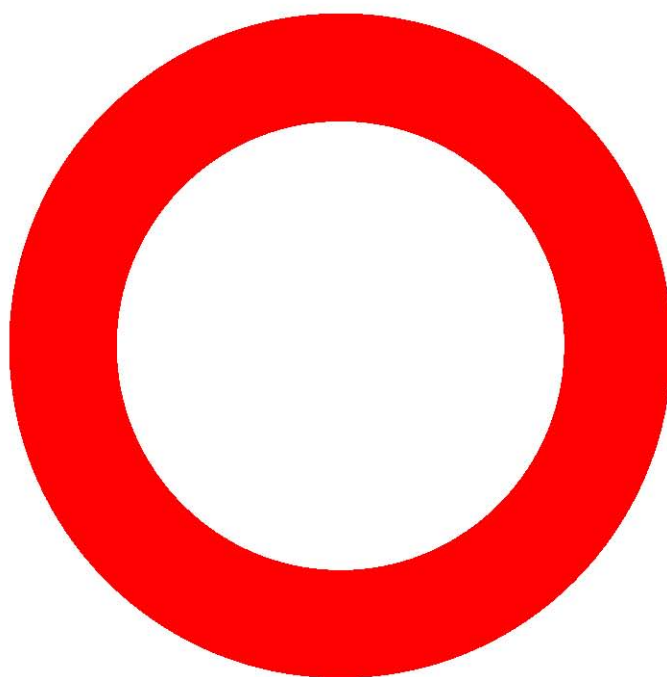


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Guest Editorial

Welcome to the bumper second/third edition of Volume 25 of the Journal. This combines selected Annual Workshop papers in 2007 with additional articles, and completes the three editions for Volume 25. Publishing the plenary and workshop presentations helps disseminate the messages delivered at the Annual Workshop and is also an opportunity to explore some of the themes in more depth. This is a great way for SSRG to maximise the impact of the event and is a model we intend to repeat for papers from future workshops. The overall collection of papers makes for a varied and valuable double edition and brings us back up to publication schedule for 2008.

Partnerships and the use and production of evidence are key themes in several of the workshop papers. The first two articles by Sue Balloch and Helen Dickinson focus explicitly on theoretical and methodological issues around partnership working. Both papers stress that 'partnership' has been one of the defining characteristics of New Labour's approach to public services and both papers also note that there has been little research evidence to support this intuitive, common sense idea about the value of collaborative working. Sue Balloch explicitly links various theoretical approaches to researching partnership working whilst Helen Dickinson's paper describes key concepts and mechanisms to identify and tackle the challenges of evaluating partnerships, such as the huge range of partnership arrangements, the difficulty of identifying outcomes and measuring whether a partnership has helped generate improvements in outcomes.

Clive Downs' paper outlines a specific application of complexity theory as a way of understanding some of the difficulties in researching partnerships and other complex organisations involved in delivering social care. The paper offers a fascinating and innovative approach to thinking about and researching partnerships and large organisations in social care, which can appear to contain virtually autonomous entities operating within them.

Andrew Kerslake's timely and detailed paper on commissioning also has relevance for partnership working, in focusing on the ways in which Local Authorities and Primary Care Trusts can develop an holistic understanding of needs in local areas. This paper also very usefully points out the value of research and other knowledge as the 'jam in the commissioning sandwich' essential to informing commissioning behaviour at a macro and micro scale. He then goes on to describe a range of issues and themes relating to the kinds of research and population data that can generate essential knowledge for commissioners.

The final article from the workshop, by Jess McEwen, describes a partnership between the University of York and Wakefield MDC. This was set up to support the implementation of Research Governance and to develop research culture in the local authority. Central Government has supported this Knowledge Transfer Partnership, in the form of funding and training from the Department for Transport. It sounds like a model that could well be followed by other authorities: it brings together the two key themes of the workshop papers (partnership and evidence-informed policy and practice).

Our additional papers in this edition offer a range of valuable practice, policy and conceptual insights into aspects of child protection, child and adult disability and domestic violence that have been under-researched and insufficiently discussed. Phil Prescott and Mike Hartill describe the development of child protection policies by sporting bodies, focusing on UK Rugby League, and argue for a clear policy initiative developing this aspect of safeguarding

children. This is a topical issue and provides a valuable example of the fast-dispersing boundaries and responsibilities around the safeguarding of children and young people.

Children's needs and related research practices also underlie the article by Debbie Kramer-Roy. She outlines how Pakistani families are often disadvantaged in multiple ways and how a climate of fear and discrimination against Islamic people exacerbates entrenched deprivations and poverty. All of which has increased the problems faced by Pakistani families of disabled children. The article calls for an emphasis on emancipatory approaches to research which can help families understand and advocate for their own needs.

The volume is brought to a close by an important and compelling paper on disability and domestic violence. The article by Joy Trotter, Jill Radford and Lynne Horne, both argues for and reveals the value of research in helping disabled women who experience domestic violence overcome barriers to accessing services. The paper offers a number of conceptual insights into the social, legal, organisational and research challenges that collect around this relatively neglected area of need.

It is very gratifying to see, in this edition of the Journal, the interface between academic theoretical thinking and applied research into pressing issues of practice and policy. There are few opportunities for such work to be published in a Journal that reaches such a broad practice and academic readership. Being able to present such links is one of the key strengths of a Journal such as RPP, which sits very squarely on the boundary between these two worlds.

Martin Stevens, Chair SSRG
December 2007

Researching partnerships: politics, ethics and pragmatism

Sue Balloch, Professor of Health and Social Care, University of Brighton

Abstract

This paper explores some of the political, ethical and practical issues encountered by researchers in studies of partnership. It briefly reviews different types of research and evaluation and the extent to which these have been politically driven. Because much partnership research is both atheoretical and ahistorical, this paper considers some of the implications of applying different conceptual frameworks, such as systems theory, complexity theory and network theory. It concludes that without more strategic steps from central government to address entrenched inequalities, much partnership working is likely to remain ineffective in improving people's lives.

Keywords: Partnerships, user involvement, complexity theory, networks, communities of practice

Introduction

Although collaborative or joint working was a feature of government policy throughout the 1990s, the emphasis after 1997 can be seen to represent a 'paradigm shift' in thinking about the delivery of welfare (Newman, 2001). When Marilyn Taylor and I embarked on editing a collection of papers on partnership working in 2000, we probably underestimated the popularity of the political ideology on which the concept was based, not expecting the book to be reprinted for a second time in 2007 (Balloch & Taylor, 2001). It is worth reflecting on the reasons for this.

Firstly, there is widespread acceptance that partnership is preferable to the unfettered workings of the market; secondly, the logic of partnership, in terms of value for money and seamless working, appears self-evident; thirdly, advances in information technology support the idea that partnerships are now easier to develop because information can be safely and easily shared; fourthly, bringing all stakeholders together and breaking down professional boundaries through inter-agency working seems bound to benefit those using services. Finally, partnership is seen as a way of involving

consumers/citizens in service delivery and empowering them by giving them greater choice and control over those services they receive. That there is fairly limited research evidence on which to base such thinking has gone almost unremarked.

In 2000 a systematic review of joint working identified just thirty two studies out of the 491 considered which demonstrated relevant research (Cameron *et al.*, 2000). It noted three major research categories which included organisational issues such as aims, roles, support, communications, co-location, resources and past history; cultural and professional issues including stereotypes, trust and respect, joint training and differing ideologies; and contextual issues such as political climate, constant reorganisation, coterminosity and financial uncertainty. A more recent survey focusing on strategic partnerships for children (Percy-Smith, 2005), created a slightly different typology of research and evaluation into partnerships including research and evaluation reports, analysis of cross-cutting issues, e.g. inter professional working, toolkits and guides, and theoretical overviews and syntheses. Both of these reviews reveal, unsurprisingly, that it is much easier to research process and context than outcomes.

Available research tends to be focused on the voluntary and statutory sectors, particularly those involved in health and social care, and this is what this paper will consider. This is not to disregard some interesting material on public/private partnerships such as in Glendinning *et al.*'s edited collection (2002) in which Rummery observes that government has little power to enforce partnership working on private companies. Rummery also notes these are usually in the most powerful position in any partnership arrangement, they are more likely to profit from a partnership than the public sector. It does seem surprising though that there is little research into collaboration between private and public agencies in those social services in which the private sector is the majority provider, i.e. in residential and home care.

Most relevant research reports have been initiated and supported by central or local government departments or health agencies, suggesting an urgency to evaluate and confirm the validity of a 'partnership' approach. There are some who would argue, of course, that research and evaluation are two different activities, often because they ask rather different sorts of questions, but I would argue that 'evaluation' is a creditable type of research when carried out according to accepted canons of validity using both quantitative and qualitative approaches. Examples of major, national evaluations of initiatives in which partnership is a central ingredient include the evaluation of neighbourhood renewal projects (Beatty *et al.*, 2007), Sure Start (Tunstill & Allnock, 2007) and the Children's Fund (Barnes & Morris, 2007). There is much of interest to be found in these.

