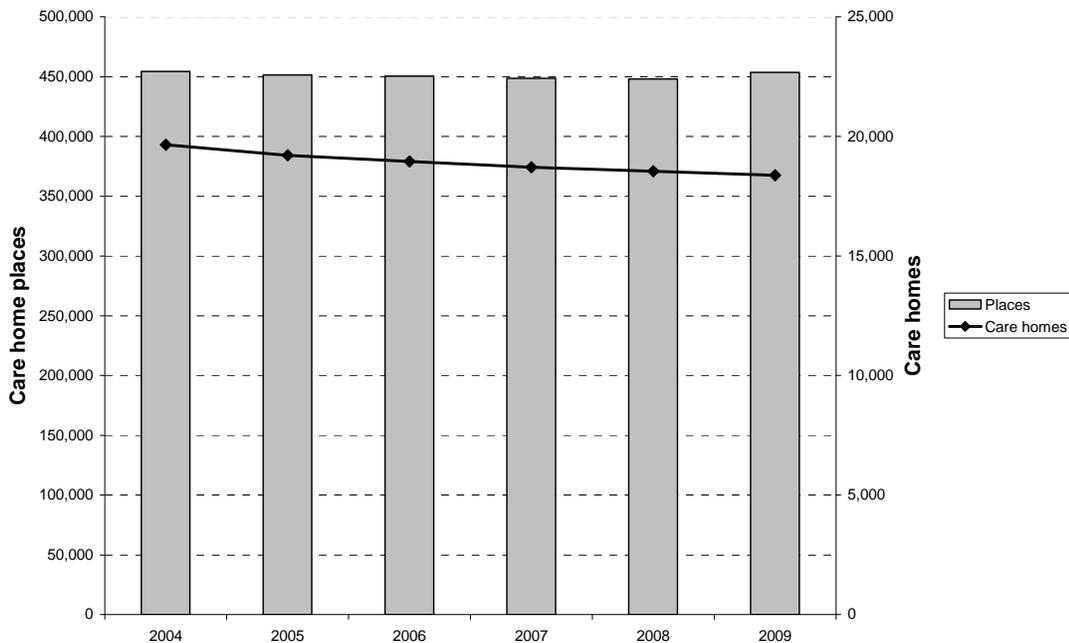
Labour also created a new market of independent sector providers in the form of intermediate care. This sector is important as the reduction of NHS hospital beds has been justified on the grounds that hospital admission will be prevented with patients receiving intermediate care instead. The Care Quality Commission (CQC), which is the independent regulator of health and social care in England, cites that the amount of both non-residential and residential intermediate care available in England has risen significantly (CQC, 2010). However,

figures are difficult to validate as they are not routinely published nor included in Department of Health statistics and, in any case, the Department has now abandoned their collection, justified in order to reduce the data burden.

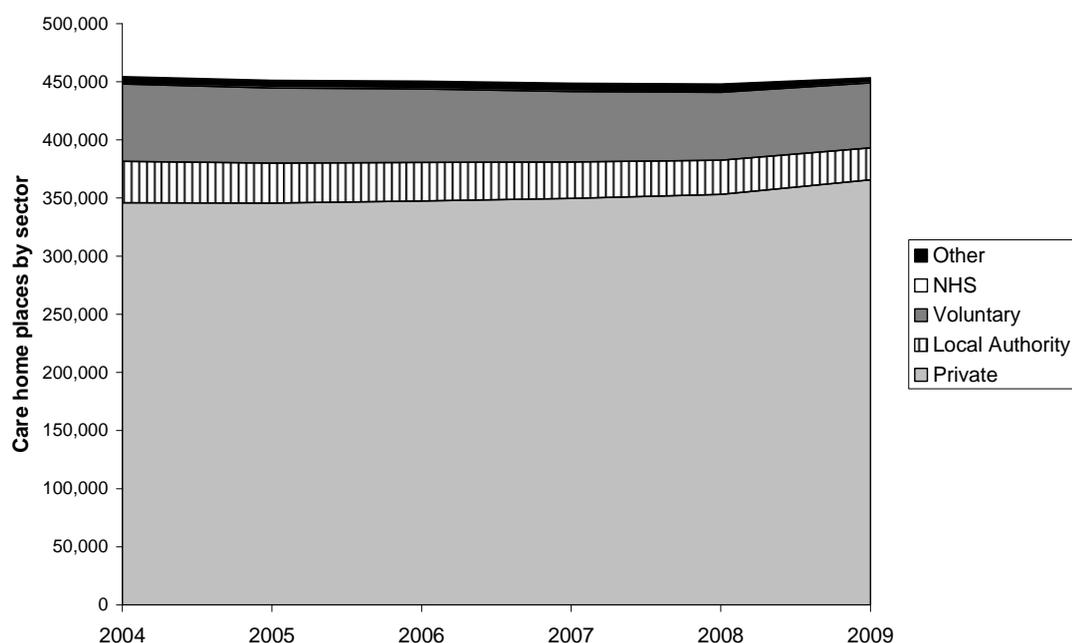
Risks of outsourcing

A major risk of relying on the independent sector is that there is nothing to prevent care home providers from simply closing down if the market changes which can be extremely serious for the health of their frail residents. Figure 2 indicates a reduction in the number of care homes (though not in places) in the last six years whilst Figure 3 shows how the proportion of places provided by the private sector continues to grow.

Figure 2 Numbers of care homes and places, 2004 to 2009, as at 31st March, 2010



Source: Care Quality Commission, 2009. Table A1.

Figure 3 Care home places by sector, 2004 to 2009, as at 31st March, 2010

Source: Care Quality Commission, 2009. Tables B1 to B6.

Regulation introduced in 2002 to protect residents from the more extreme effects of the market though the former regulatory body, the National Care Standards Commission, soon came under intense pressure from the care home lobby. By this time, local authorities depended on the independent sector to care for older people and the government made crucial concessions on staffing and building specifications, requiring only new homes to meet minimum standards that had been proposed in 1999, relieving many registered substandard homes.

The introduction of a personalised adult social care system – consumer choice and control

Direct payments and personal/individual budgets

Direct (cash) payments are paid directly by councils to individuals assessed as eligible for services. The policy was pioneered by the ‘young disabled’ movement, a small,

largely self-selected, relatively advantaged group compared with most who receive services. The concept originated in the US where they are known as ‘vouchers’ and were introduced in 1997 for working age adults, in 2000 to older people, and, in 2001 to parents and carers of disabled children. Since 2003, it has been a duty for councils to offer a direct payment as first option to eligible individuals able to provide consent with uptake a key performance indicator. The Health and Social Care Act 2008 extended direct payments to those unable to consent and those treated in the community under the Mental Health Act 1983, thereby applying the policy to society’s most vulnerable people. But uptake has been slow. In England in 2008-09, 86,000 adults received direct payments and, despite annual increases, spend equated to just 4% of the overall gross current expenditure on care. They have been found more likely to be used by working age adults and there is wide variation in how much is paid (CQC, 2010).

In 2005, the main proposals of the government consultation paper on the future of social care *Independence, Well-being and Choice* (DH, 2005) included wider use of direct payments and the piloting of personal and individual budgets, justified on the premise that this would give individuals control and choice over their care. It discussed extending personal budgets (which are for social care only) to a range of other funding streams in order to improve the quality of services and stimulate the social care market, and to shift users from being passive recipients to active consumers of care. The subsequent white paper *Our Health, Our Care, Our Say* set out to implement these proposals as policy (DH, 2006). In turn, *Putting People First* (HM Government, 2007) set out a personalised adult social care system through a ministerial concordat on the ‘transformation’ of adult social care with a ring-fenced grant worth £520 million over three years, 2008-2011, to support the agenda (DH, 2008a).

However, the white paper explicitly ruled out extending individual budgets and direct payments to the NHS, stating that this would compromise the principle that care should be free at the point of need, whereas social care had always included means-testing and co-payment. Yet, two years later, the 2008 Darzi NHS review *High Quality Care For All* (DH, 2008b) used the premise of ‘greater choice’ to completely reverse this position, proposing expanding personal budgets to the NHS, prioritising people receiving continuing care or with long-term conditions. Subsequently, the previous government completed a consultation process as part of the review to extend direct payments to health care through legislation (DH, 2009).

So what is the future for social care?

The demographic time bomb?

Government policy for older people is invariably accompanied by warnings about the demographic time bomb, with those who are not economically viable living longer, commandeering services and placing an additional burden on the rest of the population as the ratio between those working and those who are retired reduces. The Labour Government expected that, in 20 years’ time, 1.7 million more people in England would need care (HM Government, 2009), with the population aged over 65 projected to grow by almost half, and those over 85 to double. (CQC, 2010) This is seen as a problem because the age that people can expect to live without long-term illness or disability lags behind longevity. Presented in this context, a convenient argument is to propose that older people should provide for themselves, through savings, spend down of assets and insurance schemes. Therefore, despite huge increases in general standards of living, many are forced to sell their homes and spend most of the proceeds in fees before they can receive state-funded residential and social care (currently only after spend down to £23,000).

However, as pointed out by the House of Commons Inquiry this issue may be partially a transient ‘cohort’ effect due to the ageing of the population ‘bulge’ born post-war (baby boomers), who will not significantly affect demand for social care for 20 years, leaving time to prepare. Further, it is not inevitable that longer life expectancy means more years of ill-health given the work to develop effective treatments for long-term conditions as well as on preventive measures to counter risky health behaviours related to smoking, drinking, diet and exercise. Therefore, an ageing population does not inevitably lead to catastrophe provided informed decisions

are made and good planning is undertaken (House of Commons, 2010).

Personal budgets and direct payments

The transfer of the purchasing role from local authorities to individual consumers through individual budgets and direct payments leaves the most frail, elderly and long-term sick and disabled at the mercy of private providers with an unenviable record for quality and commitment. Some of the risks are:

1. Increasing inequalities in eligibility and access to services by creating a cash limit on what can be afforded and purchased locally. Despite personalisation agenda claims of providing choice and flexibility, individual budgets pass the risk of purchasing to the patient, many of whom will not want this burden. If entitlement to care is 'capped', patients would become effectively responsible for rationing their own care.
2. Cost inflation. Market systems are expensive to run with substantial administrative costs. Direct payments will inevitably reduce budgets, putting services at risk as has happened with independent sector treatment centres for elective surgery. This is bound to lead to reductions in capacity, particularly as direct payments cannot currently be spent on services directly provided by councils.
3. Social services departments could lose their skills, experience and economies of scale, leaving fewer, more expensive services for those too vulnerable to cope with the responsibility of direct payments. Though individual budgets may be held on their client's behalf, as social services focus on their purchasing role whilst expanding the private provider

market, their capacity to manage care will reduce. The other safeguard is regulation and performance assessment but, as described, the record of governments to adhere to this does not inspire confidence following the back-down on standards for residential care in 1999.

4. Through the adoption of direct payments, the emergence of an unskilled, unregulated workforce of Personal Assistants directly employed by patients. The Labour white paper described plans to introduce a licensing scheme to apply to all social care workers and this is important to safeguard vulnerable patients.

In light of the Darzi announcement and government policy U-turn to extend individual budgets to the NHS, and the commitment by the new Coalition government to a greater use of direct payments and individual budgets, it seems only a matter of time before vouchers are introduced beyond social care to health care. These developments herald the loss of the collective consensus that the state has a duty to serve and protect the basic needs of all through population-based services, guided and sustained by a shared set of ethical and professional values.

A review of the National Care Service in light of administrative change

In light of the results of the general election it remains to be seen what is the likelihood of Labour's vision set out in *Building the National Care Service* coming to fruition. However, we briefly review some of concerns.

Absence of collective funding - In the absence of collective funding as a policy option, plans for a fairer system for funding care in old age are welcome. However, the white paper dismissed the option of meeting social care needs through a collective

system. Yet the tax-funded universal system has considerable support, perceived as the most equitable way to pay for care (House of Commons, 2010). This is the principle upon which health care is funded and there is no inherent reason why a National Care Service should differ from its counterpart NHS, however it has been organised in the past.

Timing and delay - The Labour government took three terms to address social care despite its stated intentions on coming to power. The timing of the white paper published so soon before the May general election ensured that there could be no changes until the subsequent parliament. Yet, surprisingly, it was announced at the 2009 Labour Party Conference that even though the consultation period had not ended, free personal care would be introduced for those with the highest levels of need cared for in their own home. This initiative raised concerns about unintended consequences as it only applied to people at home, plus there were important questions about the details of funding.

Free personal care for all – The National Care Service promises all adults in England with an eligible need, free care and support when they need it, wherever they live. However, for those in residential homes, this does not include accommodation which accounts for at least half of care home costs. The reforms include a deferred payments scheme to enable people to keep their home while they are alive, but the advantage of the scheme is questionable as charges on their estate after death will have the same effect in the end.

Replacement of mean-tested benefits - A controversial proposal of Labour's consultation on social care was the pooling of existing benefits with the general social care budget. The two main benefits, both paid by the Department of Work and Pensions, are Attendance Allowance (AA) and Disability Living Allowance (DLA).

AA, which is the main non-means-tested benefit for people aged over 65 with disabilities, first came under scrutiny in the Wanless review (Wanless, 2006). Bringing these benefits, which could be regarded as the original direct payments, into the new NCS has been ruled out for now in the white paper, with funding for the new service envisaged to be from efficiencies and reform. Had the proposals been accepted, it was feared that benefits would become means-tested, cash-limited and rationed with criteria making it much harder to qualify, leaving many older people worse off, particularly those at the threshold of means-testing (the 'cliff-edge' effect) or needing just a small amount of help, adding to deprivation.

Eligibility criteria - A key issue is that of eligibility which the white paper promised would be determined against nationally consistent entitlements. But who would set these criteria and at what level of need, given that it is known that the level of entitlement rises progressively as resources become scarce? The Care Quality Commission's review of services in 2009 found that, in most councils (70%), people's needs must be substantial before they can get any publicly-funded social services support (CQC, 2010). The notion of eligibility criteria is also inherently at odds with the concept of a universal system.

Social care under the new coalition

The Conservative manifesto commits to increased personalisation and even greater use of direct payments and individual budgets. For older people, they propose a voluntary 'home protection scheme' which would involve pensioners paying a one-off £8,000 fee into a privately run insurance scheme that would ensure that all their residential care costs are covered. Prior to the new coalition, this scheme was condemned by the Liberal Democrats because two thirds of pensioners do not have this amount of assets unless they sell

their home. Further, the House of Commons Health Select Committee reported scepticism from the insurance industry about its feasibility (House of Commons, 2010). The prospect of a much needed consensus between the three major parties seems unlikely in view of reports of failed cross-party talks on social care late last year (Stratton, 2010). However, in the new era, agreement between at least two of the three parties might now be expected.

Summary

In summary, this review shows how, through a combination of rationing, charging and means-testing, the state has dispensed with much of its responsibility for social care leading to a system with wide variations in quality. Long-term care in particular has been neglected, paving the way for the domination of for-profit ownership since the 1980s. Many of the issues described here have been exacerbated by the internal market principles of separating the purchaser and provider function in both health and social care, rather than those of equity. This serves to fragment care, erode accountability and

create a vacuum in planning for population health and social care needs. This is demonstrated by the lack of a framework for social care and the focus of the regulator on performance targets rather than on the development of good data collections to inform on planning and monitoring services.

So, with the advent of a new government, will the ambitions of *Building the National Care Service* come to anything? The white paper steered clear of addressing how the NCS was to be funded, except that the principles of the new service should be universal, accessible and based on need rather than ability to pay. Whatever the outcome, it is vital that this time the opportunity should not be missed to halt the cycle whereby successive governments have left social care chronically underfunded and taking low priority.

Acknowledgement

To David McCoy for his contribution to the critique of Direct Payments.

Appendix

Key developments in social care

1946 – National Health Service Act

1948 – Founding of the NHS

1948 – National Assistance Act – established that local authorities would provide basic residential accommodation to disabled and older people

1972 – Attendance Allowance introduced for disabled older people

1976 – Invalid Care Allowance introduced, later became the Carer's Allowance

1990 – NHS and Community Care Act made it a duty for local authorities to assess people for social care and created the internal market by separating purchaser and provider functions

1992 – Disability Living Allowance introduced

1996 – Community Care (Direct Payments) Act

1999 – Royal Commission on Long Term Care, recommended free personal care

2000 – NHS Plan rejected Royal Commission recommendation for free personal care

2001 – Health and Social Care Act enabled the creation of care trusts which combine NHS and council responsibilities across a number of areas

2002 – Free personal care introduced in Scotland

2006 – Wanless Social Care Review recommended a partnership funding option for older people's care with state funding a proportion, then individual contributions matched by the state

2006 – White Paper *Our Health, Our Care, Our Say* and statements in the 2007 budget report and Comprehensive Spending Review described a reformed adult social care system for England

2007 – *Putting People First*, ministerial concordat set social services on the course towards personalisation

2008 – *High Quality Care for All: NHS Next Stage Review*, Darzi, proposed extending personal budgets to the NHS

2009 – Green Paper *Shaping the Future of Care Together* consultation on proposals for reform and funding of social care

2010 – House of Commons Select Committee Report on Social Care, published March

2010 – White Paper *Building the National Care Service*, published March

2010 – May general election results in hung parliament, subsequently a Conservative/ Liberal Democrat coalition government

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Notes on Contributors

Sylvia Godden holds an honorary appointment with the Centre for International Public Health. Her background is in Public Health information and research and she is seconded from a Primary Care Trust in London. Her major interest is the use and availability of official statistics to measure health needs and health service provision, and the utilisation of routine data to monitor the impact of new health policies.

Allyson M Pollock is Professor of International Public Health Policy and Director of the Centre for International Public Health Policy at the University of Edinburgh. She is a leading authority on public private partnerships, the privatisation of public services, and the effect of marketisation on public health and the public good. She has an international profile in public health and has made numerous interventions in the policy debate.

Address for Correspondence

Allyson M Pollock
Centre for International Public Health Policy
University of Edinburgh
Edinburgh
EH8 9AG

Email: allyson.pollock@ed.ac.uk or
s.godden@ucl.ac.uk

Current challenges to the quality of social care services for people with intellectual disabilities in the UK

Robin Jackson
Camphill School Aberdeen

Abstract

As the effects of the financial recession begin to bite, there is a danger that the quality of social care provision for children, young people and adults with intellectual disability in the UK will significantly decline. This article explores some of the factors contributing to this anticipated deterioration: (1) the commercialisation of social care; (2) the expansion of the 'for profit' private sector at the expense of the 'not for profit' voluntary sector; (3) the uncertainties occasioned by frequent changes in regulatory structures; (4) the move to self-regulation of care services; and (5) the neutering of the power and influence of advocacy services.

Keywords: Advocacy, commercialisation of care, deprofessionalisation, market forces, quality of life, self-regulation

Introduction

The reforms implemented following the 'commercialisation' of care which followed the National Health Service and Community Care Act (1990) brought about far-reaching changes to the provision and financing of health and social care in the United Kingdom. Market forces received an enormous boost, 'for-profit' organisations became increasingly active, notions of 'best value' became increasingly relevant within funding formulae, and users of services were more likely to be involved in decision making (Knapp & Kavanagh, 1995). Market ideals as a key principle of public service provision continued to be an acceptable feature of the neo-liberal agenda pursued by New Labour. Initially, there was the establishment of a 'quasi-market' within the public services and the 'not-for-profit' sector occupied a much more level playing field with the 'for-profit' sector.

It is clear that in the UK the provision of social care services is being increasingly opened up to market forces. The National Workforce Group for the Social Services in

Scotland has reported that over the last 10 years there has been an adjustment in employment in the sector, with the 'for-profit' and the 'not-for-profit' sectors expanding while local authority employment has remained at the same level as ten years ago. The growth in the 'for-profit' sector has been particularly noteworthy in Scotland (Scottish Executive, 2006).

This trend continues apace despite the acknowledgement, in one of the first comprehensive reports on social care, that care services run by the 'for-profit' sector in England are consistently out-performed by those run by the 'not-for-profit' sector (Commission for Social Care Inspection, 2005a). With the passage of time, competition is likely to favour those 'for-profit' companies that are able to maintain their competitive edge by keeping costs low. Pollock (2005) has argued that this is likely to be achieved by the recruitment of poorly paid, inadequately trained and under-motivated staff. The implication of this is that 'not-for-profit' organisations may be squeezed out, leaving commercial companies to dominate the market.

Bakan (2004) has provided evidence to support the notion that a 'care corporation' is a contradiction in terms. He has pointed out that the legally-defined mandate of a corporation is to pursue its own self-interest. If a corporation is caught breaking the law, it can pay the large fines and continue doing what it did before. The fines and the penalties paid by corporations can be trivial when compared with its profits, especially if the corporation is large. In the opinion of Milton Friedman - Nobel Laureate in Economics - corporate executives have but one 'social responsibility' and that is that they must make as much money as possible for their shareholders. This is a moral imperative. Those executives who place social and environmental goals over profits - in other words who try to act morally - are, in Friedman's judgment, immoral. Friedman contended that there is only one instance when corporate social responsibility can be tolerated and that is when it is insincere. In other words, the executive who treats social or environmental values as a means of maximising shareholder's wealth is committing no wrong (Friedman, 1979).

Pollock (2005) has drawn attention to a comparable situation in the National Health Service, also faced with increasing privatisation:

In the past, doctors were free to speak out – in fact they were under a moral obligation to do so – if they felt it was in the interests of their patients. In a business culture, however, loyalty is said to be due above all to the shareholders. (Pollock, 2005, p.213)

Stone (2000) has argued that there is a fundamental clash between care and business ethics:

Once care is contracted out to a 'for-profit' managed care organisation, the ethical situation becomes problematic. Every rationing decision has an impact

on the caretaker's own personal bottom line. (Stone, 2000, p.391)

While the 'for profit' sector continues to expand, there is increasing evidence that the 'not for profit' sector is struggling to compete. One of the largest providers of care for adults with intellectual disability in Scotland - Quarriers - has threatened to make all its 2000 staff redundant if they fail to agree to cuts in their sick pay, night shift allowances and payments for holidays (Unison, 2009).

The voluntary sector in the UK, which is largely comprised of organisations with charitable status, is facing a number of critical challenges for a number of reasons:

- there has been a downturn in individual and corporate giving to charities;
- falling asset values for the funds held by charities is affecting investment income;
- a number of charities were among those institutions who had deposits in failed Icelandic banks; and
- a freeze on local tax, coupled with greater autonomy given to local government in its spending, means that those sectors, like social care which are seen as low priorities, are suffering. (Outram, 2009, p.1)

A further consequence of the marketisation of social care has been the growing marginalisation of professional workers (e.g. social workers, educational psychologists, clinical psychologists, GPs, etc.) in decision-making processes related to assessment and placement. Decisions are increasingly being taken by local authority commissioners for services (Care Service Improvement Partnership, 2008). Thus a process of deprofessionalisation is occurring in which the role of those with relevant knowledge, expertise and experience and who are well placed to make informed

decisions concerning the individual needs of clients are being sidelined. These changes appear to be driven by cost and not quality of life considerations. There is a certain irony in the fact that those charged with this responsibility are called Quality Commissioners.

Regulation

Over the course of the last two decades there has been a succession of major crises in child care in the UK which has produced a series of enquiries and reports indicating profound concern about the working of the child care sector (Utting, 1991; Skinner, 1992; Waterhouse, 2000). In April 2004 the Labour Government set up the Commission for Social Care Inspection (CSCI) with the aim of modernising the system of regulating care services. In November 2004 the CSCI published its first performance ratings of all councils with social services responsibilities. However, in 2009, only five years later, responsibility for regulating and inspecting adult social care and health care has passed to the Care Quality Commission which represents a merger of the CSCI, Healthcare Commission and the Mental Health Act Commission.

In its final report in 2009 the CSCI noted that services for those with complex needs were being impeded by poor strategic commissioning, lack of person-centred care and 'marginalisation' of human rights (CSCI, 2009; Latchem, 2009). It also drew attention to the fact that some service users had little if any choice about their services and councils relied on inappropriate out-of-area residential care (Ahmed, 2009).

For its part the former Labour Government made clear that the Care Quality Commission would continue to focus on reducing its operating budget. Early indications suggest that this means a reduction of 40% on the budgets of the three predecessor organisations. Closely linked to the budget reduction is the decision to

continue the deregulated inspection methodology practised in the CSCI which was termed 'proportionate risk-based inspection'. When translated this means fewer inspections. The previous statutory requirement to inspect care homes twice a year has been abandoned. Now the minimum requirement is for care homes and homecare providers to be inspected once every three years and inspections are to be replaced by 'Annual Service Reviews' which are paper exercises based on provider 'self-assessment' and any other intelligence received (Unison, 2007).

Unison, the principal trade union representing social care staff in the UK, is campaigning to highlight the effects of these changes on the safety and quality of care provision. Union members are reporting that the new regulatory system, with its reduced staffing, is failing because of lack of time: (1) to target its resources on those providers giving a poor service; (2) to follow up on concerns and complaints or detect problems in the early stages; (3) to impose and follow up on enforcement measures; and (4) to spend time in the field talking to service users. Unison has pointed out that inspectors are 'too thin on the ground' and that the situation will be further exacerbated by planned redundancies (Samuel, 2009a).

The outgoing chair of the Commission for Social Care Inspection, Dame Denise Platt, went out of her way to warn about the ability of the CQC to be an effective social regulator. She stated that it would struggle to balance its health and social care responsibilities because the focus of public attention would be on health care which meant that failings in adult social care were unlikely to attract much attention. She highlighted the fact that the CQC lacked people with social care expertise at senior level, as many CSCI managers had not transferred to the CQC. She also questioned the ability of the CQC to shape social care policy in the way that the CSCI had done through the publication of its annual State of

Social Care reports. She further observed that the focus on social care policy was likely to be diluted in a body which had been set up to look at both health and social care (Samuel, 2009b).

Dame Denise could not conceal her exasperation that the decision to abandon the CSCI appeared to have been made out of ignorance: “there was really a big misunderstanding in central government about the nature of our role. People think social care is the mirror image of health. It isn’t” (Davies, 2005, p.1). She pointed out that their values might be similar but the underpinning policy assumptions were different, not least because users have to pay for social care. “Many of the things the Chancellor wanted to achieve around burdensome regulation can be achieved by changing the regulations, not necessarily by changing the institutions” (Davies, 2005, p.2). Not only had the Government succeeded in creating one of Europe’s biggest regulators but also there was an increased fear that the move heralded the long anticipated ‘takeover’ of social care by the health service. When asked if the Chancellor had been badly advised, Dame Denise pointedly and crisply replied: “the level of ignorance in the Department of Health about how social care as a sector operates should not be underestimated” (Davies, 2005, p.2).

Self-regulation

The rapid privatisation of the care sector over the past five years coincided with the decision by the CSCI to transfer greater responsibility for the assessment of care standards to care providers. Thus, within a short time of the CSCI having been established, self-regulation was accorded a high priority. In November 2004 the CSCI published a consultation document *Inspecting for Better Lives (Modernising the regulation of social care)* in which it proposed that self-assessment be introduced for care providers (CSCI, 2004). The

Commission indicated that it expected care providers to be honest about the strengths of their service and explain what they were doing to improve it. It went on to state that it would take a tough line on misleading self-assessments and view them as a sign that the service was not being well managed. In a follow up document, published in July 2005 entitled *Inspecting for Better Lives - Delivering Change*, it was acknowledged that there were some who believed that the adoption of a self-assessment system could be open to abuse (CSCI, 2005b). Notwithstanding these reservations the CSCI made clear its determination to introduce what it described as ‘provider self-assessment’ which it viewed as an essential part of its new ideas.

Given the scale of the problem facing the CSCI, in terms of seeking to raise care standards, it was all the more surprising that it proposed to cut its own workforce by 25%. These changes, which were a direct result of the Government’s policy of devolving powers in the public sector and its commitment to reducing public sector expenditure appear to be built upon the naive assumption that if care providers take part-ownership of the regulatory process that they will do so in a responsible manner. However, as Bakan (2004) has convincingly demonstrated, for-profit companies operating in deregulated systems invariably act in an aggressive, exploitative and self-interested manner. Are there any grounds for believing that care corporations will act differently?

Market leadership

It is instructive to look at the performance of one of the market leaders in social care which is listed on the London Stock Exchange. The accuracy of the company’s claim to being a market leader was recently assessed by examining the inspection reports on 24 of their premises which had been published by the Commission for Social Care Inspection. It was found that

one quarter of the premises run by the company had to meet at least six or more statutory requirements. In other words, a quarter of the premises were deemed to be in breach of their legal obligations. Three areas occasioned the Commission particular attention:

- 1 *Overuse of agency staff:* The inspectors drew attention to the need for the company to review recruitment procedures to ensure that more was done to employ permanent staff teams thus reducing the use of agency staff. A further matter noted was a failure to obtain satisfactory clearance for agency staff and to produce evidence that they were appropriately qualified.
- 2 *Staffing levels:* A recurrent issue noted by inspectors was a failure by the company to employ a sufficient number of staff to meet the needs of residents, particularly those requiring 1:1 attention. It was pointed out that if demands for 1:1 staffing were not met then this could lead to restricted choice for other residents thus increasing the risk of neglect and abuse. Insufficient staffing also meant that opportunities for social, educational and recreational experiences for residents were limited.
- 3 *Failure to implement Commission requirements:* The Company failed to implement the statutory requirements repeatedly identified by the Commission. In one case the registered manager had been required to ensure that suitably qualified, competent and experienced persons were working in the home at all times and in such numbers that were appropriate for the health and welfare of residents. This requirement had been made on no fewer than three previous occasions.

It might be reasonably expected that a responsible service provider would pay attention to requirements or recommendations made by the CSCI and seek to implement the changes needed as expeditiously as possible. In the view of the author, the apparent failure of the company to appoint sufficient permanent and appropriately qualified staff to meet the needs of residents would seem to imply some unwillingness to invest adequately in staffing. The evidence from these inspection reports could be interpreted to suggest that running costs were being deliberately kept down through the use of agency staff and by maintaining low staffing levels.

E-auctions or reverse auctions

Whilst the impact of self regulation is a matter of concern, a more recent market-oriented development has occasioned alarm. An increasing number of commissioners of services in the UK have been making use of e-tendering or reverse auctions. A wide range of benefits have been claimed - tangible and intangible - for this process. Tangible benefits comprise process efficiencies - time savings and reduction in overhead costs incurred during the tendering process. E-tendering solutions automate or eliminate some of the repetitive routine administrative tasks such as document preparation and distribution; assessment and evaluation of tenders. Process automation frees up time for buying staff to focus on 'value-added activities' such as negotiating better contracts. The overhead costs of tendering will also be reduced where the main elements of costs are printing, copying, paper, postage and stationery.

One of the intangible benefits of e-tendering is that, by managing the e-tendering solution centrally, tendering requirements can be controlled and co-ordinated. All documents for a particular tender can be held in a logical structure for ease of retrieval. E-tendering solutions also reduce the time spent analysing numerical information by

having parts of the responses already in spreadsheet format ready to manipulate and compare and provide a secure history of each tender from advert and tender creation to contract award. This history provides a full audit trail that encourages openness and integrity in all contractual decisions. It is also claimed that quoting performed in real time via the Internet results in dynamic bidding which helps achieve rapid downward price pressure; something which is not normally attainable using a traditional static 3-quote paper-based bidding process.