National evaluations usually define a set of indicators by which to measure progress. Ambrose (2005) has, however, challenged the validity of these national indicators for defining local progress by showing that mandatory indicators are often poorly

related to what residents of regeneration areas really want. Indicators suggested by local residents related to areas left out of the national evaluation, such as substance misuse, bullying and harassment, childcare, and difficulties with benefit agencies. These were issues neglected by the national evaluation but which local people felt, if resolved, would make a great difference to their quality of life. To measure the effectiveness of partnership working in the East Brighton area, Ambrose used three types of indicators related to structure, process and outcomes as defined by the community after fully participative discussions.

These categories were similar to those used in the national evaluation of Sure Start. Sure Start had a high rate of inter-agency involvement, including staff from primary care trusts, education, social services, voluntary organisations and the community. Surprisingly, however, 25% of its case study areas lacked any existing arrangements for partnership working. A literature review undertaken for the Sure Start evaluation focused on joined up working with children and families, multi-agency working and multi-disciplinary work in the context of child protection. It noted the importance attached to the following seven characteristics of effective partnership working:

- *Clarity and agreement around respective aims and objectives;*
- *Transcending barriers generated by traditional ways of working;*
- *Strategic level commitment;*
- *Clearly identified roles and responsibilities;*
- *Protocols and procedures for information sharing;*
- *Co-location of services;*
- *A robust training strategy.*

(Tunstill & Allnock, 2007, p. 11)

Using case studies in four local authorities, Tunstill and Allnock explored the ways in which these aspects of good practice were developed in the early stages of the *Every Child Matters* change programme. Regardless of the style of model each local authority adopted, all found that forging inter-agency links was a very complex process dependent on efficient 'complementary methods' around assessment and recording. They also found that the costs of involving, training and supporting experienced staff in partnership working were very high.

Theorising partnerships

Research into partnerships has, with some justification, been criticised for being theoretically underdeveloped (McDonald, 2005). One way of theorising partnerships, as McDonald emphasises, is to see them as part of a new, networked form of governance in which the emphasis is on user empowerment and citizenship. McDonald quotes Newman's fourfold model, each aspect of which is based on a particular form of power, as in: the hierarchy model of quasi-partnership, the rational model of strategic partnership, the open systems model (which lies between a strategic and a communicative partnership), and the self-governance model which is a fully communicative partnership (Newman, 2001). McDonald's purpose is to challenge the rhetoric that surrounds partnership, particularly in relation to empowerment within communicative style models.

Rummery's conclusion - that partnership working often strengthens the hand of the state or of the most powerful in a partnership and is not necessarily a feature of networked governance - resonates with this. She found "little evidence to suggest that partnership working delivers improved services to users" and that it could sometimes even have a negative effect (Rummery, 2002, p. 243). This view has been more recently reiterated in a themed

section of *Social Policy and Society* (April 2006) which points to the lack of any substantial body of empirical work showing that welfare partnerships lead to improved outcomes for users and communities. It also confirms the difficulties that partnership working has in putting user and carer engagement at the forefront of activity (Hudson, 2006).

One of the problems here is that definitions of outcomes continue to prove elusive. It is not just that different groups have different aspirations, as shown in Ambrose's (2005) research, but that outcomes are complex and require lengthy periods for assessment. There is also a tension between quantitative and qualitative assessment of outcomes, with the former preferred by statutory bodies even though they may be based on arbitrary statistics rather than on the views of professionals and service users. Even more difficult is ascertaining the extent to which an outcome is the result of a partnership or of some other influence.

Another approach, typified by Pratt *et al.* (1998), is to see partnerships in the context of whole systems along a spectrum in which relationships may range from purely competitive to co-operative, co-ordinated or totally integrated, with most partnership arrangements sitting somewhere in the middle and few genuinely sharing aims and pooling authority. Their categories, as in Newman *op cit.*, give us some useful tools for judging the extent of partnership working, particularly how far goals are shared and help to dispel some of the euphoric myths about what 'partnership' means.

Complexity theory

A further interesting approach can be derived from applications of chaos and complexity theory (see Downs in this issue). Chaos theory recognises how very tiny changes in initial conditions can, over time, create large-scale change. Similarly,

complexity theory emphasises the unpredictable nature of systems and is interested in the ways in which non-linear change and emerging new forms of order are based on a complex of interests.

When evaluating partnership working we nearly always think in terms of the interlocking of different 'systems' – health, education, social services, etc. when, in fact, these so-called systems are in no sense clear and comprehensible to those working within them, let alone those outside, and often defy clear description. What we think of as a system is much more likely to be a very complex arrangement of different parts that may work together under one label but are very often not co-located nor even cognisant of how related agencies work.

An evaluation of the ways in which 'winter pressures' moneys were being spent in West Sussex provided a good example of this. To try to work out how these moneys were being spent, let alone to see if they were producing good outcomes, we had to produce maps of hospitals, social services areas, step up and step down beds, home care services and so forth which surprised the staff, let alone ourselves, in their complexity (see Balloch *et al.*, 2005). Such complex systems are known to place "more importance on the individual actor and the constant creative feedback between system and individual" (Haynes, 2003, p. 26), with particular significance attached to leadership and to trust. Research has not really focused on these two factors in any detail although there is some data on increased trust in services in the neighbourhood renewal evaluation by Beatty *et al.* (2007).

Network theory

Network theory has been applied to the study of partnerships. Looking at partnership working in Scotland, Hudson (2007) identifies three types of network associated with increasing degrees of complexity – integrated pathways, managed

clinical networks and managed care networks. He argues that the current trend in Scotland is towards networks of high complexity which cut across organisational boundaries and have a whole person, whole system focus in a firmly mandated relationship. Managed networks require both top down management and bottom up participation, with leadership that inspires commitment and good relationships, but remain as virtual organisations rather than creating another tier of bureaucracy. Here again, however, there is little real research evidence that networks are effective. Evaluation could be based on their contribution to communities and individuals, retention of membership, range of services covered, strengths of relationships, efficiency of the 'network office', and extent to which they meet the needs of participants.

Communities of practice

The concept of 'communities of practice' is closely related to network theory although derived from thinking about knowledge management and learning (Wenger *et al.*, 2002). The development of such virtual communities can be attributed firstly to information technology, with the web allowing knowledge transfer on an unprecedented scale, and secondly to interest in recognising that knowledge is a strategic asset. Such virtual communities evolve when there is a shared agenda of which different individuals and agencies are supportive. They challenge conventional boundaries and encourage individuals to look afresh at their ways of working. We have found the concept valuable in both developing and evaluating Brighton University's Community University Partnership. As Hart and Wolff (2006) observe:

(the) analytic focus on practice, rather than organisational or even physical locality, helps us pay attention to what people actually do, or can do, for

relationships and projects to move forward. Hence a shared passion is identified as a helpful force in cultivating shared working, in contrast to, for example, formal organisational teams where job requirements are the drivers. (p. 130)

As with complex networks, strong leadership, equal participation and trust developed between participants are essential ingredients in sustaining the community. There is a tension here in regard to how organisations may develop and provide support. Ideally they will facilitate the growth of the community, providing the essential time, technology and travel costs needed, but not trying to institutionalise and control it. This supposes a willingness to co-operate and withdraw from competition on the part of those involved which is not always present.

Edwards (2007) has drawn on the National Evaluation of the Children's Fund (NECF) (2003-2006) and an ESRC-funded Interagency Working Project to explore interagency collaboration aimed at early interventions with vulnerable children and young people. The Fund's aim was to achieve prevention through partnership working and participation while the project's aim was to look at how professionals learnt to work collaboratively to prevent social exclusion. As in the communities of practice analysis, Edwards focuses on the range of professional knowledge distributed across organisations. She emphasises the importance of making expertise both public and accessible, "eroding the mystique of specialist professional knowledge" (p. 261) without demanding a move to an all-purpose type of practitioner. Her findings from the NECF were positive:

In NECF we found aspects of this form of negotiated responsive and adaptive practice. We observed practitioners who were hacking new local trails along

which they were guiding children and families so that they could access the expertise of other professionals. We also know that these trails were given impetus by the way the Children's Fund workers brought practitioners together to discuss their work and the resources they had available. (Edwards, 2007, p. 261)

Overall, therefore, the knowledge exchange developed through partnership working was judged to have supported the resilience of children and families.

While it is gratifying, for once, to locate positive and grounded evidence, this should not encourage us to ignore the considerable problems that such communities of practice face. Firstly, they are dependent on being able to exchange knowledge safely and effectively. This requires agreed boundaries of confidentiality, up to date technology, and, in the case of databases, information formatted in compatible and shared spreadsheets. There are numerous examples of the difficulties entailed in the latter.