However, the prices that buyers obtain in the reverse auction reflect the narrow market which it created at the moment in time when the auction is held. Thus, it is possible that better value - i.e. lower prices, as well as better quality, delivery performance, technical capabilities, etc - could be obtained from suppliers not engaged in the bidding or by other means such as collaborative cost management and joint process improvement. There is a paradox here for at a time when so much emphasis has been placed by the Government on the personalisation of services for clients with intellectual disabilities strategies are being put in place which have the effect of depersonalising them. Care is simply a commodity.

Because of increasing concern at the use of reverse auctions in Scotland, a motion was put before the Scottish Parliament on the 30th October 2007 that:

... Parliament deplores the practice of reverse auctions ... it is morally repugnant for such a system to be used for the provision of social care services in Scotland. (Scottish Parliament, 2007)

Then, as a result of a BBC Panorama programme screened in May 2009 - *Britain's Homecare Scandal* - the Local Government Committee of the Scottish Parliament undertook to look at the practice of using online bidding auctions.

Undercover filming for the BBC programme revealed carers rushing between appointments, with some clients being missed entirely. Hidden camera footage revealed the case of a 78-year-old man who received care from the private company that was successful in the e-auction. He was fed mainly on a diet of crisps, had not had a bath or shower in six months and received visits from carers lasting only a matter of minutes (East Kilbride News, 2009).

Advocacy

One might have expected that some of the problems identified above would have been picked up and addressed by advocacy services representing people with intellectual disabilities. However, the problem here is that most advocacy schemes in the UK are dependent on statutory sector funding from health authorities and/or social work departments. Although this financial support is welcome and serves to provide stability and security to local advocacy projects, there are inherent dangers in relying too heavily on such funding. A particular concern is the trend for advocacy schemes to be funded through contracts rather than grants. In other words, the provision of advocacy services has also been impacted by the process of marketisation.

As early as 2001 the Scottish Executive had noted that the tendering process was not a creative way to achieve the effective provision of advocacy and for a number of reasons (Scottish Executive, 2001). It requires the commissioners to specify in considerable detail what is to be provided, when a better picture of what people need most from advocacy emerges more clearly over time. A purchaser-supplier dynamic is set up, where the advocacy scheme is expected to see itself as delivering a service on behalf of the commissioners, not in response to the people who need advocacy. This compromises an agency's independence. It encourages advocacy

schemes to be dependent on the funding provided by the commissioners, so that the advocacy only happens if this funding continues to be provided. By definition, advocacy means a continuing commitment to people over time and not abandoning that commitment in difficult times. This tends to encourage the choice of the larger, national advocacy agencies which can present bids, demonstrate a track record and negotiate contracts which makes it harder for advocacy to become genuinely rooted in the community.

One development in England has given particular cause for concern (Gould, 2003). In the face of widespread opposition the (then) government decided in 2003 to abolish Community Health Councils, the long established voice of the health service user, and replace them with a bewilderingly complex bureaucratic edifice comprised of:

- Patients' Forums which are based in every primary care trust and National Health Service trust. They are funded by the Commission for Patient and Public Involvement in Health and monitor and review services arranged or provided by the trust. They seek the views of patients receiving services, inspect premises and make reports and recommendations to trusts.
- Patient Advice and Liaison Services (PALS) are provided in every trust to resolve problems on the spot; provide information to patients, carers and families; put people in contact with local support groups; and tell them how to access the complaints procedure.
- Patients' Forums also provide an Independent Complaints Advocacy Service (ICAS) to enable anyone to make a complaint about NHS services. ICAS offers free impartial confidential support, information about complaints procedures, assistance with letter

writing, support at meetings and has a brief to listen and act on the patient's behalf. ICAS also helps and guides a complainant through the whole process from local resolution to formal investigation.

- The operation of the Patients' Forums and ICAS is monitored by the Commission for Patient and Public Involvement in Health (CPPIH). It is the funding body for Patients' Forums and ICAS and submits reports to the Secretary of State for Health on how the system of patient and public involvement is working. (Jackson, 2005)

The problem here is that the advocacy element in this arrangement is owned by the hospital trusts it exists to monitor and challenge. The high profile adoption of this model hinders rather than helps the development of an independent advocacy culture since it gives a tacit nod to other large service organisations which would be only too happy to create 'in-house' advocacy for their users and to dispense with the rigours of independent scrutiny. Market principles when combined with an emphasis on clinical outcomes inevitably lead to a form of advocacy that does not differ significantly in its mode of operation from the service that it is monitoring. The neutering of advocacy services in this way communicates a damaging image to both public and professional audiences of the integrity, value and purpose of advocacy. Such an image is likely to act as a deterrent to any potential user considering approaching such a service. Recruitment of advocates, too, is likely to be adversely affected by this negative image (Jackson, 2005).

A further example of the way in which advocacy schemes can be absorbed into the statutory system is provided by the introduction and implementation of the Mental Health (Care and Treatment) Act

2003 in Scotland (Jackson, 2005). The primary objective of the Act is to ensure that people with mental disorder – defined as covering mental illness, personality disorder and developmental disability – can receive effective care and treatment. This Act enshrines the right of access of a ‘patient’ to advocacy. It places a duty on each local authority and health board in Scotland to ensure the provision of independent advocacy services to any person with a mental disorder within their area. In other words, a local authority or health board has a statutory obligation – a legal duty – to involve an advocacy service and the advocacy service has a duty to respond. If representation is sought then there is an expectation on the part of the local authority, health board and client that the advocate appointed is thoroughly familiar with:

- all the principles, roles and responsibilities involved in the implementation of the Act;
- the range and nature of the powers relating to compulsory treatment and detention;
- the law concerning people with a mental disorder who enter the criminal justice system; and
- knowledge of a person’s rights and safeguards in accessing mental health services.

(Jackson, 2005, p.26)

If for any reason an advocacy scheme is not able to offer representation then this could lead to the withdrawal of funding because of the failure by the service to meet its obligations. Representing a ‘patient’ may result in the advocate making an appearance before a Mental Health Tribunal where the advocate is likely to be ‘opposed’ by a professional who is familiar with the legislation or has been briefed by legal officers from either the local authority or health board. If ‘patients’ are not to be disadvantaged then advocates need to be thoroughly grounded in the relevant law

which means that some form of specialist legal training is required. It is open to question whether there are many volunteer advocates who would have either the competence or confidence to act in such a capacity.

There are those who believe that the provision of training runs the risk of ‘professionalising’ the role of the advocate and transforming their identity to that of a quasi-human services worker (Peters, 2000). It has been argued that one of the main strengths of advocacy is the independence of representation provided by advocates to their clients. In representing their clients advocates are asked to act as ‘free agent’ citizens unencumbered by significant conflicts of interest. However, if advocates undergo training it is possible that the content of the training – whether intended or not – can serve to control their actions. The training may impart knowledge of a highly prescriptive nature which can discourage advocates from exercising common sense, initiative and flexibility – the essential qualities sought in the ideal advocate. Peters (2000) has argued that the case against the provision of advocacy training is that it is incompatible with, and even destructive of, the identity of advocacy.

In any event the life span of advocacy schemes may be shortened for other reasons. It has been suggested that advocacy schemes have an ephemeral existence passing through a four-stage life cycle (Gray & Jackson, 2002, p.19):

- *Initial phase*: a short period characterized by general enthusiasm for the idea of advocacy;
- *Awareness phase*: when statutory services begin to realize the potential threat that independent advocacy poses;
- *Containment phase*: when efforts are made ‘to rein in’ advocacy schemes as the performance of local authorities and health boards funding the schemes

comes under increasing critical scrutiny; and

- *Final phase*: when the integrity of advocacy schemes is progressively subverted either through their absorption into the statutory structure or through the imposition of contractual arrangements that limit operational freedom.

The failure of advocacy schemes to recruit sufficient volunteers to sustain a viable advocacy network, coupled with increasing evidence that other kinds of formal advocacy are being slowly absorbed into the statutory system, may explain why increasing attention has been directed to the role of self-advocacy, which has been described as a process of development through which individuals acquire the skills and confidence to voice their own views and concerns. However, it can also refer to the activities of groups of people who have come together to voice their collective concerns. Whilst the growth of a vibrant self-advocacy movement over the past few decades has generally been welcomed, some reservations have been expressed. In Wolfensberger's opinion, the adoption by the People First Movement of the ideology of radical individualism and self-determination threatens to antagonise and alienate those whose support is vital if appropriate services are to be developed (Wolfensberger, 2003).

Conclusion

The economic recession should have taught us that nothing can be taken for granted. Who would have anticipated a situation where the Government in the UK would be forced to bail out the banks and in the process nationalise them? This point is made because the 'for profit' care companies, many with extensive property holdings have seen a precipitous and precipitate depreciation in property values - in some cases of the order of 30%. And in order to grow their businesses they have

been heavily reliant on banks providing large loans. It is evident that some of the smaller 'for profit' care companies are finding it increasingly difficult to compete and as a result are being swallowed up by the larger companies which recognise that only by pursuing an aggressive policy of acquisition can they secure increased dividends for their shareholders. It may not be too long before commissioners of care services in certain parts of the UK are presented with a situation where there is only one competitor for a tender as that company commands a monopoly position.

The 'nuclear scenario' would occur if monopoly providers found themselves financially overstretched and as a result subsequently collapsed. Will local or central government be forced to step in to re-nationalise the social care service? This scenario may seem far-fetched until one recalls Dame Denise Platt's strongly voiced concerns about the ability, capacity and willingness of the newly created social care regulator - the Care Quality Commission - to monitor effectively developments in the social care field. It should also be noted that it was, in part, a failure on the part of the Government established financial regulator - the Financial Services Authority - to see the danger signals in the financial market and to take appropriate and timely remedial action to prevent or in some way mitigate the effects of the market crash.

There may be those who feel that the general argument advanced in this paper is unjustifiably doom laden. What cannot be in doubt is that the quality of care services for children, young people and adults with an intellectual disability is under serious threat.

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Notes on Contributor

Robin Jackson PhD FRSA is a consultant to the Camphill School Aberdeen. He has held a variety of posts in the disability field: Principal Lecturer in Special Education at King Alfred's College, Winchester; Co-ordinator of the South Aberdeenshire Advocacy Service; and Development and Training Co-ordinator, Camphill Scotland.

Address for Correspondence

Robin Jackson
4 Deeview Gardens
Drumoak
Banchory
Aberdeenshire
AB31 5AF

Email: robin@dalmaik.demon.co.uk

A depth of data: research messages on the state of social work education in England

Jo Moriarty¹, Jill Manthorpe¹, Martin Stevens¹, Shereen Hussein¹, Endellion Sharpe², Joan Orme³, Gillian MacIntyre³, Pam Green Lister³ and Beth R Crisp⁴

¹ Social Care Workforce Research Unit, King's College London

² Sharpe Research Limited

³ Glasgow School of Social Work, Universities of Glasgow and Strathclyde

⁴ School of Health and Social Development, Deakin University, Australia

Abstract

In the light of extensive media coverage of social work education, this article uses information from the Department of Health funded three-years multi-method evaluation of the social work degree qualification in England to discuss areas in which qualifying education might be improved. It argues that too great a concern with the 'A' level performance of social work applicants risks not paying enough attention to the non-academic qualities that they will need to work in the changing world of children's and adult services. Better partnership working between employers and universities will help students make the transition into the workplace. This includes greater opportunities for employers and practitioners to be involved in candidate selection and teaching on qualifying programmes.

Keywords: Social work education, higher education, academic achievement, employment, evaluation

Introduction

Since the news of the circumstances around the death of Peter Connelly ('Baby P') became public in November 2008, media coverage of social work in the United Kingdom (UK) has been extensive. Included among this has been the assertion that social work programmes attract poorer quality applicants than other subjects (Goodwin, 2009) and are harder to fail (Newman, 2009). Following the establishment of the Social Work Task Force (Hansard, 2009) with a remit to "undertake a nuts and bolts review of frontline social work practice and make recommendations for immediate improvements to practice and training as well as long-term change in social work", the first Task Force report (Social Work Task Force, 2009c) observed:

We have been told that new social workers are often not properly prepared for the demands of the job and that the education system does not effectively support ongoing development and specialisation. Many people have told us that new entrants to social work can lack the mixture of practical, analytical and report-writing skills they need to become effective professionals. (p.4)

The previous year, the Department of Health had published the results of a three-year multi-method evaluation of the new social work degree qualification in England (Evaluation of Social Work Degree Qualification in England Team, 2008a, 2008b) following the major changes to social work education (Department of Health, 2001) which had resulted in the decision to make social work a degree level qualifying profession. The evaluation showed that there had been substantial

increases in the number of students on social work qualifying programmes, that there had been some increases in student diversity, and that students and educators were broadly pleased with their experiences thus far, although they identified some problems, for example in securing sufficient good quality practice placements and in mixed experiences of inter-professional learning. It might, therefore, be concluded that the new degree would be considered a success in policy terms. However, as the opening lines of this article show, the extent to which this viewpoint is widespread appears to be in question.

This article draws on the research team's submission to the Social Work Task Force in response to the Task Force's Call for Evidence. Our submission addressed two of the themes raised in the Task Force's first publication (Social Work Task Force, 2009c): Theme 3 – perceptions that new social workers are not being prepared for the demands of the job; and Theme 6 – concerns that the profession is under-valued and poorly understood. Specific concerns over training and education were raised:

- Lack of readiness for working on the frontline among newly qualified social workers;
- Questions about the quality of entrants to degree programmes;
- Questions about the content and quality of social work programmes;
- Problems with the availability and quality of practice placements, especially in the statutory sector.

Other issues identified by the Task Force were beyond the remit of the Evaluation. We developed our submission into three main questions, using data from the multiple sources outlined below. In doing so we take the opportunity to consider areas where there are limits to the research evidence and draw on some of the content of the Task Force's interim (2009b) and final reports (2009a). It is striking that, of the 15

Recommendations made in the Task Force's final report, four relate directly to social work qualifying education (strengthening the calibre of entrants to social work education, overhauling the content and delivery of social work programmes, setting up new arrangements for securing sufficient high quality practice placements, and more transparent and effective regulation of social work education) while a further two (setting up systems for forecasting levels of supply and demand for social workers and developing an action programme to improve public understanding of social work) have implications for recruitment and retention on social work programmes. Finally, two further recommendations, the creation of an assessed and supported year in employment as the final stage in becoming a social worker and a more coherent and effective national framework for the continuing professional development of social workers, imply the need for the development of closer partnerships between employers and higher education institutions. It is worth noting that the former Government (2009) accepted all 15 recommendations of the Task Force and undertook a commitment to carry forward a new reform programme for social work over the next five years.

This article complements other detailed information drawing on the study data including the perspectives of practice assessors (Moriarty *et al.*, 2010a), applications (Manthorpe *et al.*, 2009, advance access-b), admissions (Manthorpe *et al.*, 2009, advance access-a), student motivations (Stevens *et al.*, in press) and comparisons with nursing (Moriarty *et al.*, 2010b).

Methods

The Evaluation of the New Social Work Degree Qualification in England was a multi-method longitudinal study combining national data with case studies of six higher education institutions offering nine social work qualifying programmes. Detailed

accounts of the methodology are available elsewhere (Evaluation of Social Work Degree Qualification in England Team, 2008b; Orme *et al.*, 2009). Data collection took place from 2004-2007. Taken as a whole, the data on which the study findings were based included: anonymised enrolment records on 12,925 degree students and 12,565 students on the predecessor qualification, the Diploma in Social Work (DipSW), representing the total population of social work students enrolling between 2001-2006; 15,090 records of practice placements; 3,944 responses from students to an online survey administered over seven waves; face-to-face group interviews with 168 students; 64 face-to-face individual interviews with social work teaching staff; face-to-face individual and group interviews with 58 people with experience of using services and/or caring, who were involved in social work education; 195 responses to a postal questionnaire from practice assessors; 98 telephone/email surveys with staff from universities offering the social work degree; surveys and interviews of 62 employers; and 352 written answers to two scenarios, or vignettes, completed by students at the beginning and towards the end of their social work qualifying programmes.

How are students selected?