Secondly, the trust that has to be built between individuals in a community of practice takes time to establish and requires a degree of stability in the workforce. This is difficult when major re-organisations occur with such regularity in health and social care as they do in England. Pollitt (2006), in an unpublished seminar paper, made this point forcefully in an analysis of organisational change in the Major/Blair era, noting:

Few countries could match this talk of relentless re-structuring, partly because there are few countries in which the political and legal procedures for changing the structures of public organisations are so easy as in the UK and so totally within the control of a one-party central executive.

Instability is further exacerbated by uncertain funding for the voluntary sector

and the short-termism associated with many government funded initiatives.

Thirdly, accountability is an issue which communities of practice are not well-placed to address. Line management and responsibility for clients usually remains firmly based in separate organisations. Where priorities and cultures are different, tensions and conflicts can easily arise which no virtual community has the power to resolve.

Ethics and governance

Researching partnerships has become more difficult in the last few years because of the different ethics and governance approvals required. Where both health and social care agencies are involved, permissions are necessary from both Local Research Ethics Committees (LRECs) as well as governance approval. Local authority approval is also required through different procedures. This is very time consuming for researchers and, in a small project, may eat up much of the budget before work has started. In our local area – East and West Sussex and Brighton & Hove – we are, perhaps, more fortunate than in other areas as systems for ethics and governance approval are well developed. Even so, a recent hospital discharge study still ran into difficulties because the only permitted access to those discharged was through hospital staff, with university researchers not allowed to make a direct approach to ex-patients. Unsurprisingly, the response rate for discharged interviewees was poor and it was therefore very difficult to assess the outcomes of joint working for patients. Ethics issues in health and social care research are well documented in Leathard and McLaren's edited text (2006).

Conclusion

While discussions of partnership in academic papers tend to express disillusion with its effectiveness and exasperation with its vagueness, politically partnership has

held its place as a major policy platform. At grass-roots too, many in health and social care have accepted the validity of the ideas in which it is grounded and tried to implement them. Looking just at the distribution of the social work workforce, for example, at least 25% of social workers now work in health settings, compared with a much smaller number in the 1990s. Shared protocols for hospital discharge are commonplace even if not well implemented. Partnership initiatives, such as the Partnership for Older People Programme (POPP) are still getting off the ground. Our Brighton Making Research Count seminars, originally designed for social work staff, are now very well supported by health staff sponsored through SERDSU - the NHS funded Sussex Education and Research Development Support Unit. The significance and depth of recent inter-professional debate on issues such as looked after children, elder abuse, managing change and so forth are impressive and indicate a groundswell of support for partnership working and a belief among professionals that it is improving services.

We should not be misled into thinking, however, that partnerships can provide a panacea for society's ills. A recent report from the Joseph Rowntree Foundation on inequalities (Dorling *et al.*, 2007) showed headline poverty levels rising (headline poor are those excluded from normal social life because they live below a relative poverty line) and socioeconomic and geographical polarisation of the rich and the poor increasing. There are now some city areas where half the households can be described as 'headline poor'. Partnership working in regeneration areas, with children, older people or any other group, can do little to redress such inequalities and is made more difficult by the power differentials that such inequality creates. Without more strategic steps from central government to address entrenched inequalities, much partnership working is

likely to remain ineffective in improving people's lives.

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Evaluating the outcomes of health and social care partnerships: the POET approach

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Abstract

Health and social care partnership working is a central feature of the current government's approach to public policy. Yet despite this, and a proclaimed interest in evidence-based policy, partnerships have not empirically demonstrated that they produce better outcomes for service users. This is problematic because if partnerships are seen to have not delivered, this may result in the concept losing legitimacy in the eyes of the practice community. This paper argues that this may, in fact, be a result of the way in which we have attempted to evaluate partnerships – rather than an indication of the ineffectiveness of partnerships per se. After providing an overview of the various ways in which the 'partnership' label has been used in health and social care, the paper moves on to give an overview of the range of difficulties involved in evaluating partnerships. When it comes to evaluating partnerships the challenge is huge - but not insurmountable – and may involve us asking different kinds of questions about partnerships than have tended to be investigated thus far. The paper then moves on to outline POET (Partnership Outcomes Evaluation Toolkit) which has been specifically designed to determine what kinds of partnership deliver what forms of outcomes, to whom and when.

Keywords: Health and social care, partnerships, evaluation

Introduction

Since the New Labour government came to power in 1997, partnership working stands out as a *leitmotif* of their approach to public policy. Although it has long been recognised that, for particular issues and for certain individuals and communities with complex, cross-cutting needs, the co-operation of a range of agencies might be necessary to address these issues - partnerships have become ever more prevalent over the past decade. A range of policy documents have referred to the importance of health and social care organisations working in partnership (for example, Secretary of State for Health, 2000; Department of Health, 2005a; Secretary of State for Health, 2006) and the government has introduced a range of legal flexibilities (for example, The Health Act 1999) and mechanisms (such as Care Trusts, Children's Trusts, Local Strategic Partnerships, etc.) to encourage public sector organisations to work with others. In

recent years, the collaboration agenda has been further extended, beyond health and social care, to education, housing and welfare. Moreover, the most recent health and social care white paper *Our Health, Our Care, Our Say* (Secretary of State for Health, 2006) also indicates the importance of the involvement of commercial and third sector organisations in addressing a number of the key issues which today's society faces. Sullivan and Skelcher (2002, pp. 25-7) estimate that public sector organisations in the UK are involved in approximately 5,500 different partnerships and that these partnerships might have a total annual direct and indirect expenditure of between £15-20 billion. Whilst an estimate, rather than a precise calculation, and one which is now slightly dated, it cannot be in doubt that partnerships have a significant presence within the public sector.

The legislation which established the welfare state in the 1940s assumed that it was possible to distinguish between people

who are sick (that is, those who have health needs which are met by the NHS free at the point of delivery) and those who are frail or disabled (and are viewed as having social care needs, which fall under the remit of local authority social services and are often subject to means-testing for user charges). Despite a range of attempts to overcome this boundary, this underlying distinction still exists and has resulted in two separate agencies with different structures, priorities, financial systems, cultures and ways of working. This boundary continues to exist today and, although to some extent recent policy has become more sophisticated at hiding and blurring this divide, the government recognises that this boundary still causes significant difficulties for service users, particularly those who access services at times of significant stress or illness (Department of Health, 1998). Thus, partnership working has, to some extent, been seen as the mechanism to overcome the organisational complexities which are inherent within the current health and social care structures.

As well as being firmly wedded to the concept of partnership working, the incumbent government has also made extensive reference to the concept of evidence-based policy. Although evidence-based policy and practice is by no means a new phenomenon within health and social care (see Swinkels *et al.*, 2002), the present government has placed a particular emphasis on this concept. The Cabinet Office states in the Magenta Book (official guidance notes for policy evaluation and analysis), that “evidence-based principles are at the heart of the Government’s reform agenda for better policy making and policy implementation” (Cabinet Office, 2003, p. 17). Tony Blair himself has stated that “what counts is what works” and the government has been quite clear about its intentions to make policy according to what has been proven to work, rather than on the basis of ideological fiat – as the previous government was critiqued for. Given this

dual emphasis on partnerships and evidence-based policy, combined with a recent interest in user outcomes (expressed through such policy documents as HM Treasury, 2003; Department of Health, 2005b; Secretary of State for Health, 2006), it might be expected that partnerships have been empirically demonstrated to improve service user outcomes. Yet a number of evaluations of health and social care partnerships have consistently found little in the way of improved outcomes for those who use services (for example, Peck *et al.*, 2002; Brown *et al.*, 2003; Kharicha *et al.*, 2004; Townsley *et al.*, 2004; Davey *et al.*, 2005). Given the rhetoric about linking partnerships to improved service user outcomes and the central and local efforts that have gone into making a range of partnerships effective, for there still to be a lack of evidence demonstrating their impact for service users might be considered problematic to say the least. Moreover, a range of critical reports about partnerships have served to dent – if not completely destroy – credibility in this concept (see for example, Audit Commission, 2005; O’Hara, 2006; Community Care, 2007) The failure to evidence this way of working runs the risk of it losing legitimacy and professionals becoming disengaged from the partnership agenda.

This paper argues that this lack of evidence in part relates to the scale of the evaluation challenge, rather than a lack of demonstrable evidence *per se*. After defining the term partnership, outlining the scale of the evaluation challenge and the range of critiques which this concept has recently attracted, the paper goes on to provide an approach which is currently being developed and is intended to overcome these evaluative difficulties. The Partnership Outcomes Evaluation Toolkit (POET) is designed to determine what kinds of partnership deliver what forms of outcomes, to whom and when. Furthermore, POET is designed to offer a more nuanced view of the difficulties and challenges

associated with working in partnership and the sorts of support and development mechanisms which are necessary to support and overcome the complexities of working in collaboration.

What is partnership working?

As illustrated above, partnership working is not a new concept and to some extent is a necessary mechanism in order to overcome the structural difficulties associated with the existence of separate health and social care agencies. To this end, partnership is an important concept which aims to bridge the complexities caused by this boundary in terms of policy, practice and services for users. The UK is not alone in affording such a central role to the collaboration concept; in almost every country of the developed world there are problems of fragmentation and a lack of continuity in services for frail older people and other groups with complex, multiple needs (Banks, 2004; Glasby, 2004; Leichsenring & Alaszewski, 2004). Almost irrespective of language, culture, structure, context and funding, within most developed countries there are different services responsible for different aspects of service provision, often with different financial and regulatory systems, roles and responsibilities, and organisational and professional cultures (see Glasby & Dickinson, forthcoming). In pursuit of more joined-up services, a number of models have been developed to promote more seamless care for service users and more effective inter-agency collaboration. Therefore, although partnership is currently a key term within UK public policy, this is a reflection of a much wider phenomenon which is being experienced in many other parts of the world.

The term partnership is used to refer to a range of different forms of relationship or working arrangements within the health and social care arena. Leathard (1993, p. 5) identifies 52 separate terms which have been used to refer to 'partnership', a number

of which are often used interchangeably. No wonder then that she goes on to describe partnership as a 'terminological quagmire'. This plethora of terminology and imprecision of usage poses a potential difficulty, in that it can be problematic to establish what particular way of working is being specifically referred to when the term 'partnership' is used. Much of the established literature on inter-organisational relationships tends to suggest there are three ideal forms of relationship between organisations. These are most commonly referred to as markets, hierarchies and networks (Thompson *et al.*, 1991) although Ouchi (1991) speaks of markets, bureaucracies and clans, Bradach and Eccles (1991) of price, authority and trust, and Mayntz (1993) of markets, politics and solidarity. Rodríguez *et al.* (2007, p. 158) characterise these approaches as: rules (hierarchy); incentives (market); and, interactions (network). Each of these ideal types is thought to be optimal for governing interactions between organisations under different conditions and, consequently, each has different characteristics and behaviours. These ideal types are useful in predicting the behaviours of inter-organisational relationships. However, one of the difficulties with the partnership concept, as it has been used within recent health and social care policy, is that it has been used to refer to *all three* of these ideal types of relationship.

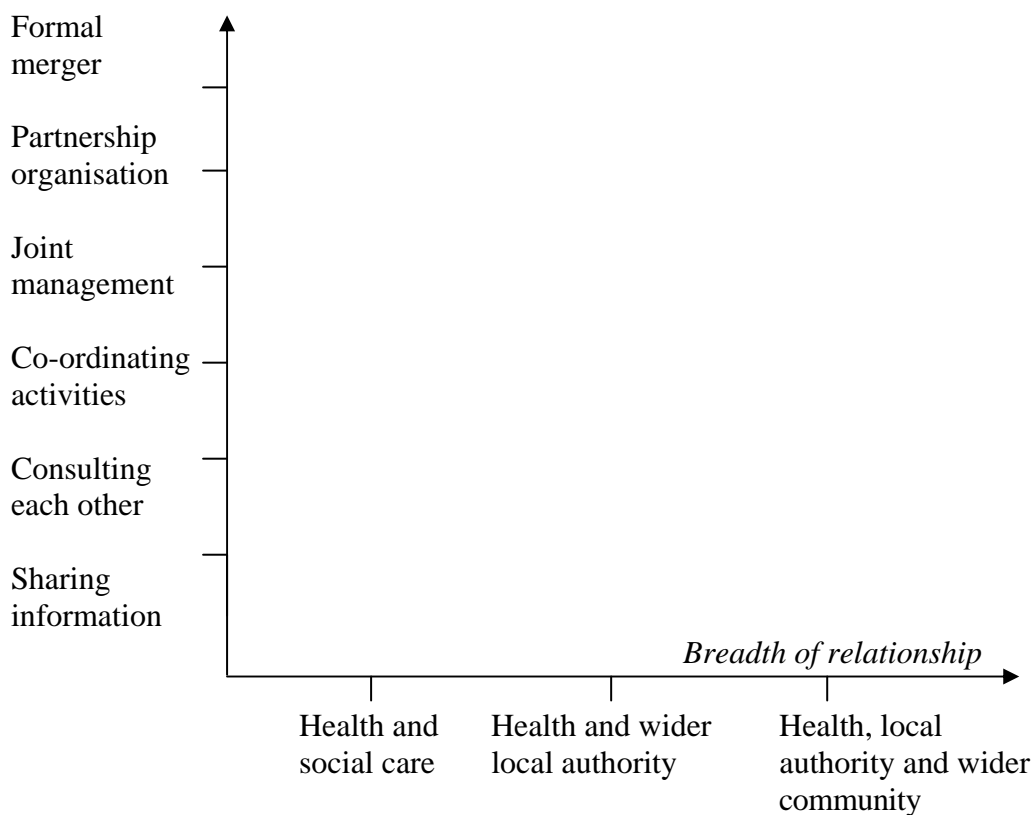
For example, we use partnership to refer to Care Trusts (which some would argue are effectively hierarchies), to Private Finance Initiatives (which are arguably market-based relationships) and to clinical networks (which relate more closely, if not entirely, to the ideal network form). Although we know each of these forms as partnerships, they are underpinned by different regulations and behaviours and, as such, we would expect very different outcomes to result from each of these arrangements. Although there are limitations to this idealised tripartite of inter-organisational relationships – and, in

practice, interactions usually exist as a hybrid or as several of these forms over a life-span (see also Lowndes & Skelcher, 1998) - this classification is useful in demonstrating the wide range of different entities known as partnerships within the health and social care arena. As Banks (2002) suggests, this can lead to a number of different forms being grouped together under the same term, when they may, in fact, be different (albeit perhaps only marginally so in some cases). In practice, what this means is that it is difficult to generalise the service user outcomes of partnerships, as partnership has been used to refer to so many different ways of working. Some commentators (see McLaughlin,

2004, for example) have suggested that it is this very lack of definitional clarity over the term partnership that has helped it become so popular. By being relatively broad and encompassing, the answer to any number of potential difficulties could be suggested to be 'partnership', and arguably it has been seen as such an answer in much health and social care policy over the past decade. One framework which is quite useful for characterising typologies of partnership relationships is illustrated in Figure 1. This framework can be employed to establish what types of relationships characterise a partnership and thus which partnerships are similar in nature.

Figure 1: Depth and breadth of partnership relationship (adapted from Peck, 2002)

Depth of relationship



The evaluation challenge

The range of definitions associated with the partnership concept is one of several evaluation challenges related to this way of working. As suggested above, partnerships may take a number of different forms and tend to be locally implemented, rather than existing in some centrally mandated form. Therefore, it is quite likely that each partnership will have slightly different aims and, consequently, different understandings of what constitutes success for that partnership. Moreover, as Dowling and colleagues (2004) note, the aims of partnerships are often similar to those of other public sector policies (i.e. improved efficiency and effectiveness). Therefore, demonstrating what it is *specifically* that partnerships aim to achieve outside of traditional modes of service delivery is difficult to establish. Thus, there is no single set of outcome indicators which can be used to assess whether a partnership has been successful. Drawing on evidence from the US, Schmitt (2001) suggests what is often missing from evaluations of collaborative efforts is an explanation of *why* certain outcome indicators were selected. In other words, outcome indicators have been selected but it has not been clear what the rationale behind this selection is, or how working in partnership should affect these indicators. As different types of partnership might aim to achieve very different things, it is important that the most appropriate outcome indicators are selected for that partnership – and these may differ from the outcomes another partnership is aiming to impact upon.

Furthermore, partnerships are often comprised of a number of groups who may have quite different perspectives of what it should achieve, and consequently of how the partnership should be evaluated (Thomas & Palfrey, 1996). Not only will different partnerships have different ideas of what counts as ‘success’, but it is likely that the stakeholders comprising that partnership

will vary in their opinion of what success will look like (see Barnes *et al.*, 2005, for an example of this in relation to Health Action Zones). Although partners should have some common goal in terms of the partnership, outside of this initial aim partners will likely have different agendas which they may not necessarily have shared with one another in their entirety. Failure to recognise different concepts of success leads to inappropriate conclusions about the effectiveness of partnerships, and potentially to the inappropriate application of research results (Ouwens *et al.*, 2005). Clearly, this poses a significant evaluation challenge when looking to generalise not only within a partnership but also between partnerships.