The Task Force expressed its concern that the selection processes for social work qualifying programmes attract applicants without the intellectual and personal skills they will need to be effective practitioners (Social Work Task Force, 2009a, 2009b, 2009c). In doing this, it repeated concerns that social work students are less academically qualified (with all the implications of this in terms of intellectual ability) than students on other qualifying professional programmes, such as teaching or nursing. Results from the study suggested that the UCAS tariff (UCAS, undated) - the system for allocating points to qualifications used for entry to higher education - of applicants accepted for social work has risen

in the years since the degree was introduced, although it is still generally lower than the tariff of acceptances for higher education as a whole. Information from admissions tutors suggested that they now had a larger pool of applicants from whom to select and, in some cases, they had raised the tariff scores applicants were expected to achieve. However, in common with the Joint University Council Social Work Education Committee's (JUCSWEC) submission to the Task Force (2009), we argue that there are three key reasons why comparisons between the previous educational qualifications of applicants for social work, teaching and nursing professional qualifying programmes need to be contextualised.

Firstly, social work programmes recruit from a wider range of applicants, including those who may have been disadvantaged by negative experiences at school. As has been pointed out (Green Lister, 2003; Dillon, 2007; Gibbons *et al.*, 2007), this is consistent with the value base of social work. Students such as these may have considerable personal commitment to success which helps them adjust to the levels of academic work required on a degree programme.

Secondly, there is no maximum tariff score and improvements in performance in 'A' level examinations and an increase in the average number of subjects taken mean that the most academically able younger students are likely to have achieved a higher UCAS tariff than their equally academic able older counterparts. This emerges clearly in UCAS data on all degree acceptances which show that applicants aged 25 years and over are over-represented among those without a tariff score or with lower tariff scores. In 2008, of the 38,516 acceptances for *any* undergraduate degree in England among people aged 25 and over, just 32 had a tariff above 360. Although social work programmes have seen rises in the number of applications from people aged 18-24, two thirds of those enrolling on

social work qualifying programmes are aged 25 and over. This is in contrast to nursing and teaching which have higher proportions of applicants aged 18-24. Consequently, socio-demographic factors, such as age, need to be considered when comparing tariffs across these three subjects. Furthermore, subject tariffs do not only reflect applicants' previous educational achievements. In subjects such as medicine, they reflect a greater demand than there are places available. This demand is influenced by a number of non-academic factors, including perceptions about the earning power of graduates from a particular subject.

Thirdly, UCAS figures exclude the 20% of students enrolling on social work degree programmes who are already graduates. In addition, the proportion of applicants for whom there is no tariff score varies considerably by subject, making it harder to draw comparisons. It is possible that some of these applications are from people who did not provide details of vocational qualifications. Puzzlingly, a high number of social work acceptances are recorded by UCAS as having a tariff score of '0' but this is at variance with data from the GSCC supplied to the evaluation team showing that the overwhelming majority of social work students do have qualifications at the equivalent of 'A' level or above.

Furthermore, if too great an emphasis is placed on social work applicants' UCAS tariff scores (typically 'A' levels), these scores may not give a true reflection of anyone's potential to be a good social worker when considered in isolation from other factors. This was a point echoed by the Association of Directors of Children's Services (ADCS) whose own submission commented:

To be a successful social worker requires more than purely academic abilities and any alterations to the entry requirements for qualifications should reflect the need

for a social worker to have the required maturity and resilience for the role that they hope to undertake. (ADCS, 2009, para 1.3.1.1)

It is also consistent with Australian research (Ryan *et al.*, 1995, 2005) suggesting that it is non-academic qualities, such as resilience, which are the key to success among social work students and subsequently once they enter practice. This is not to imply that academic abilities are unimportant: the changing nature of social work has highlighted employers' expectations about the need for IT literacy (Peckover *et al.*, 2008; Parton, 2009; Peckover *et al.*, 2009) as well as reinforcing the need expressed in earlier research for social workers to be proficient in maintaining records, writing reports (Marsh & Triseliotis, 1996; Pithouse & Scourfield, 2002) and communicating effectively with other professionals and people using services (Trevithick *et al.*, 2004).

Comments focusing on the apparent ease with which students can be selected for social work programmes are also at variance with data collected from students and staff directly involved in selecting applicants for social work programmes. While many other subjects offer applicants places on the basis of their UCAS form and a personal statement, the majority of social work programmes have rigorous procedures in place for the selection of students which involve testing by written exercises and individual and/or group interviews (Manthorpe *et al.*, 2009 advance access-a, advance access-b).

It is exceptional for social work programmes to only minimally follow the standards laid out in the *Requirements for Social Work Training* (Department of Health, 2002). Instead, a multiplicity of factors make up a decision to offer an applicant a place, including professional suitability, literacy and numeracy at Key Stage 2, motivation, and commitment to

social work. In addition, applicants are often asked to provide a commentary on a written scenario or video depicting a situation in which a social work intervention might be needed. The accounts from students and from admissions staff showed that, in addition to applicants' previous academic achievements, the interview covered areas such as their motivation and understanding of the social work role. Many students pointed out that it was their personal experience of using social care services, or those of a family member, which had motivated them to go into social work. Service users and carers said that they particularly valued personal experience and capacity for empathy as desirable qualities among students. Other students had experience of paid social care work, perhaps as a family support worker or community care assistant. While most social work programmes had developed ways of including employers in the recruitment and selection process, the extent of their involvement varied as indicated by student and social work educators' accounts of the selection process. This contrasted with developments for involving service users and carers which appeared to be more consistent.

As there are over 80 higher education institutions (HEIs) in England offering social work qualifying programmes, ranging from research intensive universities to local further education colleges attracting students following mainly vocational courses, it would be unrealistic to expect that they would all use the same criteria for student selection.

Another of the Task Force's themes - the poor understanding of social work and negative media coverage - also impacts upon recruitment and selection. Unfavourable comparisons of social work (Leslie, 2003; Green, 2006) with other subjects in terms of academic achievement means that schools and parents may be less inclined to encourage potential applicants to

choose social work. This appears to be reflected in data on trends in applications prior to the new degree, particularly among those aged 18-24 (Sanders, 2000; Perry & Cree, 2003; Moriarty & Murray, 2007). However, the national social work recruitment campaign is thought to have been very successful (although funding has never been made available to evaluate the extent to which enquiries are translated into applications for qualifying programmes) and recent years have seen increases in the popularity of social work as a subject among higher education applicants (BBC News, 2006). Even in the context of negative media coverage, applications for 2009-2010 appear to have remained stable (UCAS, 2009). In order to maintain these improvements, there may be potential to tailor recruitment campaigns - including advertising using those media that are most popular among young people - to coincide with the times at which they are considering their UCAS applications.

What are the availability and quality of practice placements?

Not surprisingly, the Evaluation observed that the availability and quality of practice placements in statutory settings were important for students and HEI staff alike, and were critical factors in contributing to the overall quality of programmes. However, it heard from practice assessors that they too need access to training and support and to be assured that their responsibilities for supervising students are considered in light of their caseload allocation and workload. An increasing number of placements take place in voluntary and private organisations. This means that it is important to consider the quality of placements in these settings too, especially as these organisations may be in a strong position to prepare students to deliver personalised support in adult services or to work preventively with children and families.

The Evaluation found that most students were able to undertake at least one placement in the statutory sector. However, competition to secure good placements was high, particularly where several universities were trying to obtain placements in the same locality. There may be regional variations in the provision of placements in children's services, highlighting the importance of developing good partnership arrangements between HEIs and social work agencies. These difficulties often meant that students had to travel long distances, adding to the pressures they reported in balancing completing their placement portfolios and college-based assignments.

Students valued practice placements for the greater understanding they developed of the social work role and of inter-professional working, the opportunity to develop communication skills, and the chance to work as a member of a team. They were least content when they felt they had not been given an opportunity to develop sufficient understanding of statutory work, particularly if they thought this would impact on their chances of securing employment. Students' understandable beliefs that to gain employment they needed to have statutory experience chime with the views of statutory employers that experience in the sector is a necessity for newly qualified social workers. However, these views highlight the tensions faced by many programmes in obtaining sufficient statutory placements and also conflict with the reality that many private and voluntary practice learning opportunities do equip students with the skills, experiences and challenges that they may need in the changing world of adult social care and children's services. Research will not provide the answers to these multiple imperatives but it does expose the nuances of balancing demand, expectation, wish, and supply.

Practice assessors strongly supported the requirement for 200 days to be spent in

practice. They were broadly pleased with students' performance, especially during their final placement, but wanted HEIs to ensure that students were given clear ideas about what would be expected of them in the workplace and for any concerns with issues such as literacy or interpersonal qualities to have been addressed before students arrived on placement. They valued the opportunity to attend workshops and receive advice from HEI staff. Some also illustrated ways in which they had tried to improve the quality of placements, such as creating more opportunities for students to have 'placements within placements', by spending time with other members of a team or giving students discrete pieces of work to help hone their practice skills.

Do programmes prepare students for the workplace?

The extent to which social work qualifying programmes prepare students for the workplace is clearly of central importance to the future of social work. Student satisfaction with teaching and learning was generally high and analysis of the teaching and learning methods showed that teaching staff had adopted a wide range of methods designed to prepare students for the workplace, such as role play, case scenarios, and skills workshops. Students appreciated most those topics they rated as being 'relevant to practice' and there are clearly opportunities in some higher education institutions (HEIs) to better tailor the content of modules such as psychology or social policy so that their significance for social work is made more explicit. This may help counter some of the concerns expressed by employers that learning tailored to changing service provision, such as the impact of personalisation (Association of Directors of Adult Social Services, 2009) or multi-agency working and child development (Association of Directors of Children's Services Ltd, 2009) has been slow to develop. Presentations from service users and carers and social work

practitioners were particularly valued. By contrast, inter-professional learning was the main area in which student feedback was mixed, highlighting the challenges of finding effective ways of developing the knowledge-base students will need in their future professional practice. There is clearly a need for a continuing debate about where and how inter-professional learning should take place (MacIntyre & Orme, in press).

However, teaching staff commented that the curriculum could sometimes feel overloaded because of the number of topics that needed to be covered. Students also felt that programmes were pressurised. However, few students and none of the teaching staff expressed a preference for separate adult and children's social work degrees as a way of concentrating learning into certain areas. The generic approach to initial qualifying training is dominant in most countries, as the response of the Joint University Council Social Work Education Committee (JUCSWEC, 2009) to the Task Force observed. However, there were ways in which students might be helped to be better prepared for work in specialist areas. Legislation, mental health, working with children and families, and human development featured highly among the topics students thought were important but programmes faced pressures in matching the teaching timetable to practice placements so it was not always possible or feasible to ensure that students had received teaching on a particular area before going on practice placement, thus limiting students' opportunities to link theory and practice.

As well as identifying HEIs' responsibilities, it is also important to clarify the role that practice placements play in preparing students for the workplace. Practice assessors pointed out that the increase in the proportion of students without direct paid experience in adult or children's services (because more were recruited straight from school) meant that students on first placement were often

unfamiliar with procedures and the nature of the work and so practice assessors had to adjust their teaching accordingly. They wanted this need for additional teaching to be recognised in allocating their caseloads.

In the second round of focus groups with students, held shortly before they completed their qualifying programmes, almost all considered their social work education to be worthwhile and relevant. Although some felt nervous about moving into the workplace, they saw this as appropriate to the stage of their development and not a reflection of lack of preparation. They were also strongly committed to the notion of continuing professional development. Final year students completing the online survey also thought that undertaking the programme had increased their motivation to do social work and expressed a strong intention to seek employment in social work.

The enhancement of analytical skills was an intended outcome of the move to a degree level qualification (Orme *et al.*, 2009). Students' progress in developing practical, analytical and report writing skills was mainly measured through analysis of answers to a set of two vignettes, one relating to children's services, the other to adult services. Analysis of the answers completed towards the end of the programmes showed that students had acquired a greater familiarity with the social work role, were more familiar with the legislative frameworks in which they operated, and showed evidence of some abilities to assess risk and prioritise. Nonetheless, consistent with existing research (Benner, 1984; Fook *et al.*, 2000), our data suggest that students reaching the end of their programmes generally operate at the level of advanced beginners, only acquiring professional expertise once they move into practice. Thus, there will always be a presumption that further continuing professional development will be required.

Discussion

Persistent and widespread problems in recruiting sufficient experienced social workers among local authorities (Local Authority Workforce Intelligence Group, 2007a, 2007b; Local Government Association, 2009) have highlighted the relevance of debates about the quality of social work qualifying education and the arrangements for inducting newly qualified social workers into the workforce. Higher vacancy rates in child protection and mental health services (Commission for Social Care Inspection, 2009) mean that newly qualified social workers often begin their employment in extremely challenging areas (Social Work Task Force, 2009a). While policy documents (Department for Children, Schools & Families, 2008; Department of Health, 2009) emphasise a continuing role for social work in children's and adult services, uncertainties have been expressed, particularly in adult services (Mickel, 2008), about how this will be implemented. These factors mean that debates about the content of qualifying and post-qualifying education will continue. How research can contribute to this is a continuing challenge. The tensions between research and policy in social work (Jones, 2001; Jordan, 2001; Orme, 2001) are well rehearsed but, as evidenced by their existence in other areas (Jones, 2001; Scott, 2003), will probably continue to be intractable.

However, one difficulty to which social work seems to be particularly vulnerable is in its relationship with the media. Research (Galilee, 2005; Lombard & Maier, 2009) suggests that media representations of social work, and by extension, social work education, are often unfair. Galilee's (2005) literature review suggested that there were two reasons for this. Firstly, he argued, due to its complexity and generally protracted nature, social work is usually of little interest to the media. However, secondly, stories about social work failures, particularly those involving children are

viewed as newsworthy (p.3). The JUCSWEC (2009) submission to the Task Force commented on the negative impact that media coverage had had upon student morale and it would be an irony if increases in applications to social work programmes, evident since the introduction of the degree and the national recruitment campaigns, were to be compromised by negative publicity from within the sector implying that 'anyone can get a place' on a social work programme when our evidence from both students and educators was that this was rarely the case. Programmes may also have a role in improving awareness among the media and general public in highlighting the existence of suitability procedures and the availability of exit opportunities for those thought to be better suited to another area of study.

In comparison with research into the involvement of service users in social work education, less attention has been paid to the involvement of employers and practitioners in qualifying education. There needs to be a clearer understanding of the relationship between HEIs and employers and the factors that help make for effective partnerships. This echoes the General Social Care Council's (GSCC) (2009) submission to the Task Force which stated that:

We want to persuade universities and employers to work more effectively together to ensure that the graduates emerging from qualifying courses are better equipped for their first job. (GSCC, 2009, para. 5)

It also highlights the sharp contrast between our improving understanding of how people using services and carers might be involved in learning (for example: Beresford & Croft, 2004; Levin, 2004; Anghel & Ramon, 2009; Green & Wilks, 2009) and our lack of knowledge about how practitioners' experiences and skills can be brought into the classroom. Is this a matter of presenting authentic 'experiences from the frontline'

and explaining how policy and procedures operate, or of exploring how skills can be transferred? It is all too easy to say that practitioners should be involved in teaching but how many feel they have the skills and confidence to be trainers and how likely are their employers to release them for teaching when we already know the pressures on social workers' time (News Item, 2006; White *et al.*, 2009)?

Nevertheless, despite these gaps, the advent of the social work degree has contributed to renewed interest in social work qualifying education. It is essential that continuing debates take place about its effectiveness but these debates need to take place in a spirit of critical enquiry. In particular, care needs to be taken that the motivation and enthusiasm of students (Stevens, *et al.*, in press) are not affected by unfair representations of their abilities.