The contexts in which different partnerships exist vary widely and impact significantly upon the functioning of partnerships. In terms of learning lessons which may be applied within other contexts in the future, it is important to understand what it is about this context which has facilitated certain types of relationship. McNulty and Ferlie (2002) talk about the importance of ‘receptive contexts’ in terms of organisational change, and these contexts are similarly important for understanding what it is about certain partnerships which make them effective. As Pollitt (1995) illustrates, what works in one context may not apply within another, and as such it is important to understand the key features of particular contexts for these initiatives. An understanding of context is also important in another key way. Partnerships, like all policy initiatives, exist within broader policy environments which can make it difficult to demonstrate that it is this initiative specifically which has impacted on service user outcomes and not another. Indeed, the issues of attribution and causality are perhaps the largest challenges which partnership evaluations face, particularly given the breadth of outcomes which have been outlined in recent health and social care policy (for example,

Department of Health, 2005b; Secretary of State for Health, 2006). The interim report from the evaluation of Local Strategic Partnerships (LSPs) (Department for Transport, 2005, p. 17) suggests that it is difficult to demonstrate any clear outcomes of LSPs as the chains of causality are extremely complex. As such, the influence of partnership working may be subtle, indirect and cumulative – rather than a direct reflection of a programme. It could further be argued that this issue of attribution has become more complex under the current government, who in the early years of this decade, introduced a plethora of ‘initiatives’ (e.g. Health Action Zones, Sure Start, New Deal for Communities, Education Action Zones, Children’s Fund projects, etc.) which tend to have broadly similar aims and co-exist, often within socio-economically deprived areas.

Part of the difficulty with demonstrating causal links between partnership interventions and service user outcomes may stem from the fact that a number of the outcomes which partnerships are set up to address are often rather long-term in nature. For example, the national Sure Start evaluation (Wiggins *et al.*, 2005) found little in terms of impact of the programme in those areas targeted by the initiative – in fact some children were found to be worse off in the areas targeted by the scheme. There were a range of evaluative difficulties associated with this programme (for example, the population being quite mobile), but one key issue is that of timescales. Many of the targets that Sure Start is set up to achieve are long-ranging and it could be argued that we would not expect to see the real impacts until the children in these areas reach the latter half of their teenage years. There is a substantial difference between expecting to see changes take place within short (more politically acceptable) timescales of say three years in comparison with the 15 years plus which it might actually take to demonstrate change in practice. This poses a significant

challenge to partnership evaluations of this type – as it does to the evaluation of other policy initiatives. Moreover, many health and social care partnerships are increasingly being established with a preventative agenda. With the preventative agenda gaining increasing credence within recent policy documents (for example, Secretary of State for Health, 2006) a number of organisations are finding themselves grappling with the issue of how to prove that they have prevented something from happening.

This section has provided an overview of the predominant difficulties which may be encountered when attempting to evaluate partnerships, although, as suggested above, these are not all purely specific to partnerships but are encountered in most evaluations of complex policy initiatives. For the purposes of this paper, these tend to be the main difficulties reported within health and social care partnership evaluations - although there are others (for a detailed examination of the challenges in partnership evaluation see Glendinning, 2002; Dickinson, 2006). Clearly these difficulties are also contingent and will affect some environments more than others. However, what this section aims to illustrate is the scale and complexity of the evaluation challenge. Although, as previously outlined (and covered in more detail below), health and social care partnerships are yet to demonstrate that they appreciably impact on service user outcomes, this may in part be a reflection of the significant evaluation challenge associated with analysing these mechanisms rather than a lack of impact *per se*. This is reflected by Dowling *et al.* (2004) who, in an extensive search of the literature, found that there was little evidence documented about health and social care partnerships affecting service user outcomes and that the majority of partnership evaluations tended to focus on process rather than outcomes. That is, evaluations tend to look at how effectively partners are working together, rather than

whether working in this way necessarily impacts on the outcomes of those services.

This interest in process may partly reflect some tacit but ingrained assumption within the public sector (and evaluators' beliefs) that partnerships lead to better outcomes. Thus, rather than investigating service user outcomes, evaluators analyse the process of partnership working and, if this seems smooth, presume that positive benefits must be produced for service users. There is a fairly well-established literature which examines the main features that are necessary for the process of partnership to be effective (see for example, Wildridge *et al.*, 2004). This evidence is quite useful to draw upon, not least because central government has introduced a number of initiatives (such as the Health Act flexibilities, reorganising PCTs in an attempt to gain greater coterminosity with Local Authority partners) to mitigate the health and social care boundary. However, these have been largely at the structural and legal level as opposed to guidance to local health and social care economies about *actually* producing effective partnerships in practice. Such a view by government presumes that, by demolishing the structural and legal difficulties, local organisations should simply be able to create effective partnerships. When, in practice, as Armistead *et al.* (2007, p. 218) note, "partnerships are often overlain on a palimpsest of previous attempts at collaboration, which may betray a history of inter-organisational, interpersonal or clan conflict". As such, Glasby (2003) argues that three levels are essential in forming effective partnerships; structural, organisational and individual. These levels re-enforce each other, but all require attending to in the attempt to build effective partnerships. Whilst the government has been fairly attentive to questions of structure (such as legal and bureaucratic issues) it has been less so to organisational and individual matters – yet arguably these are the

challenges in which local health and social care economies require most support.

A number of partnership 'health assessment' tools, such as the Partnership Assessment Tool (Hardy *et al.*, 2003) and the Working Partnership (Markwell *et al.*, 2003) are available to assist partnerships by assessing the key features of effective 'process' in partnership working. These are generally cheap, quick and cost-effective, whilst designed to be generic and so applicable in a wide range of contexts. Critics have pointed out that, as useful as these tools are, they sidestep the issue of what partnerships might ultimately reasonably be expected to achieve; improved outcomes for welfare users (Rummery, 2002). These tools do not provide a comprehensive framework, and do not make explicit distinctions between inputs, processes and outcomes of successful collaboration (Asthana *et al.*, 2002). Many of these process assessment tools reflect this and point out that they are more useful as developmental aids, rather than as a means of central assessment (Hardy *et al.*, 2003; Halliday *et al.*, 2004).

A further reason for this evaluative focus on process over outcome, could be due to the fact that, as suggested above, actually choosing what outcomes to study is quite a complex task when thinking about multi-agency, multi-stakeholder entities like partnerships. When evaluating partnerships, it is insufficient to think simply of process, with little regard for outcomes; similarly it is insufficient to simply study outcomes with no consideration of the process of partnership working. Without understanding how effectively partners are working together, it will be difficult to know whether the expected outcomes should flow from the partnership. Partnerships are difficult to make work at the best of times (Hudson, 2006) and there are likely to be sticking points, which could potentially influence the impact which the partnership might have on services and, consequently, upon service

user outcomes. Thus, it is imperative that partnership evaluations can encompass both the process and the outcome of partnership working.

The POET approach to evaluation

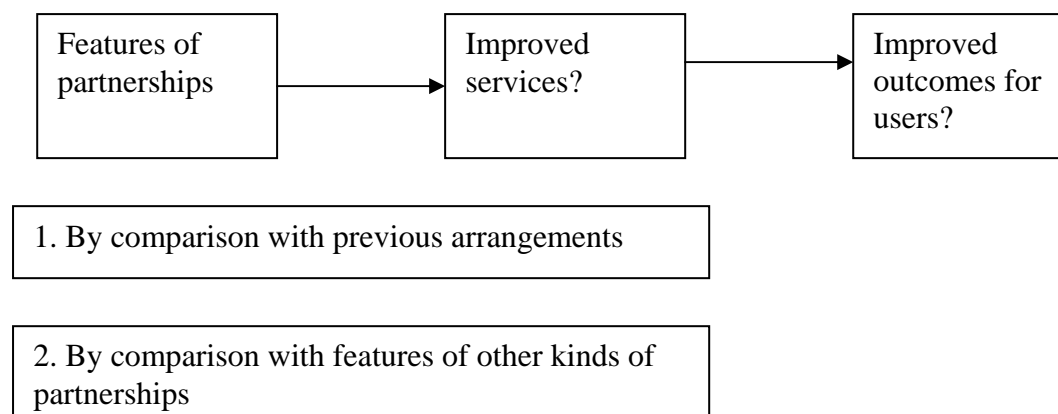
The government has expounded much rhetoric around the positive impact which health and social care partnerships should have on service users, but this has not been evidenced and, given the range of difficulties which a number of partnerships are presently experiencing, there is a danger that the concept will lose legitimacy and that front-line workers will no longer be prepared to engage with this agenda. Perhaps then, instead of asking “do partnerships improve outcomes of service users?” it is more appropriate to ask, “which service users do partnerships improve outcomes for, when, where and how?” Glasby *et al.* (2006, p. 373) characterise this question in Figure 2.

The Health Services Management Centre at the University of Birmingham has set up a project to test the question posed in Figure 2, producing the Partnership Outcomes Evaluation Toolkit (POET). POET is a generic toolkit (in that it can be used with a

range of health and social care partnerships that fit at different areas in Figure 1) designed to analyse both the process and outcomes of partnerships. This project aims not only to determine what sorts of service user outcomes are produced by different partnerships, but also offer a more nuanced account of how partners might work together more effectively and the sorts of support mechanisms this way of working demands.

As this paper suggests, in attempting to evaluate the outcomes of partnerships, it is insufficient to simply measure outcomes and compare these with previous results or those produced by similar contexts. Given the dynamism and complexity of partnerships as socio-cultural institutions, to only look at outcomes would miss the processes taking place within the ‘black-box’ of the partnership. With that in mind, POET takes a two-pronged approach consisting firstly of a staff survey and, secondly, of work with service users and carers. It is intended that, by combining these findings, a more rounded view of the partnership process and associated outcomes might be gained.