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Notes on Contributors

Jo Moriarty and **Martin Stevens** are Research Fellows in the Social Care Workforce Research Unit, King's College London. **Jill Manthorpe** is Professor of Social Work and Director of the Social Care Workforce Research Unit at King's College London. **Shereen Hussein** is Senior Research Fellow in the Social Care Workforce Research Unit, King's College London. **Endellion Sharpe** is Managing Director of Sharpe Research. **Joan Orme** is Professor of Social Work at the Glasgow School of Social Work a joint school of the Universities of Glasgow and Strathclyde. **Gillian MacIntyre** is a Lecturer at the Glasgow School of Social Work. **Pam Green Lister** is the MSW Qualifying Course Director at the Glasgow School of Social Work. **Beth R Crisp** is Associate Professor in Social Work and Associate Head of School (Teaching and Learning) at Deakin University, Victoria, Australia.

Address for Correspondence

Jo Moriarty
Social Care Workforce Research Unit
King's College London
Strand Campus
Strand
London
WC2R 2LS

Tel: 020 7848 1697

Email: jo.moriarty@kcl.ac.uk

The positive outcomes of developing a research bid with young carers

Janet Warren

Anglia Ruskin University, Cambridge

Abstract

This article reports on the positive outcomes of developing a funding application with nine young service users to undertake participative research about young carers' assessments. Through a series of intensive workshops, using children and young people's participation methods, young carers were involved in the complex planning of a research proposal, developing the statement of aims and designing the methods for data collection, analysis and dissemination. The paper explores the outcomes of this process, focusing in particular on the knowledge developed about statutory assessments of young carers' needs, their experiences of assessment practices and their perceptions of the value of participating in bid development. The author concludes that, whilst time consuming, young carers' involvement in the early stages of bid development is important in ensuring the development of research that is more robust and which has greater relevance, by reflecting the issues and experiences of those people most affected by its outcomes.

Keywords: Young carers, assessment of need, children's participation, service user involvement in research bid development

Introduction and background

The participation of children and young people in social work research, policy and practice is a relatively new phenomenon. Historically, adult interpretations of children's wishes and needs have determined service development, and influenced research and policy (Franklin & Sloper, 2004). Children have been perceived by adult researchers as vulnerable, in need of care and protection, and as incompetent and, consequently, incapable of understanding the research process or of being able to give trustworthy, reliable accounts of their experiences (Christensen & Prout, 2002).

For many years, the disparities in power and status between adults and children, which derive from historical attitudes and assumptions about the nature of childhood, were reinforced in legislation, policy and practice (Lansdowne, 1994). Perspectives on children's status in UK society shifted, however, following the implementation, in

England and Wales, of the Children Act 1989 (and parallel legislation in Scotland and Northern Ireland) and the ratification of the United Nations Convention on the Rights of the Child (United Nations General Assembly, 1990; see also Kellett *et al.*, 2004; McLaughlin, 2006), which increased awareness of children's rights and "paved the way for children's involvement" (Alderson, 2001, p.141) in research as both participants and co-researchers. The momentum for child focused research has been intensified in the UK, moreover, in the wake of the government's *Every Child Matters* initiative (HM Government, 2003) and the Children Act, 2004. Children's participation is now central to a range of UK health and social care policies which place emphasis on the need to listen to, and consult with, children and young people in decisions that affect their lives (see Warren, 2007).

This article seeks to add to the emerging debate concerning the participation of young service users in the development of

research proposals, and to add to the ongoing debate about the value of assessment processes and practices in preventing children and young people who provide care, assistance or support to another family member, friend or neighbour who has care needs (commonly referred to as 'young carers') from undertaking inappropriate levels of care. Despite a growing body of research which explores the needs and experiences of young carers and their families, very few studies focus on young carers' experiences of assessment, and there are no studies to date which examine how the different assessment practices that have developed in England and Wales since the transformation of Children's Services set out in the *Every Child Matters: Change for Children* programme (HM Government, 2004) impact on the lives of young carers and their families. The findings presented here are based on discussions and group work undertaken by the author, during a five months sabbatical, with a group of nine young carers to develop a collaborative research proposal that would investigate the similarities and differences in the assessment experiences of young carers. It is not my intention to explore here the issues associated with the process of involving young service users in the writing of the bid, but to focus, instead, on the outcomes of that process and its impacts in terms of knowledge development.

Young carers as researchers

There are currently very few studies in which young carers have been able to demonstrate their abilities as participative co-researchers rather than research subjects, and where young carers have been active participants able to demonstrate, through each stage of the research project, their capacity "to shape, change and challenge the research process and knowledge development" (McLaughlin, 2006, p.1399; see also Jones *et al.*, 2002; Moore & McArthur, 2007). Although the idea for the

research proposal was initiated by academics, the involvement of young people in the complex planning, design and development of the proposal was important in reflecting their real experiences rather than academics' own perspectives or perceived priorities. During the development phase, young carers brought unique and important perspectives and insights to the partnership, making all key decisions about the design and development of the research, including its aims and methods for data collection, analysis and dissemination. The author acted as a conduit to this process.

Of the nine young carers who participated in the workshops, two were male and seven were female. Their ages ranged from 15-19 years, the majority (eight) falling within the secondary school/post 16-education band, with an average age of 17 years. Whilst most were white British, one young person described her ethnic origins as Pakistani and another as dual heritage. All of the young people provided care to at least one or both of their parents, the majority (seven) providing care to their mothers. In addition, two young people also provided care to one or more siblings.

Methods underpinning the development of the research proposal

As little is known about the extent and nature of current assessment practices, a scoping exercise was undertaken by the author to generate baseline information that could inform the development of the bid, through the distribution of a short questionnaire to two young carer project networks (The Princess Royal Trust for Carers and The Children's Society), reaching an estimated 350 projects based in both the voluntary and statutory sectors. In addition, a series of eight workshops were held with nine young carers, drawn from two young carer projects in contrasting local authority areas of the West Anglia region

(The Hub in Bedfordshire and West Anglia Crossroads in Cambridgeshire) between April-May 2009. The two local authorities were chosen on the basis that they were known to have adopted diverse ways of assessing young carers' needs: in one area, young carers' assessments were commissioned by the local authority and undertaken by the Young Carers' Project staff whilst, in the other authority, approximately twenty five miles away, assessments were undertaken by statutory agencies, with support from the Young Carers Project Manager. We were interested to learn more about young carers' perceptions of these different assessment practices and how their experiences might inform the development of the research proposal.

Key Findings

The findings are discussed in two parts. The first part focuses on the preliminary evidence that emerged from the scoping exercise which provided some sense of the assessments taking place currently and which, together with young carers' own experiences, was used to inform the development of the research proposal. The second part focuses on the outcomes of the work undertaken with young carers, in particular, what has been learnt about their needs and assessment experiences, and their experiences of participating in developing a research proposal.

Preliminary evidence from the scoping exercise revealed a broad diversity of assessment practice with regard to the number of assessments undertaken, the approach adopted and the assessment frameworks in use nationally. Thirty six of the estimated 350 specialist young carer projects across the UK responded to the request for information; 32 were located in locally governed areas in England, three in Scotland and one in Wales. Of these, 34 provided statistical information on the numbers of young carers known to their

project and 31 provided additional statistical information about assessments completed with these young people. Of the five respondents (located in England) who gave no information on young carers' assessments, one no longer had a role as a direct service provider working with young people and four had not been advised of any assessments undertaken and, therefore, held no statistical information on young carers' assessments. Thus, of the 28 specialist projects located in England (27) and Wales (1) that were in a position to offer information about young carers' assessments, the response rate was 100%. Whilst, no claims are made that the findings reported on here can be generalised more widely, they do point to the need for further investigation.

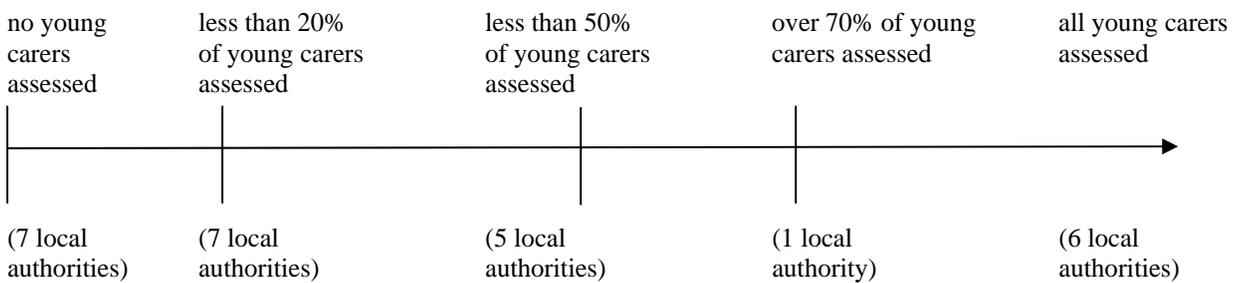
Overall, the emerging data from this study suggests that, over the past five years, there has been an increase in the number of young carers receiving a statutory assessment of need. Of 4,884 young carers known to the 31 projects in 29 local authorities in England and Wales who returned statistical data, 1,685 young carers (34.5%) had received a needs assessment prior to April 2009, compared with 18% (885) in 2003 in a study conducted across the UK by Dearden and Becker (2004). As can be seen in Figure 1, the scale of assessments completed ranges from local authorities in which there are no assessments taking place to authorities where all young carers receive an assessment of need. The data show that, whilst in 6 authorities all young carers received a formal assessment of need, in 12 authorities less than half of known young carers had been assessed and in 7 authorities no young carers had received a formal assessment. This suggests that the likelihood as to whether a young carer receives an assessment of need in England and Wales is dependent primarily on geographical location rather than familial circumstance. When viewed in this way, assessment (and intervention) appears to be based on a 'postcode lottery' which pays little or no

regard to young carers' legal rights and entitlement. This is particularly concerning given that the legislative framework provided for by the Carers (Recognition and Services) Act 1995, the Carers and Disabled Children Act 2000 and the Carers Act (Equal Opportunities Act) 2004 very clearly outlines young carers rights to an assessment and the duty of local authorities to inform carers of their right to an

assessment in certain circumstances (see Frank & McLarnon, 2008).

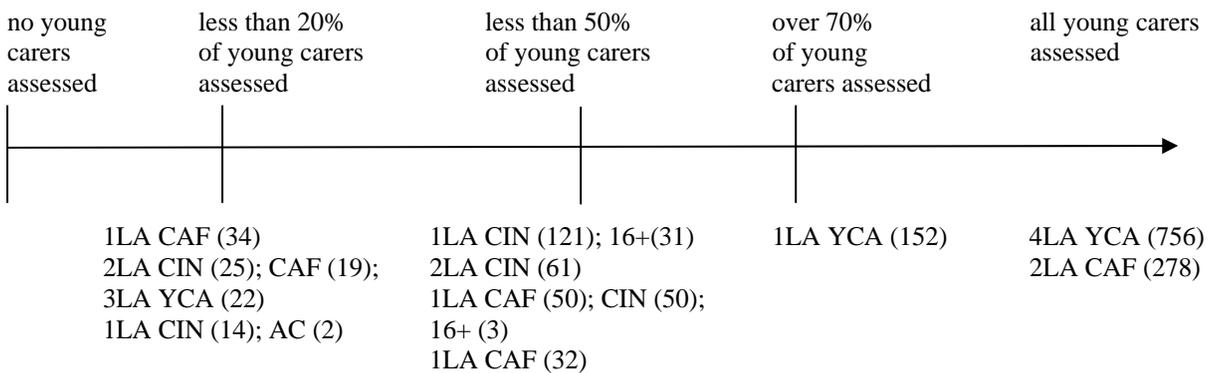
The emerging data also show that those local authorities in England and Wales that are undertaking formal assessments of the needs of young carers are doing so under different pieces of legislation, using a diverse range of frameworks as shown in Figure 2.

Figure 1 Assessment completions



NB. In 3 local authorities, project staff were unaware whether young carers had received a statutory assessment
 Number of assessments: 1685
 Total number of local authorities: 29

Figure 2 Assessment completions and types (n=1650)



Type of assessment:

YCA = specially designed in-house young carer assessment

CAF = common assessment framework

CIN = child in need assessment under Children Act 1989

16+ = assessment of young carers aged 16 or over under Carers and Disabled Children Act 2000

AC = adult carer assessment (legislation not identified)

Figure followed by LA denotes number of local authorities using type of assessment

Figures in brackets denote number of each type of assessment

(NB. data missing on 35 assessments)

The data show that authorities where approximately 70–100% of all known young carers have been assessed, use either a specially designed in-house young carers assessment framework or the Common Assessment Framework (CAF) (a shared assessment tool, designed to help early identification of need and promote co-ordinated service provision), which was implemented in all local authorities between April 2005 – March 2008. This may be a sign that some authorities have shifted their thinking and systems of assessment for young carers towards active prevention. In contrast, however, as shown in Figure 2, some authorities undertaking substantially less numbers of assessments relative to the number of young carers known to them (under 50%) are assessing young carers as either *children in need* under the Children Act 1989, or as *carers* (16+ or over) under the Carers and Disabled Children Act 2000 or the Carers (Recognition & Services) Act 1995. Whilst these local authorities are, quite rightly, acting within the parameters of the legislation, some commentators (see Frank & McLarnon, 2008) have expressed concern that the very act of labelling children as ‘in need’ is a sign that support for a parent and their family has already failed and that parents need to be able to access support at a much earlier stage so that their children are prevented from having to take on caring roles.

There are indications from the data, however, of a change towards a more preventative, proactive approach by some authorities, positioned at the lower bands on the continuum, to the assessment of young carers’ needs. In line with the Government’s Carers Strategy (HM Government, 2008), a number of projects responding to the scoping exercise, who are undertaking fewer assessments (less than 50% of known young carers), are using the Common Assessment Framework alongside other assessment frameworks, as can be seen in Figure 2. What is not clear from this data, however, is how many of these assessments pre-date the

implementation of CAF in these particular authorities and whether, overall, more assessments have been undertaken since the implementation of CAF. Also not known is the extent to which the common assessment information may have been fed into the specialist assessments identified or prevented some children from needing to be assessed as ‘in need’ at some future point.

The scoping exercise has highlighted the need for further research that will provide more robust statistical data on the extent, nature and outcomes of statutory assessments of young carers, and the reasons why it is that some authorities are undertaking substantially more assessments than others when, in theory, all authorities should be operating under the same pieces of legislation. We are aware that local authorities have all been at different stages with regard to introducing and embedding the Common Assessment Framework and the findings from the scoping exercise may, in part, reflect the extent to which these changes have been embraced in different regions nationally. In Figure 2, for example, both the lower and upper bands of the assessment completions continuum suggest that a number of authorities may not be using the Common Assessment Framework routinely to assess young carers’ needs. Whilst a recent small-scale survey (involving 50 young carers and staff from 8 councils) undertaken by Ofsted (2009) to examine the assessment and delivery of services for young carers and their families found that, where the Common Assessment Framework was most developed, “it had proved effective in the identification and assessment of young carers’ needs” (Ofsted, 2009, p.14), the study also found that, in children’s social care services, there was no consistent pattern with regard to assessments of young carers who were not suffering, or likely to suffer, significant harm and that, in practice, resource constraints meant that assessments tended to be only carried out if there were clear child protection issues.

The scoping exercise has also highlighted the need for research that will examine the quality of the different assessment approaches currently in use and explore how assessment processes and practices are perceived, both by those on the receiving end – the young carers – and by those who conduct the assessments. Currently, little is known about how and by whom young carers' needs are best assessed. The scoping exercise revealed a diverse range of approaches to assessment practice which has been useful in informing the development of a research proposal that will enable us to understand better the implications of young carers' experiences of assessment, through an examination of the relationship between the content, process and outcomes of assessment for children and young people, so that those interventions most likely to result in positive outcomes for young carers may be identified.

Outcomes of Young Carers' Bid Development Group

The involvement of young carers in the writing of the research proposal resulted in a number of positive outcomes. First, the young carers' insider knowledge of assessment practices, and of the needs of the community that we proposed to research, was highly valuable in confirming for us both the need for a piece of research about young carer assessments and the value of involving young carers in that research as a way of enabling them to take action for themselves. The desire to inform other people, such as service providers and policy makers, about young carers' views and experiences, and to effect change in assessment practices and service provision for other young carers and their families, were strong motivators for the young carers both to join and maintain their membership of the Bid Writing Group and provided us with a clear indication of the young people's commitment to act upon the findings of any

future research that we might undertake together.

Second, involvement in the project also resulted in both the facilitator and the young people developing greater awareness and understanding of the quality (and quantity) of individual assessments and their impact on individuals and their families. As a starting point for developing the research proposal, young carers explored their own views and experiences of assessment, to help identify similarities and differences between the experiences of the two project groups and to identify key areas and issues that could be explored further in the research study. The differences between the assessment experiences of the two project groups were striking. Young carers, whose assessments had been undertaken by their own project staff, described their experiences of the process and its outcomes in positive terms:

When the young carer's worker did it [the assessment] – ok – more comfortable; less pushy.

I didn't think my words would be twisted by the young carers' project.

The help that I got after the assessment made a big difference! I was offered respite and I found out I was eligible for funding to help me get a break from home life and I got more regular one-to-one meetings.

However, for the majority of young carers, whose assessments had been undertaken by social workers in children's or adult social care services, their experiences of both the process of assessment and its outcomes appeared negative:

When it happened it went on for a long time.

Unannounced visits are awkward and uncomfortable for a young carer.

Interviewed at their [social workers'] convenience.

Forms are too formal – it looks like an exam paper.

Boring – questions were pointless.

When the social did it – noseey.

Not listening and interrupting. Just the opinion of the person cared for are listened to as they are the ones who have an assessment.

Copies of assessment received weeks after the interview.

Whilst in this regard a palpable sense of anger dominated our early workshops, the process of talking about these experiences was important in building a group identity and in enabling the young people to develop a shared understanding of the issues to be researched. As one young carer commented:

I learnt that some of the other carers had assessments which either did or did not benefit them for one reason or another. It was an opportunity for those, such as myself, who did not have an individual assessment or could not remember them, to learn what they were all about; it was also nice to hear the different experiences - even if they were not particularly positive.

For many young carers, the realisation “that other people have had the same experiences as me” was notably cathartic. As one young carer wrote:

I really felt as though I was part of a community talking about how I have had problems with the crisis team ... and having trouble with trying to get a home assessment. I thought the project was a huge success especially when we talked about the good and the bad experiences about assessment and what they did when they got to the home of the carer.

As can be seen in Figure 3, the young people’s views about the purpose of assessment were closely associated with the outcomes that they wanted to see, and whether the assessment had led to improvements for themselves and their family as a whole – in particular, the introduction of, or increase in community services, specific support for themselves (and for the person with care needs) or equipment in the home. For those young carers in the group whose assessments had been undertaken by statutory agencies, the lack of action or noticeable outcomes resulting from their assessment had left them feeling angry. Young carers were particularly concerned about the gaps in support around the family and the person they provided care to, so much so that, for them, the primary outcome of assessment, i.e. better support for their parent and family, was a priority.

Figure 3 Young carers’ views of the purpose of an assessment

Young carers were asked about the purpose of assessment and what it meant to them. Their responses included:

- Being asked lots of questions.
- Getting your point across.
- Helps you to know where you stand.
- Helps you to plan and know who to turn to, what they [social workers] can do.
- Getting decent help - giving help to people in our situation.
- Improving support that we would have liked if had more money.
- Making things better for young carers in the future.
- Being able to deliver what they [assessors] promise.

Figure 4 Young carers' perceptions of the assessment process

Young carers from both projects contributed their experiences of the assessment process:

- Assessments are a waste of time unless something is done after the process.
- When assessments do happen, they go on for a long time or are never ending and lack action.
- Assessors do not care. They visit unannounced, interview at their convenience and never arrive on time.
- Young carers are not fully informed or prepared for assessment.
- Assessors ask too many questions. The process is boring and pointless. Some questions are personal and unimportant.
- Assessors don't listen. They interrupt and jump to conclusions.
- The assessment forms are too formal. It looks like an exam paper.
- Professionals don't see young carers as a priority – they ignore others in the family.
- Young carers are not asked but told what is happening.
- Copies of the assessment are received weeks after the interview.
- The responsibility (for care) is transferred back onto the carer.

The young carers welcomed the opportunity to have their views heard and discussions which focused on their own experiences were helpful in confirming the immediate relevance of our proposed research in focusing not only on the outcomes but also the content and process of young carers' assessments. This resulted in a proposal that was firmly rooted in the reality of their experiences. As can be seen in Figure 4, the young carers explored and reflected on aspects of their own assessment experience which was helpful, not only in terms of identifying the key areas and issues to explore in the research study, but also in enabling the young people "to find out their own standpoint and any biases that they may hold" (Kirby, 1999, p.80). These experiences provided some insight into the challenges and complexities that we faced together, both in designing the research approach and in supporting the young carers as researchers, if our funding application was successful.

Outcomes were also evident in other contexts. A third outcome of the Bid Development Group was its effect in increasing young carers' knowledge of, and access to, decision making structures which might enable them to take action for themselves (see Kirby, 1999). User-informed research, particularly involving

children and young people, is still very much in its infancy. Indeed, few studies exist which highlight the value of young carers' participation as collaborators or peer researchers in the development of research parameters and in conducting and analysing research interviews (Jones *et al.*, 2002; Moore & McArthur, 2007). The starting point for this project was the desire to involve a group of young carers in the development of a research proposal about young carer assessments but also, subsequently, to enable those same young people to participate in undertaking the research, if the application for funding was successful. It is not my intention to explore here the process by which the project moved from a user-informed to a user-led research bid but, as has been discussed elsewhere, it is important to acknowledge that, through the life of the project, the young carers did develop ownership of both the process and outcomes of the research proposal. Through a process of intensive discussion and group work, using children and young people's participation methods, the young carers developed the statement of research aims and designed the methods for data collection, analysis and dissemination. One important identifying element of their ownership of the research, towards the end of the development phase, was the young carers' decision to maintain control of the

research, if the bid was successful, by undertaking all of the required research tasks themselves (designing and conducting the research, analysing the data, and disseminating the findings) with support from the author, rather than buying in the services of a researcher to undertake some or all of these tasks.

It was essential to evaluate young carers' experiences of the workshops and, in particular, how this influenced their views of user participation. As can be seen from the reflections below, the project did impact on both young carers' awareness and understanding of the development of a research proposal as well as their perception of the value of user participation.

I have learnt the importance of allowing others to have a voice so that their confidence has grown in a strange environment. Participation in helping to write the bid has helped me to understand that young people should be able to be involved, as it is, after all, about their experiences and how to make things better. ... Overall, I felt that we have been able to compile a set of information from different experiences we have had in the past which has helped me to realise that things do differ from place to place and are not set in stone. Things can always be changed so long as views are treated with sensitivity and used appropriately within the research project to express thoughts and feelings. The facilitator was able to listen and also explain why our views were important in getting the funding for the bid itself. (Female young carer, 17)

Similarly, another young person observed that:

I learnt overall from this whole experience that we could make a big difference if we really tried and put our point across to everyone. I also learnt that I could work in a group and maybe

would want to work for this kind of work in the future. I also learnt that we can help one another with the kind of problems that young carers face in life and professionals do not take any notice of what we got to say and do not help us with our problems. This project had a big advantage because by us doing this, we could maybe get young carers' points across and make our... future better, and get things done quicker, and could also help ... future young carers. ... Overall, I enjoyed the experience. (Female young adult carer, 18)

Young people can benefit substantially from taking part in research projects, particularly in regard to their own personal development (see Precht, 1998). Motivated at the outset by a desire to write about the project in a future employment, college or university application, a number of the young people indicated that this had been a major incentive for joining the group. Whilst the nature of the group would help to improve personal confidence in that all the young people would be involved in working with some people who they did not know, there were also opportunities for the young people to develop knowledge about research methodology, assessment policy and information, group work and understanding of themselves in relation to others, as well as particular skills such as building relationships and interpersonal communication. Structures were put in place to enable the young people to reflect on their own learning and development throughout the life of the group and, by the end of the development phase, most of the young people could identify several areas of personal growth and development. The development of interpersonal, group work or team building skills was frequently mentioned in workshop feedback forms. One young carer commented:

My knowledge of group work and team building has increased and how to conclude all of our decisions together. It

has also given me a stronger passion to help as well as changing the way things are run and improving the lives of many young carers. I now have higher confidence and determination to continue helping this research project as it has done so much for me and others, and will also increase people's awareness.
(Female young carer, 15)

Another young carer, reflecting on what he or she had learnt about working with others, commented:

It is important to note what others say as they have valuable points to contribute.

There was general acknowledgement of the value of working together on issues with others in the group and recognition of the importance of listening to others and being listened to. As one young carer poignantly commented:

If you co-operate you can do anything.

Conclusions

This bid writing process has been just one stage in what is hoped will be a long term development process, and not just a means to an end, or an end in itself. Whilst time consuming, involving young carers in the development of the bid has, without doubt, brought us closer to the reality of young carers' lives. As a result, the research proposal is quite firmly grounded in their experiences. The research aims and objectives now have greater relevance, the data collection methods and analysis are appropriate, sensitive and inclusive, and the dissemination strategy will ensure that the key messages from the research will inform the development of future research-based policy and practice with young carers and their families as shown in Figure 5 below.

It is acknowledged that the context for developing this bid was unusual, in that the conventional barriers to the participation of service users and carers, namely the provision of financial support for their time and expenses, and funding of the facilitator's time, did not exist. Whilst it is not uncommon for such barriers to prohibit researchers from involving service users or carers at this most crucial stage of the research process, this article has focused on some of the positive outcomes of service user participation in bid development. As the project here has highlighted, participation presents important opportunities for ensuring the development of research that is more robust and has greater relevance, by reflecting the issues and agendas of those people most affected by its outcomes, rather than the perspectives or perceived priorities of academics. In presenting opportunities for personal growth and development, involvement in research also has the potential to promote further opportunities for young service users and carers, improving employment, educational or community orientated opportunities.

Many of the young people involved in this project were formerly, like other young carers throughout the UK, unaware of their rights and entitlement to ask for an assessment of their needs (see Becker & Becker, 2008; Frank & McLarnon, 2008). Whatever the outcome of this bid application, it is hoped that, at the very least, the process of participation has helped to increase young carers' access to local assessment processes which will, in turn, enable them to fulfil their rights as young people, carers and citizens to participate more fully in the decision making processes that affect their lives.

Figure 5 Overview of the research proposal

<p>Research Aim To explore the similarities and differences in the assessment experiences of young carers, to understand better the different assessment practices undertaken in statutory social care authorities in England and to explore the impacts/outcomes of these practices for children, young people and their families.</p> <p>Research Design and Methodology The study will combine quantitative and qualitative methods in two phases of data collection and analysis:</p> <ul style="list-style-type: none"> • a UK-wide e-survey to generate descriptive statistics on the nature, extent and outcomes of young carers' assessments. • individual in-depth telephone interviews conducted with 20 young carers and their respective assessors by a team of young carer researchers. <p>All research instruments and information leaflets will be developed, with support, by a team of young carer researchers.</p> <p>Data Analysis Young carers will maintain a high level of control over these processes through:</p> <ul style="list-style-type: none"> • choice of which frequency counts and percentages to calculate, which relationships and comparisons to investigate, and by working together to build a thematic analysis. • reviewing interviews to identify key themes, writing analytic summaries of each interview and collating data to assist with writing the final report. • making decisions about the key messages that should be taken from the research. <p>Writing up and Dissemination Young carers will contribute to the design, content and production of a research report and supportive practice guide about good assessment practice. They will help launch both documents at a seminar for researchers, policy makers and practitioners.</p>

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Notes on Contributor

Janet Warren is a Senior Lecturer in Social Work and Pathway Leader for the Post Qualifying Award in Specialist Social Work: Children and Young People, their Families and Carers at Anglia Ruskin University, Cambridge. She has a long-standing interest in the needs, experiences and rights of young carers and their families. Her publications include a textbook on service user and carer participation in social work.

Address for Correspondence

Dr J.L. Warren
 Department of Social Work & Social Policy
 Faculty of Health and Social Care
 The Webb
 Anglia Ruskin University
 East Road
 Cambridge
 CB1 1PT

E-mail: janet.warren@anglia.ac.uk
 Tel: 0845 196 2535

Proud2B: An evaluation of outcomes for adults with a learning disability from minority groups in Hampshire participating in a club celebrating and exploring culture

Dominique Rawlings

Hampshire County Council, Learning Disability Commissioning Team, Adult Services

Abstract

Social care is changing. Making choices, becoming or remaining independent, choosing your care or the right service for your needs are key elements of the new system. Expressing choices and needs related to culture can seem very intimidating if you have a minority culture, even more so if you have a learning disability and feel isolated living in an area where diversity is low. This report is an evaluation of the Proud2B groups, set up as a positive opportunity to encourage people with a learning disability from black and minority ethnic backgrounds to develop self-confidence and self-advocacy skills in order to express their needs and wishes. The aims of the groups are to celebrate and explore members' and other cultures. Through the analysis of data from interviews, questionnaire and diaries, the research concludes that attending the Proud2B groups has had a positive effect on members' lives and identifies additional effects for supporting staff and community engagement.

Keywords: Learning disability, black and minority ethnic, culture, group-work

Introduction

Changes in social care mean that it will be increasingly important for service users to be able to express their needs to obtain the service they want. It will also be essential for providers, if they wish to remain competitive, to demonstrate how they meet those needs beyond basic care and support. Expressing needs related to a minority culture can seem very intimidating and initiatives that encourage and empower people to do so are important. There is little research about this subject and few initiatives aimed at increasing the self-advocacy skills of people with a learning disability from an ethnic minority origin. This report is an evaluation of outcomes for people with a learning disability from black and minority ethnic origin who participated in a group called Proud2B. The aim of the group was to celebrate and explore members' and other cultures to increase self-confidence and encourage the development of self-advocacy skills. The

research explored whether participants enjoyed attending the group and whether it had an effect on their lives and skills. It also constitutes a useful example of practice for all those striving to develop a more appropriate service for everyone living in their area.

Hampshire is a large and substantially rural county with relatively small and widely-dispersed ethnic minority communities (CVS, 2004, p.5). Figures from the 2001 census suggest that the ethnic minority presence in Hampshire, while still below the national average, had increased by 73% since the previous census. More recent data from local services and the voluntary sector suggest a further, accelerating growth and an increase in the diversity of origin. Ethnic minority settlement has remained dispersed although there is an historical 'pocket' of concentration in the south of the county, near Southampton, and some new patterns of concentration emerging in two areas in the north. As this is a recent development,

communities are seldom organized or represented making it difficult for providers to identify and engage with them. Another peculiarity of Hampshire is that ‘travellers’ are one of the larger ethnic minority groups (CVS, 2004, p.5). Finally, recent figures from Hampshire learning disability strategic commissioning team show an under-representation in support services of adults from black and minority ethnic origin (Hampshire County Council, 2009).

The North Wales Race Equality Network (undated report, p.7) identified lack of information as one of the key barriers in accessing services and support. The Network also found that rural isolation was likely to exacerbate racism and gives four reasons why this problem is often ignored:

- Denial of ethnic minority presence in rural areas;
- Colour blind approach to ethnicity, or ‘we treat everyone the same’ approach, which leads to people’s diverse needs being ignored;
- A belief in rural areas that racist violence is an urban problem;
- A lack of effective support and consultation for ethnic minority people isolated in rural areas. (p.43)

In rural areas, where the ethnic minority population is dispersed, it is also difficult to find and receive accurate and up-to-date information; an early scoping exercise by Hampshire Ethnic Minority Learning Disability Project (EMLD) found a widespread lack of awareness of the availability of support services amongst the Black and Minority Ethnic (BME) population (EMLD, 2005). Williams *et al.* (2007) highlight the apparent lack of information and access to care for BME populations in Wales and conclude that the lack of appropriate information, language barriers, culturally-alien services and institutional discrimination are all issues mirrored by the research findings of studies conducted elsewhere in the UK. This makes

it all the more important to develop structures and activities that reduce isolation, encourage participation and empower ethnic minority people to identify their needs and gain access to the appropriate services. *Valuing People Now* emphasises the importance of including everyone in the development of strategies and services, especially in rural areas where diversity may be less visible (Department of Health, 2009, p.41).