Figure 2 Effective partnership working (in theory) (Glasby *et al.*, 2006, p. 373)



Staff survey

The first part of the POET approach is to invite all, or at least a representative sample (depending on the size of the partnership), of staff members from all the partner organisations to complete a questionnaire. This part of the toolkit is based online which aids the speed of data collection, and all individuals are given a personalised user name and password which only they have access to. This means that all the information gathered in this survey is anonymous and non-identifiable and early indications show that individuals value this opportunity to be candid about their views. This survey has two distinct aims:

- Based on an extensive literature search on the process of partnership working, the survey aims to test the ‘health’ of the partnership. That is, this process is similar to the health assessment tools earlier referred to, and highlights the areas partners are working well together in and the areas where some developmental work might be necessary.
- As suggested earlier, partnerships differ in their aims and individual partners may also differ in their concept of what the partnership should achieve. In order to determine what outcomes should be analysed when evaluating a particular partnership, a ‘Theories of Change’ approach has been built into the staff survey. This theory-led evaluation method originated in the US (Connell *et al.*, 1995) but has recently been used in national evaluations such as the Children’s Fund (Barnes *et al.*, 2006), LSPs (ODPM, 2005) and Health Action Zones (Barnes *et al.*, 2005). This approach aims to ‘surface’ the assumptions held by individuals within the partnership concerning what the partnership is aiming to achieve in terms of service users and carers. In other words, information is

gathered from all stakeholders about what success would look like for the partnership.

Once the data from staff members has been gathered and analysed, a ‘health of the partnership’ report is produced, illustrating staff perspectives of the partnership along with areas for celebration and development. This report also gives an in-depth view into the processes and contexts behind the partnership and how this might influence services provided by the partnership. Furthermore, this stage produces a range of information from all the stakeholders about what the partnership is aiming to achieve in terms of outcomes for those who use its services. Theory-led evaluative approaches are increasingly being used to overcome issues of attribution; this approach unlocks the ‘black box’, and looks at the processes which go on within the programme rather than simply at the outputs (Robson, 1993). This allows the researcher to then say with confidence which parts of the programme worked and why, whether they would be applicable to different situations and if there are any positive or negative effects which would otherwise not be anticipated (Birckmayer & Weiss, 2000). Rather than inferring causation from the input and outputs of a project, as experimentation does by excluding all other rival causal links, theory-led evaluation aims to map the entire process (Pawson & Tilley, 1997).

Service user and carer research

The second part of the research is very much informed by the first part. Therefore, although this is ostensibly a generic toolkit, it may be used within partnerships with quite different characteristics, but still be valid for that particular context. This part of the evaluation process takes the outcomes which were surfaced in the staff survey and forms a research schedule which:

- a. Checks with service users and carers whether these are the ‘right’ outcomes

that the partnership should be aiming to deliver. Are these what service users and carers value and are there any aspects which are missing?

- b. Verifies the extent to which the partnership is delivering on these particular outcomes.

As this process is determined by the context and nature of the partnership, this part of the evaluation process can look rather different from partnership to partnership. However, the outcomes which are expected to flow from partnerships would similarly be expected to vary, depending on the nature of the partnership. The toolkit provides guidance and examples exploring the different ways in which this stage of the evaluation might be carried out, and the kinds of approaches which are most appropriate for particular service user groups.

In this way, POET is both:

- *Formative* - it seeks to evaluate how well partners are working together, helps people to understand and make sense of their current context, and highlights both areas for celebration within the partnership as well as areas where development work is needed. It also allows partnerships to benchmark their performance and check back over a period of time to see if these issues have been resolved.
- *Summative* - POET is evaluative in that it requires partnerships to be explicit about desired outcomes and then analyses the degree to which the partnership is successful in achieving these aims.

POET is currently reaching the end of its initial testing and refinement stage, after which it will be launched nationally in conjunction with the Care Services Improvement Partnership. Although the initial testing is producing a series of key

lessons which seem salient across some of these sites, it is hoped that, once launched nationally, a much larger evidence base will be able to be captured. POET has been designed within a critical realist framework (see Dickinson, 2006, for further on the theoretical and philosophical underpinnings) which seeks to search for mechanisms behind observed phenomena. Such an approach acknowledges the complexity of the world, but argues that by using particular techniques, aspects of programmes or policies may be uncovered which tend to behave in particular ways under a set of specific circumstances. In this way, it is anticipated that POET will be able to offer generaliseable lessons about what kinds of partnership are able to produce what sorts of outcomes, for whom, where and when – but also come up with best practice guidance relating to how to make partnerships more effective in practice and some support and development initiatives that might assist this process.

Conclusion

Health and social care partnership working is not a new phenomenon but, over the past decade, has received a particular focus from the New Labour government. Interest in this way of working has largely been predicated on the notion that it will improve services, and consequently outcomes for those who use services. Despite being a central feature of much health and social care policy over this period, and a range of mechanisms and initiatives which have been introduced to encourage and make the process of partnership working more ‘smooth’, there is still a lack of evidence to demonstrate that partnership working improves service user outcomes. Furthermore, in recent years, partnerships have been critiqued for their potential risks, and more recently there have been reports of partnerships coming under significant pressures. Partnership working is an internationally encountered phenomenon, and there are numerous reports from the UK and elsewhere of the damaging effects

which working in organisational silos can have on service users. Yet, a lack of evidence and current difficulties on the ground is leading to a crisis of confidence in this concept, which may lead to staff disengaging with this agenda.

This paper argues that it is the complex nature of partnership working and the scale of the evaluation challenge and the range of associated difficulties which this poses to evaluators which may prove to be the primary difficulty – rather than partnerships having a lack of impact *per se*. Rather than trying to establish whether partnerships lead to improved services for users, we should instead be investigating if partnerships do improve services, who is this for, where, when and how? Partnerships are difficult entities to make work and require much input. Although the government has introduced a series of mechanisms to aid this process, these have tended to be structural and legal fixes, rather than practical advice about how ‘to do’ partnership. Drawing on previous experiences of partnership evaluation, this toolkit aims to overcome these evaluative difficulties, incorporating both process and outcome evaluations. The POET project aims to offer a more nuanced account of partnership, offering practical advice on the kinds of support mechanisms and development opportunities which aid partnership working and the potential impacts different sorts of partnership might have, moving the debate to a more mature and subtle level concerning the ways in which health and social care services can be improved for the individuals receiving them.

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Complexity, connectivity, and management information systems: new possibilities for understanding social care?

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Abstract

Complexity research is a relatively new discipline that has developed from advances in biology, physics, computer science, and the social sciences. Organizations providing social care can be seen as complex systems, and the new perspective of complexity may give insights that will enable policy-makers and managers to make the provision of social care more effective. The paper presents data from a survey of social care that has a 'Zipf-type' distribution, characteristic of complex systems. The paper also considers the ontology of social care organizations, and the relevance of this in complexity research.

Keywords: Complexity, social care, connectivity, management information system

Introduction

There are many definitions of complex systems: Johnson (2006) notes that one source identifies 31 definitions of the term. In brief, complex systems are those with a massive number of elements that interact in a dynamic manner. Examples include business organizations, the internet, ant colonies, and the human brain. Typically, complex systems have emergent properties - for instance, the human brain produces a property of consciousness (many would argue). Consciousness is also a phenomenon that emerges from other attributes of the system (that is, in some way, that we do not fully understand, from the biochemistry of the brain).

If we consider an organization (e.g. a local authority working in partnership with other agencies), one of whose functions is to provide social care, as a complex system, it can be argued that complexity provides a new perspective to enhance our understanding of how and why the organization behaves in a certain way, and eventually may help us to manage the organization better.

Complexity may also provide a new perspective in research, since it is different from the predominantly statistical models currently used to study social care. Such models tend to use techniques based on regression (whether logistic regression, multi-level modelling, or multiple regression) for predictive and explanatory modelling of social care.

One may also consider a management information system (MIS) as an example of a complex system. Social care organizations typically collect information about their clients, the services provided, cost of services, key events that clients experience, and more, in corporate IT systems. In a sense, IT systems are a representation of 'reality'; to some extent, MISs provide the raw data analysed in research (of course they might not include information collected specifically for research projects, such as that resulting from questionnaire surveys). In addition, it can be argued, they are not intended to hold data on every variable that would be relevant in research (they hold only all the data needed for the range of corporate functions they support). Nevertheless, even with these limitations, they, too, are a kind of model of the complex system they represent.