The UK government is now committed to radical social care reforms where people’s personal needs, independence, well-being and dignity are placed at the core. Hampshire County Council (HCC) has developed its own model of support to citizens in which services, whilst still important, play a secondary role to what people can do themselves with the support of families, friends and the wider community (HCC, 2008, p.92). For all in Hampshire to benefit, steps must be taken to reduce ethnic minority residents’ isolation and encourage participation.

In this study, the terms ‘ethnic minority’ and ‘minority group’ are used to represent any ethnic group except White British. They might also apply to people from faith groups other than the main Christian ones. The Commission for Human Rights and Equality emphasises that it is the level of social exclusion suffered by a particular group (this could be on the grounds of ethnicity, religion, sexual orientation or other) that matters when working to ensure everyone has equal access and opportunity to be involved.

Proud2B Groups

Proud2B are two groups for people with a learning disability from ethnic and other minority backgrounds. The aims of the groups are for members to have fun, make new friends, celebrate their own culture and explore other cultures; this is then a stepping stone to develop self-esteem and pride and thus self-confidence to express

their own needs, particularly those linked to culture. The groups were set up as a positive opportunity for people who would usually be 'surrounded' by White British people and who might not feel confident or comfortable to express their own different needs, feeling as if they were in a 'fish-bowl'.

A new, positive and innovative opportunity

The Ethnic Minority Learning Disability Project was set up in 2005 by Hampshire Learning Disability Partnership Board in response to *Valuing People* (Department of Health, 2001). The aim of the project is to be a two-way link between individuals with a learning disability and families from ethnic minority groups and support services. Therefore, the project runs training sessions in the community to raise awareness of learning disability issues and of the availability of services. It also supports individuals and families to access services. Finally, it supports services with cultural awareness training and advice on specific issues. A major part of the project work is to engage with communities and specific projects, such as the Community Tree (Rawlings, 2008, p.85), provide positive and innovative ways to do this. The Proud2B groups were established with a similar purpose and represent a day-opportunity that is open to all. There is no cost involved for the individual or the family, no lengthy assessment nor referral forms to fill in and no eligibility criteria.

Rationale

The Social Care Institute for Excellence (SCIE) (2006, p.10) has denounced the widening gap between the participation of black and minority ethnic and other service user groups. It also criticizes providers who engage only with prominent figures or community leaders, rather than with potential recipients of services and their families. The Proud2B groups were set up to provide an opportunity for engagement with

disabled ethnic minority individuals, rather than with prominent figures, in a community group.

In the past, debate about participation has tended to use the term 'hard-to-reach', suggesting that there is something about these individuals that prevents their engagement with services. A report by SCIE (2009, p.v) about developing inclusive participation in social care explains that 'seldom heard' is a better term as it stresses the responsibility of agencies to reach out to excluded people, ensuring that they have access to social care services and that their voices are heard. The Report also explains that getting involved includes sharing experiences with people in the same situation or enjoying oneself, i.e. having fun through shared experiences and activities (p.5). Finally, it gives an example of a mainstreaming approach to equalities (p.10) where, as in the Proud2B groups, people learn about each other's cultures through festivals and celebrations. In the new social care context, if personalisation is to bring benefits to all, the participation of 'seldom heard' individuals and groups is vital. People with a learning disability from a minority background constitute such a group and it is in that participatory spirit that the Proud2B groups were established.

Personalisation includes the recognition that every person is unique and has unique needs. Thompson (2002, p.93) argues, further, that anti-discriminatory practice must include recognising the individual, not just in the abstract, but within the concrete circumstances of her or his cultural and social context. Scourfield *et al.*'s (2005) study of cultural identity in virtually all-white communities found that diverse individual histories and family relationships interact with available minority cultural identities and local and national cultural influences. They concluded that some respondents maintain minority ethnic identities with pride and that, for others, the maintenance of a minority ethnic identity is

put under extreme pressure. For personalisation to become a reality, diversity initiatives such as the Proud2B groups are essential. Diversity is the celebration of differences between people; it goes hand in hand with equality of opportunity but is not the same. While the EMLD project contributes to equality of opportunity, the Proud2B groups help the work go further by providing opportunities for people to celebrate their 'differences'.

Organisation

Initially, interest was raised and members recruited by advertising a potential new group via the EMLD and other networks. Funding was identified and secured for two groups. It included an element covering transport, so that people from any part of Hampshire could join. It also included provision to rent venues in the community, accessible and acceptable to all.

At the first meeting, people were encouraged to think about which activity they would like to get involved in and also to draw some common rules for the group. Talking about where each person came from quickly became a firm favourite as well as looking on a large world map where the country was situated. Activities were then developed to match country of origin with other interests. The meetings take place monthly and each time there is a different theme: carnival and dance, fabric patterns, celebrations and henna tattoos, musical rhythms of the world, printing, food, going/eating out.

Membership

The groups include 11 members from 10 different ethnic origins: two are fully bilingual and use a language other than English at home, a further three know and speak the language of their country of origin but use English in their everyday lives. All speak and understand English, some members use signing (Makaton).

Research design and data collection process

The main research question was whether participation in the group had had an effect on members' lives, opportunities and skills. The primary objectives were to find out whether participants enjoyed attending the group; whether it helped them want to investigate other cultures and whether it helped them feel proud of their own. Finally, whether it gave people more self-confidence and opportunities to participate in social activities.

There has been little research on similar opportunities. Singh (2005) highlighted the importance of including heritage and cultural tradition in projects for building trust with participants and the wider community. He also concluded that sharing personal life stories in safe group settings proved highly effective in changing people's lives. Brown (2008), in a review of a similar group in Oxford, found that members were afforded an opportunity to spend time in an environment that provided culturally-appropriate support. It was set up as a self-advocacy group but became much more, encouraging members to celebrate their culture and develop confidence.

Methodology

Qualitative data was collected from three groups of respondents: participants; supporting staff; and parents/carers. Methods included:

1. Semi-structured interviews for participants, conducted in small friendship groups as many participants would have felt very intimidated one-to-one. The interview started with closed questions, based on specific activities, to make people feel comfortable by talking about something concrete. More open questions followed to capture people's views and feelings;

2. Face-to-face, semi-structured interviews with staff;
3. Postal questionnaires sent to parents with an option to use a telephone interview covering the same questions. This was done to minimise inconvenience to carers – who might prefer not to be called at home – while still being able to capture the views of those carers who did not feel comfortable with a written exercise;
4. Diaries kept of the meetings with comments and observations.

The sample included nine group participants, four paid supporting staff and one volunteer, nine families and carers. The aim was to represent the views of people involved in the group, as well as of people who might observe the effect of the group on participants outside meetings.

Validity

Because the main researcher was involved with the groups, a co-researcher (not involved with the group and unknown to the participants) was used to conduct the interviews. Accessible consent forms were produced and explained by support workers, not the researcher. Data collected was coded and analysed according to the research objectives and bias avoided by using a second coder. A high level of intercoder agreement was achieved, reinforcing the credibility of the findings.

Ethical considerations

Approval was obtained from Hampshire County Council Research Governance Board. To uphold confidentiality, neither name nor country of origin were recorded during interviews. All participants were identified in their care setting as having capacity to make a decision about participating in this research. An accessible letter and consent form were drafted and given to participants at one of the group meetings, in advance of the co-researcher's

visit. This allowed supporters to explain it on a one-to-one basis according to people's needs. Two group members needed more time to think about giving their consent. The letter and the aims of the research were re-explained to them on a different day. Separate letters and consent forms were also produced for parents or carers and for staff and included pre-paid envelopes for replies.

Results and discussion

Data from interviews, diaries and questionnaires were first coded according to the primary objectives of the research and a summary of findings is presented below.

Do participants enjoy attending the group?

Analysis of the data shows that, overall, members enjoy attending the group. Enjoyment is expressed differently depending on a person's ability to verbalise. Only a few members were able to answer this question directly during the interview, partly because of their level of communication but also because the researcher asking the questions was a stranger - group members seemed very intimidated by his presence initially. Most members required considerable prompting, by the interviewer and (primarily) by the supporters, to enable them to speak at all. However, the interviewer quickly noticed that observation of facial expression particularly and body language in general would enable identification of responses. As the session progressed, group members also began to use drawing, Makaton signing, photographs and personal possessions they had brought to communicate their ideas. This allowed the interviewer to conclude that most enjoyed coming to the group. However, one member was unable to communicate, though his supporter tried a variety of activities with him. Eventually, he assisted a little with gluing items for a poster. The interviewer was unable to draw any conclusions directly from this member

although his supporter indicated that he was happy to come to the group each time it met and that he was capable of demonstrating his dislike of something. This indicates that traditional interview methods might not always be suitable for people with limited verbal communication and learning disabilities. Researchers must be prepared to use other clues, using interview questions only as a frame.

Enjoyment was also confirmed by responses from carers and from diaries. These show that appreciation was not always immediate but developed over time. For the first two meetings, there were still reports of people saying they are bored at specific activities or, on one occasion, that they do not like the venue; these no longer appear after the third session. One member is reported asking at the first meeting “why do I have to be here, I am British?” Nevertheless, she attended further meetings and, on the fourth one, introduced herself to a guest with these words: “Hi, I am ..., I was born in London and my mum comes from ..., I love both, what about you?” Furthermore, whereas during the first few sessions, there are occasional reports of people smiling and laughing, this progresses to becoming reports of eager anticipation and excitement: one supporter reported in the diary “she cannot wait for the next session; she has talked about it all week!” or “her dad tells me she got up at 5 a.m. this morning and was signing about today’s activity”. With regards to the member who did not communicate at the interview, later diary reports show him enjoying an outing, being engaged throughout and talking to a supporter using a full sentence.

Beyond answering our research question, the data also shows the importance of giving people time to develop and enjoy the group. For some, this only occurred once members became familiar with supporters and settings. It would therefore be important for a future group to run consistently over time so that people became familiar with it. Also,

new members should be given the chance to experience several meetings before being asked to decide whether they carry on coming or not.

Do participants want to investigate other cultures?

Responses to the interview questions show that the activities people preferred were looking at the world map, identifying which country people came from, as well as watching films about these countries. The diaries also show that, over time, members became more confident and interested in asking visitors about their country and culture: some asked guests questions about some aspect of their culture or religion, in one case also asking how people with a learning disability were considered.

One group has decided to try different food and restaurants as part of their meetings and is writing a local restaurant review. Originally, they had chosen to go to traditional outlets but, with encouragement, they tried other options and are even bringing in recipes from their own culture for others to try. After a trip to an exhibition about Ghana, one person commented that it was a shame they had not talked to someone from that country.

Reports from diaries show that members now expect the world map to be available at each meeting and that they will meet people from different cultures and countries. Over time, many would enquire in advance about the theme of each meeting. They developed an awareness of the importance of culture and origin and understood that this was a subject many people liked to talk about. This, in turn, gave them confidence to talk about themselves as shown in the next section.

Most supporters reported that attending the group had had an effect on their practice and one commented, “it has helped to raise my awareness of how important it is to support

people to explore their background, culture and custom, and respect differences. It is important to ensure people have opportunities to do this". One day-service attended by a group member felt inspired by the experience and is now running its own cultural diversity group. The service reported that diversity had become much more a part of their work and that even people in a 'nature group' were asking questions about where different plants grew and were pleased to find out when it was a country someone at the centre came from.

Are participants showing pride in their own culture?

The interviewer noted that activities that encouraged identification with the country of origin appeared to be of greatest importance to individual members. His conclusion from the interviews was that the group related to issues that were important to members and provided a 'me-time' that was not usually available in traditional services. The diaries consistently contain reports of members spontaneously asking others where they came from and talking about their own origins. One member, on returning to his day-service went round telling everyone where he came from and the centre manager described him as "beaming". On an outing, this same person engaged in conversation with a shopkeeper about countries of origin and explained where he, as well as other group members, came from. This person does not usually communicate easily and has a speech impediment when pressured.

The group has also provided members with opportunities to use their first language. Brown (2008) found that this had been very welcome by group members and allowed "true feelings and expression to show" (p.19). At Proud2B meetings, guests were invited who spoke the languages of the members. Facial expression of contentment was clearly evident when conversing in first language. One of the supporters reported

that he felt much more proud of his own background and said, "I feel privileged to be different". This shows that such groups, set up primarily for service users, may also benefit staff and demonstrate commitment to equality and diversity, as well as promote harmony within the workplace.

Effect on self-confidence and social activities participation

The interviewer reported a mutually-supportive relationship within the groups. In his view, this helped to raise members' confidence while all supporters reported participants becoming more confident. One commented "participants appear to be growing in confidence. I believe this is due to the groups' activities and the interaction/socializing of participants". Diaries show that confidence took time to develop but, slowly, members became more assertive when talking with visitors or when on visits, interacting with the public or shopkeepers. They developed confidence to take their place in society, living the same lives as everyone else: they queued to buy tickets, they bought refreshments and souvenirs, and they chatted. Some members also became much more confident in visiting the different food outlets where they live.

A wide range of local community members are regularly invited to talk about their culture and run workshops for the group. On one occasion, this resulted in a guest being invited to the 'women's group' the member belongs to. Community members have also been invited to take part in an oral history project one of the groups had been involved with. Diaries show that community guests often express their surprise at how much they enjoy the visit and confess to having been slightly apprehensive to come. One also commented how useful this had been for her as she did not know what the words 'learning disability' meant when she had been invited. Another became very interested when Proud2B members explained to him what an advocacy service

was. This clearly illustrates the advantage of inviting local community members to visit the groups. Inviting them to share their culture or to join the group in projects linked to culture and heritage is usually well-received, and even empowering (Ruiz, 2004). This is a much more positive engagement approach than simply distributing leaflets or giving presentations. Through their visit or participation, community members increase their understanding and awareness of the availability of support for people with a learning disability in this country and, maybe, start overcoming their own pre-conceived ideas and fears. It is hoped that they take this knowledge back to their own community where it could help to encourage more people from minority backgrounds to ask for the support they need.

Specific celebration events provided unexpected opportunities to engage with families. One parent helped with one of these by suggesting recipes and, in the questionnaires, three parents stated that they would be happy to help occasionally. In the oral history project, family and community members were interviewed around the theme of 'Favourite Places'. This provided an opportunity to learn to use new recording equipment and also to find out about people's stories and why they now live in Hampshire.

Conclusion

The Proud2B groups appear successful for the individuals taking part. However, the small sample in this study means that the findings cannot be generalised nor considered predictive. It is also important to remember that, in Hampshire, diversity is lower than average. There are few service users from a minority background but, at the same time, there is a great variety of countries of origin. As a result, families are isolated, there are few community groups and service users seldom have an opportunity to celebrate their ethnic

background. This will, no doubt, have influenced the findings of this research. Nonetheless, there is evidence that participating in the Proud2B group has had a positive effect on members' lives. It has resulted in enjoyment, increased awareness of and interest in diversity, heightened sense of self-pride and confidence and increased participation in social activities. This indicates that groups of this type could be beneficial in achieving similar outcomes for other people with a learning disability from a minority background. There is also evidence that the groups have brought bonus effects for staff in their support for members and in terms of professional practice. This could be of interest to service providers. Finally, the research has shown how such groups engage positively with families and the wider community.

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Notes on Contributor

Dominique Rawlings has been working for Hampshire County Council for over 10 years, first in children services and now in adult services. Her background is in education and, as part of the Ethnic Minority and Travellers' Achievement Service, she ran several projects aimed at community engagement and, in particular, improving parents' skills to support their children. In 2005, she set up the Ethnic Minority Learning Disability project for Hampshire Learning Disability Partnership Board in response to the Valuing People agenda.