Applications of complexity in social care

One can distinguish between what may be called qualitative and quantitative applications of complexity. In qualitative applications, concepts from complexity are introduced to give fresh insights into the phenomena in question (e.g. in social care), but data are not collected nor analysed by means of quantifiable variables (nor is a simulation usually created). This more qualitative application of complexity has been popular in strategic management and organizational change. There are many ideas from complexity that have been used in this way. For instance, the idea of ‘agents’ as originated in complexity research has inspired a new perspective in understanding how organizations function. The concept of agents is also associated with its meaning in computer science, where it refers to a specialised program that is self-activating, for example, on the internet those that inform website customers of new products when they are launched (see Antoniou & van Harmelen, 2004). Axelrod and Cohen (1999) discuss the idea of an agent (a person, a team, or any element in a system that is a coherent whole, interacts with other elements, and has purposeful behaviour) as a useful concept in considering organizational change. In passing, they give the example of placing children for foster care as a process involving many agents: a child, the foster carers, the professional arranging the placement, a manager who develops placement policies, the team responsible for foster care, all are agents. Interactions between these agents are part of the dynamics of the system.

In general, there is little published literature on applications of complexity in social care. An exception is Pinnock’s (2004) discussion of complexity and the influence of metaphors we use in conceptualising organizations. By contrast, there are several published reports on applications in health care (e.g. Sweeney & Cassidy, 2001; Zimmerman *et al.*, 2001; Plsek, 2003). A

thorough critical review of complexity and strategic management can be found in Stacey (2003).

Quantitative applications are those that involve collection and analysis of data using a systematic method specifically associated with complexity research, or simulations intended to investigate theories of complexity. There does not appear to be any published research on quantitative applications of complexity in social care. On complexity in general, there is an extensive literature and accessible introductions (see Barabasi, 2002; Watts, 2003).

Connectivity

One of the most important ideas in complexity is connectivity. Complex systems typically consist of many elements with massive connections between them. One can think of complex systems as, in part, multiple interconnected networks, where a network is a set of well-defined ‘things’ connected via some well-defined relation. Social networks are those where the ‘things’ are people, and the relation is (for example) one of social affiliation (i.e. a person knows the other person to whom they are connected). There are many applications of complexity where connectivity is a central concern. One that is often discussed is the internet. The internet consists of information distributed across thousands of interconnected computers, and its physical architecture (the way computers in the network are connected) is, in part, designed to be resistant to attack and failure of individual computers or parts of the network. By contrast, social systems, and in particular business and services organizations, are in most respects far more complex than computer networks. Organizations depend on the connectivity between component elements. For instance, a partnership of organizations providing social care will probably have contracts, agreements and understandings about how

they will operate. To work in this way will involve coordination of people (e.g. employees, consultants, contractors, volunteers), plans, policies, services, and information. Imagine the same organization without any connections between elements: for instance, what would happen if there were a plan, but nobody was aware of it: of course, it would have no effect. In fact, it is impossible to imagine an element of an organization that is not connected to anything else in the organization - it is a paradox, because by definition an element can only be part of an organization by virtue of its connection to some other element. Disconnections do occur, and sometimes this can cause problems, for example if two employees take some action that mutually conflicts and fail to talk to each other. In fact, organizations tend to be very resilient in many situations, in that they continue to function even with many disconnections. In other circumstances, though, disconnections can, of course, lead to catastrophic failure.

Information is of pivotal interest since large organizations generally have to manage great volumes of information in order to function effectively (indeed, failure to do so can have serious consequences in some cases). Most organizations now depend on management information systems (i.e. computer systems) for many management functions, such as finance, marketing, customer information, planning, and project management. In many cases, such IT systems will be based on relational databases that in a sense, are designed to create a model of the real world phenomena they represent. In particular, relational databases consist of tables and joins, where a table represents a type of entity, and a join represents a relation between two tables (e.g. a customer table is joined to an orders table). Information flows are very important for how organizations work together. An illustration of this principle is the high-profile case of Victoria Climbié, where several agencies (police, social services, and others) had information that indicated the

serious risk she faced, but poor communication between agencies contributed to the failure to prevent her abuse and eventual murder (Laming, 2003).

Zipf distributions

There are many ways to explore how complexity applies to organizations providing social care. Let us start by exploring a 'quantitative' application. Often there are occasions in managing social care when one has to interpret a set of values: e.g. in managing a budget for foster care provision, a manager may be presented with a report showing 1,000 cases and their cost for the latest quarter. When analysing such data, it is usual to examine their distribution, which may follow one of several patterns. Each case may have a similar cost (thus producing a uniform distribution). Or the data may follow a normal distribution, (looking like a bell-shaped curve when charted), where there are a few low cost cases, a few high cost, and most fall in the middle region.

An example of data from one local authority participating in a recent England-wide survey of social care spend is illustrated in Figure 1. In this survey, all local authorities that provide social care collected detailed data on services to children and families during a one week period. Services included those for children in care (looked-after children), fostering, services associated with clients on the Child Protection Register (children at risk of serious harm), and services provided to support families experiencing problems in caring for their own children. Data were collected on the amount of time spent by practitioners (social workers and others) in direct contact with children (e.g. therapeutic work), in travelling, administrative work, meetings, on the cost of services, demographic characteristics of clients, and a variety of other variables. Figure 1 shows the distribution of spend for cases in a large Borough Council. Spend is comprised of

direct spend (e.g. on residential accommodation), one-off payments (e.g. for clothing or furniture), the cost of practitioners' time, and all other costs to the organization. The distribution is highly positively skewed, that is, there are many relatively low-value cases, and a few high-cost cases. Analysis of both a different local authority and the larger national survey dataset (c. 250,000 cases), showed a similar distribution. In other words, the pattern does not seem to be a peculiarity of the authority in Figure 1 but is quite general. Thus the distribution of spend on social care is characteristic of measures associated with complex systems.

The distribution in Figure 1 is similar to the family of distributions known as Zipf distributions, often encountered in complex systems. A Zipf distribution is a type of frequency distribution that has a precise mathematical specification (in outline, one that follows an inverse power curve) and in essence, has a few high-value cases and many low-value cases (for details of the exact mathematical specification of such distributions see Downs & Johnson, 2006). We see such distributions in word frequency (in English there are a few words that occur very frequently, e.g. 'and', 'the', and many that are infrequent, e.g. 'disinter', 'opprobrium'). Such distributions are also seen in city populations and in the internet. As far as city population is concerned, there are a limited number of cities and towns in the world with huge populations, and thousands with relatively small populations. In regard to the internet there are a few sites, such as Google, that get a massive number of visits, while there are thousands that receive only a few. For example, Figure 2

shows the distribution of downloads from the Rhapsody music site over a one month period. A few tracks are downloaded thousands of times, while there are many that are downloaded only a few times (hence the long tail of the distribution made famous in the book of that name).

Simulation

Simulation has often been used in complexity to investigate how complex systems develop and change. In some cases, this involves applying simple rules to a computer simulation to see if this can generate complex behaviour. An example is the study of 'boids' - a computer simulation of birds. In this research (Reynolds, 2007) the rules were designed to apply to individual birds. When the rules were applied in a simulation with many individuals, the complex behaviour seen in flocks, where the birds manage to synchronise with each other, and avoid collision, was reproduced.

Simulation, in some situations, proceeds by building a detailed computer model of the system being studied. One notable example is the TRANSIMS model developed at the Los Alamos National Laboratory (see Johnson, 2006, p. 35), a simulation of the transportation network of Los Angeles. The model holds information on households, family members, trips made, the transportation network, and many other variables, derived from population census data, surveys, and other sources. TRANSIMS has been used to examine the effect of introducing changes in the network, e.g. the effect of building a new highway.

Figure 1 Zipf-type distribution of social care case spend in 2005 Children in Need Survey (English Borough Council)

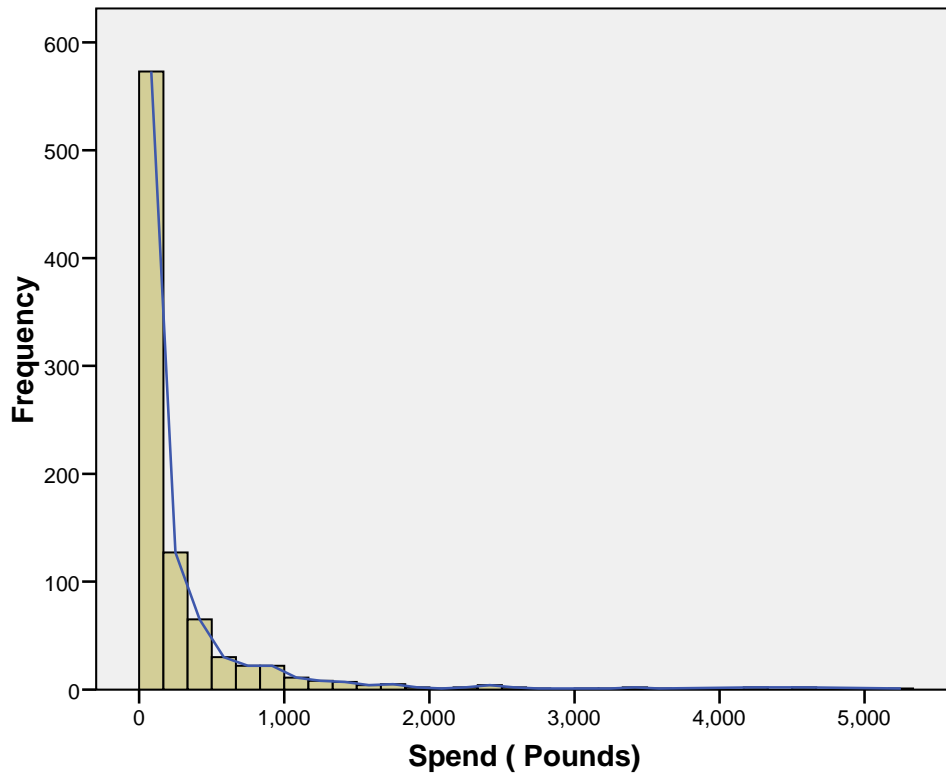


Figure 2 Rhapsody: music downloads Dec. 2005 (top 25,000 tracks)