Address for Correspondence

Dominique Rawlings
Hampshire County Council
Learning Disability Commissioning Team
133 Stoke Road
Gosport
PO12 1SD

Tel: 075 15 084 083

Email: Dominique.rawlings@hants.gov.uk

Book Reviews

Critical Practice in Social Work

Adams, R., Dominelli, L., & Payne, M. (eds.)

Basingstoke: Palgrave Macmillan, 2009, pp.429, ISBN: 978-0-230-21863-5, £23.99 (pbk.)

Forming the second part of a trilogy of connected texts edited by this familiar trio of highly respected authors (the others being *Social Work: Themes, Issues and Critical Debates* and *Practising Social Work in a Complex World*) this new edition of *Critical Practice in Social Work* reasserts its intention to support the learning of social work students in the middle of their professional qualifying degree in social work. Following the theme of trios (three books, three authorial editors) the book itself is in three parts, set out in the Introduction as: *exploring how values affect your personal and professional development* (Values into Practice, Part One); *surveying the main theoretical perspectives on, and approaches to, practice* (Theories for Practice, Part Two); and *studying in more detail particular areas of social work, from the viewpoint of how you develop your critical practice* (Developing Critical Practice, Part Three).

As can be seen above, the book addresses the student directly and sets out its stall as being the core text for the student journey through the middle year of the qualifying degree. Does it match up to its aspirations? To answer simply the rhetorical question: yes it does. Like a compilation album of multiple tracks, the overall impression is one of comprehensive coverage and cohesive value to the reader. Explored in terms of 'Values into Practice' in Part One, the theme of 'academic criticality' runs through the book and acts as a springboard for becoming a 'critical reflective practitioner'. This message is clearest, and most effectively communicated, in Part

Three of the book, where the 'protocolization' of practice (to quote Munro, 2004) is exposed in relation to a broad range of service delivery contexts.

In spite of the seemingly inexorable march of rational-technical management of social work processes in much of contemporary local authority practice, social work students on qualifying degrees are still, thankfully, required to explain, analyse and justify their practice in terms of theoretical frameworks and paradigms. The constituent chapters in Part Two are therefore most instructive for the student searching for clear, coherent signposting summaries of the most common approaches. In order to reflect and mirror the theoretical frameworks being attached to contemporary settings, the editors might have included chapters on Crisis Intervention and Solution Focused/Strengths Based Work, particularly as these models have such evident currency in Mental Health and Family Support work. Furthermore, it would have been helpful to separate and distinguish between - as has been done by many established authors (such as Sibeon, 1989) - theories *for* social work understanding and theories *of* social work intervention. In spite of these minor criticisms, this section offers the reader accessible and easily applied examples of theoretically informed critical social work practice, written by authors notable for their expertise and their proven capacity to communicate and explain.

Part Three takes the student into the realms of practice scenarios which, whilst necessarily general, cover the future employment settings for most registered social workers. The range of practice examples has been expanded for this edition and it is particularly pleasing to see the sphere of palliative and 'end-of-life' practice being given due regard as an area of specialism.

Some publishers are sceptical of the value of edited texts, being unconvinced by the effect of having such disparate voices within one volume. This could well have been a problem here, given that there are 33 authors at work in this publication. However, this proves to be an unnecessary concern. Through the adoption of a standard format for each chapter and with the help of careful editing, the text hangs together beautifully, being strengthened by the expertise and self-evident passion of many contributing voices.

Effective, critical social work is necessarily an improvisation, like jazz, built up during the moments of performance, in the unique style of the performer, but around a theme, a prescribed structure. Once such capacity for spontaneity is eradicated, one is merely left with procedurally driven, formulaic reproduction, 'following the score'. This book makes a significant contribution to helping fledgling practitioners find their reflective critical voice which can only be to the good of social work itself.

Nigel Horner

Deputy Head, School of Health and Social Care
University of Lincoln

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Social Work with People with Learning Difficulties

Williams, P.

Exeter: Learning Matters Ltd, 2009, pp.167, ISBN: 978 1 84445 215 6, £17.00 (pbk.)

People with learning difficulties deserve an ordinary life. To be seen and treated as equal to others and to be afforded the same opportunities, rights and respect in the 21st century continues to present a challenge for many disabled people. Realising this goal is not dependant solely on political will through legislation. For disabled people, a deep rooted recognition of their equal place in society goes beyond the creation of legal structures as means of enforcement. To be treated as equal through the social care system relies upon the creation of informed social work practitioners who see things from their client's perspective, using mechanisms which enable the person being served to shape practice. This book sets out to help social workers and social work students to develop knowledge and skills of practice which equip them to work with disabled people.

The first set of chapters (One and Two) detail the complex notion of how one may define learning difficulty, alongside the historical developments which have informed the way disabled people have been seen and treated in the UK. Both chapters are descriptive and reflect the author's ambition for the book to be of practical use – he makes the point that, as the aetiology and definition of disability are socially constructed (and therefore contested), readers should look to other published sources for a more critical view.

The practical nature of this book is a positive feature. Social workers and students will value the approach adopted by the authors. The main elements of social work activity such as care planning and co-ordination are discussed in chapters Three, Four and Five. Here a more contemporary model is offered. Readers are provided with

scenarios through which to work. These are intended to help practitioners consider alternative ways of understanding the needs of disabled people where a proxy is no longer acceptable. The most effective section is Chapter Five. The role and nature of assessment are explored within the confines of policy-driven assessment strategies indicative, one might suggest, of the neo-liberal position.

The book is easy to use. A variety of case scenarios are dotted across the chapters to help social workers consider ways of working with learning disabled individuals, their families and others in their lives.

The book offers a wide range of well-researched resources which accompany suggested activities. These are all geared towards helping the practitioner improve her or his perception of what really matters to people with disabilities when carrying out their statutory social work duties.

The book has the potential to become an essential text for social workers occupied in services for people with learning difficulties. This is, in most part, due to the way it creates knowledge for practice.

The seven chapters are interrelated and all use the key theme of human value to challenge social care practices, offering social workers and those in training ways of working which value the individual by promoting user involvement. Each chapter is dedicated to demonstrating how its central themes can support social workers return to more traditional, value-based practice.

The final two chapters review the function of care management. The needs-led approach to planning and commissioning is examined against alternative models such as person-centred planning, brokerage, life histories and risk assessment. This is an excellent section.

Although not particularly political or analytical, the author does offer opportunities for social workers to develop more creative strategies in identifying need beyond a process-driven methodology.

There is, undoubtedly, an expectation that students and social workers will need to build on their understanding with further reading. Every chapter concludes with suggested further reading. However, in summing up, the authors should be complimented for what is an excellent contribution to social care practice.

Tony Bottiglieri

Senior Lecturer, Faculty of Health and Social Care
Anglia Ruskin University

Big Steps for Little People: Parenting the Adopted Child

Foster, C.

London: Jessica Kingsley, 2008, pp.216, ISBN: 9781843106203, £12.99 (pbk.)

This book provides an excellent insight into the experience of adopting children from the perspective of one particular set of adoptive parents. In doing so, the book raises some pertinent issues such as: parenting a child who has a separate family history; the grieving process that may arise; and acknowledging the role emotions play in family behaviours.

The main theme of Chapters One to Three is how to create a sense of continuity for adoptive children. The reader is encouraged to imagine how it may have felt to live in the birth family of the adopted children. The detailed description of scenarios from the children's life history invites the reader to empathize with what children may have experienced prior to coming into the adoptive family context and how this history may affect their ability to adjust to the permanent adoptive family context.

Pragmatic advice is offered on how to respond to some of what the author describes as “the realities of the settling in period” (p.48).

Chapters Four to Six discuss the importance of setting age-appropriate tasks. Foster describes the centrality of working together as a team and discusses important issues such as how to deal with friends, friendships and the notion of identity. The grieving process associated with adoption is addressed along with the different stages or steps that the adopted children may experience. The author introduces the concept of ‘reframing’ which emphasizes the importance of creating a context where the children may unlearn the conditioning experienced in the birth family environment.

Chapters Seven to Nine address issues around the birth family history. A prominent theme is the importance of being open and honest to the children about what happened to them and explaining why they had been taken into care. The chapters also provide some insights into the adoptive parents’ experience of using therapeutic services for their children.

Chapters Ten to Twelve discuss the importance of understanding that difficult behaviour in the adopted child may be linked with issues of power and control. Foster explains how these issues of control may be linked with early survival strategies devised within birth family environments and discusses how a state of fear may arise when the children experience a sense of loss of control over a situation.

Chapters Thirteen and Fourteen describe real-life examples of problem-solving that link in very well with more in-depth discussion on the importance of communication, listening and raising awareness of the power of language. The importance of confidence boosting is outlined and other mechanisms for raising

levels of self-esteem in the adopted child are described.

Foster puts forward a convincing and useful account of how they attempted to create an environment that would allow the child to ‘grow’. She imparts some particularly useful advice for adoptive parents on how to help children make sense of their past. She also argues that, through verbal reiteration of a set of new ‘core beliefs’, the child was able to potentially move away from historic conditioned responses. Whilst the use of behaviour charts, progress charts for school and rewarding ‘nice’ behavior, provide useful practical responses to challenging behaviour, these tactics perhaps assume an overly specific understanding of how and why particular behaviour emerges.

It may also be relevant to consider that the use of the behaviour management strategies articulated by the author may lead to individualizing the reason for the adopted child’s behavior and subsequently place too much responsibility on the adopted child to adjust their conduct accordingly. There are a myriad of reasons that may lie behind particular behavioural difficulties. These might not always be understood or articulated by the adoptive child and the reason for their origin may be something that is felt in the environment in which the child is situated. I would therefore have liked to have seen more discussion of behaviour being understood as an inter-subjective process rather than as something that, as the book implicitly suggests, resides inside the adoptive child and is attributed to their birth family history and subsequent adoptive status.

The book would be enhanced by incorporating some more in-depth, critical reflection on the emotional response of the adoptive parent which (similar to other parents) can often be found in the tension between what one would hope to feel as a parent and what one actually feels - such as rejection by their adoptive children even

after all reasonable behaviour management strategies have been implemented.

The book provides a valuable compendium of ideas and strategies. However, it is culturally specific, leaning towards a Western, white, middle-class and gendered norm of how family life should be performed or conducted. Perhaps a more nuanced and subtle understanding of the dynamics around identity, care, membership and love within the adoptive family might have been developed. Nonetheless, this is an important and welcome text that deserves to be widely read by professionals and parents.

Cecilia Love

PhD student, School of Social Sciences
Cardiff University

Anti-Social Behaviour

Millie, A.

Maidenhead: Open University Press, 2009, pp.226, ISBN: 978-0-33-5229161, £20.99 (pbk.)

This is an exhaustive account of the concept of anti-social behaviour, measures taken against it and the varied circumstances of the activities that attract this label. Alternative perspectives are offered. The mushrooming literature is comprehensively reviewed.

Andrew Millie provides a handbook which will undoubtedly attract a student readership and others who, with the help of the extensive bibliography, will want to verify or probe particular aspects. Although the author provides little that has not been presented elsewhere and the text is over-weighted with detail, it is nevertheless a valuable addition to the large library on this subject.

So what is the subject under review? As Millie shows from the outset, anti-social behaviour is a contested label, stretching

over disturbances in public space, environmental eyesores and intrusive noise, as well as bullying and harassment within neighbourhoods. The latter was what sparked the political crusade culminating in the introduction of the much criticised anti-social behaviour order (ASBO) but its use, and that of other measures to curb uncivil behaviour, have since stretched to a multitude of phenomena which have been deemed to cause, or potentially cause 'harassment, alarm or distress'. From fly-tipping to poor parenting, from drunken behaviour in town centres to children playing football in their own street, there is, seemingly, no end to the activities punished or controlled in the name of preventing anti-social behaviour. There are many absurd examples, such as that of a suicidal woman given an ASBO forbidding her to go near lakes and rivers.

The book gives a thorough account of government initiatives and legislation in this field, but makes a plea for greater tolerance of diverse activities and wants local people to have a greater say in what is or is not acceptable. However, Millie fails to acknowledge the extent to which local practices vary, both in the use of ASBOs and the development of less punitive options for controlling uncivil behaviour. His statistics do not reveal the sharp fall in ASBOs imposed (especially those attached to a criminal conviction) since 2005. At the risk of crowding his text still further, he could have made more of the key role of social landlords in curbing anti-social behaviour and the extent to which informal methods, such as visits and warning letters, have been found sufficient in the great majority of cases involving social tenants.

Millie is rightly concerned at the extent to which concerns about anti-social behaviour, and measures to deal with it, have focused disproportionately on young people, with 'youths hanging about' (so what?) a favourite source of anxiety expressed in the *British Crime Survey*. Only very recently

has the survey tried to pin down how far the actions of groups of teenagers, as opposed to their mere presence, have really provided cause for complaint.

It may seem unfair to complain about the excessive detail in this book and then to pick on aspects which have been ignored or underplayed. What we have is a conscientious account of the British obsession with anti-social behaviour in terms of both theory and practice, which does not ignore the unacceptable problems in certain neighbourhoods but attempts to promote ideas of mutual respect and reciprocity – not unlike declared government policy but shorn of its punitive overtones.

Elizabeth Burney

Senior Research Fellow, Institute of Criminology
University of Cambridge

Kinship Care: Fostering Effective Family and Friends Placements

Farmer E. & Moyers, S.
London: Jessica Kingsley, 2008, pp.253,
ISBN: 978 1 84310 631 9, £22.99 (pbk.)

When I became a *Guardian ad Litem* in the 1990s the importance of valuing the resources of families of origin was considered a primary aim in securing a child or young person's best interests and future well-being. Yet, on many occasions, I discovered that birth relatives who had been prepared to care for children had been passed over in favour of unrelated foster carers. Where kin placements existed, these were usually as a result of families making arrangements between themselves in fraught situations. Social care services became involved after the event.

This book provides an extensive study into a neglected area of research. Drawing on evidence from practice, it should support

much needed development in this area of work. It uncovers the myths, realities and impact of kinship care on families, on social workers and on children and young people themselves. The book is split into three parts. Part One provides an introduction to the research design and methodology. Here, consideration is given both to family and friend care arrangements and how placements come to be set up. In some cases, this is by children and young people themselves. Part Two gives a comparative analysis of kinship and unrelated foster care, looking at sustainability and outcomes of arrangements for children and young people. Unsurprisingly, findings indicated that kin carers seemed significantly disadvantaged when compared to unrelated foster carers. This was particularly true where resources and foster care support were concerned. This part of the book gives a much needed insight into family and friend carers and children's needs, as well as looking at the various advantages and disadvantages in related and unrelated placements. Part Three examines practice relationships within family and friend care, including standards of care and the quality of social and financial support. There are both excerpts from, and analysis of, interviews with children, young people, carers and social workers. In the final chapter, consideration is given to implications for policy and practice.

Practitioners looking for some guidance for their own cases should find Part Three particularly helpful as it brings the research alive. There are interviews with carers, social workers, children and young people who all share their experiences of the impact of kinship care on families. There are clear implications for practice here. For hard-pushed practitioners with little time to read, this part of the book provides a valuable insight. Social workers may well recognise dilemmas. This may provide them with ways to reflect on and reframe their practice. I appreciated the evidence-based approach. It makes the book, in my view, of

good practical value to practitioners and managers.

The authors bring together much needed research. They also demonstrate the confusion and lack of knowledge about how to manage and support family and friend care for children and young people. The book lays out clearly the issues for the practitioner, looking at what family and friend carers need and want from services in order to secure the best possible outcomes. Because much of the research is based within practice experience, it provides persuasive evidence from which to develop knowledge.

Debbie Amas

Senior Lecturer in Social Work
Anglia Ruskin University