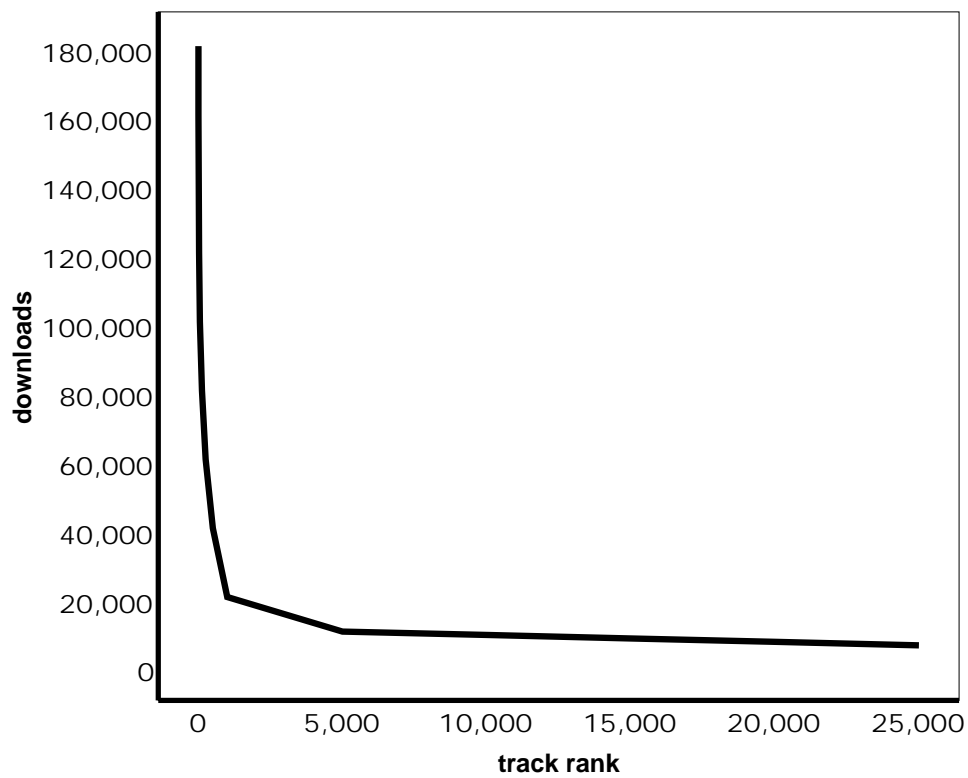


Chart adopted from "The Long Tail", Chris Anderson, 2006.

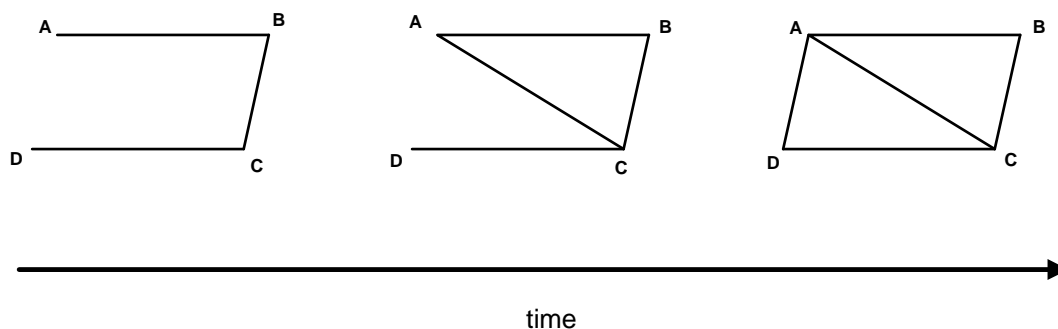
Simulation has also been used to model the development of Zipf distributions in city growth, simulating the development of a Zipf distribution of city size (population) as a result of the interaction between urban and rural centres (Pumain, 2004). Given that we see Zipf-type distributions in the social care domain, we might discover more about how and why they occur, by applying simulation to model their development. It may be of benefit to understand these mechanisms better. Managers and policy-makers will want to control spend in social care, and if (as the above survey suggests) a large portion of spend is determined by a few high-cost cases, then if one can understand why these cases become so costly, this may help to control spend better.

Simulation and social care

We have suggested that it may be of benefit to managers and policy-makers to understand mechanisms that underlie the development of Zipf-type distributions in social care. We also know that the study of distributions in complexity is associated with connectivity. Some aspects of connectivity in the social care domain may be associated with the development of Zipf distributions. Social networks have been researched a great deal, in particular in complexity research, and thus this appears

to be one possibility worth exploring. Social networks as a field of study is concerned with relationships between people (and in other species) and how such relationships develop and change over time. Often, studies of social networks of people are concerned with friendship or other social affiliations. In the 1950s the mathematician Rapoport developed a theory of how social networks develop, and his theory has been of interest in complexity research. As Watts (2003, p. 56) describes, Rapoport suggested the following mechanism by which social networks develop. Imagine four people A, B, C, and D. (Figure 3). A is a friend of B, B a friend of C, and C a friend of D. If A forms a new friendship, is the new friend more likely to be C or D? Rapoport suggests that A is more likely to make friends with C, since C is a friend of a friend (C is a friend of B, and B is a friend of A). If D then forms a new friendship, who is most likely to be the new friend? Perhaps there is a random factor at work as well, so D may form a friendship with A. Thus the theory suggests that two mechanisms operate in the way social networks develop - one a bias to form new relationships with friends of a friend, the other a random effect. Hence Rapoport's use of the term 'random biased nets' to conceptualise the way that networks might develop.

Figure 3 Rapoport's random biased nets and the development of social networks



(adapted from Watts, D. (2003) *Six Degrees: The Science of a Connected Age*, p. 61)

As Watts (2003) explains, Rapoport's theory has proved of interest since it defines simple principles which can be built into computer models; one can then study the effect of those principles in large datasets through simulation in computer models. With the recent, huge advances in computing power, it is now possible to test a simulation, by writing a program to implement the principle or rule in question, and applying the principle to a large dataset. The idea of social networks can be expanded in the social care domain. While Rapoport's original theory concerned friendship relationships, one could extend this to a network, centred around a child (receiving social care), where the relationships include not only the child's friends, but also their family relationships, relationships with professionals (teacher, medical practitioner, etc.), and other personal relationships. The network could then be further extended to other entities. For instance, with the current interest in social exclusion, there is a focus on why children become looked after (taken into care). In the vocabulary of networks and connectivity, this question can be framed as: how is it that a connection with a new node (the event of becoming looked after) arises? In searching for an answer it would be valuable to first identify connections to intermediate nodes that typically come about before being taken into care (in other words, events that precede that situation, or relationships with other people that precede it). By analogy with Rapoport's notion of bias it may be that connections with some nodes predispose (bias) later connection to becoming looked after.

Multiple node and multiple relation types

In the previous section, it was suggested that there is a limitation with Rapoport's theory, in that a social network has only one type of node (person) and one relation (social affiliation). Indeed, most examples in the complexity literature are of this type (one node type and one relation type). In

contrast, most complex systems in the social domain have many types of node and relation. As Searle (1995) observes, the ontology (in the sense of trying to identify exactly what range of things exist in social phenomena) of social reality is staggering in its complexity. To illustrate this point, Searle examines a relatively simple scenario, where an American citizen orders a beer in a bar in Paris. He outlines the ontology involved - there are many layers: the customer has an American passport and is legally entitled to be in France, the bar has to display a tariff of the price of drinks, the waiter does not own the beer he serves, the bar owner is bound by numerous rules and regulations. Consider then the ontology of organizations. They consist not only of tangible elements such as computers, buildings, products, and people, but a vast array of abstract, social, and psychological entities such as services, values, information, policies, rules, objectives, roles, legal duties, strategic plans, budgets, beliefs, feelings, knowledge, understanding, concepts, and added-value (see Table 1).

'Information' as an entity has a unique place in the ontology: it is itself a kind of ontology, since it represents many of the other elements in the system and the relationships between them. Information is evident in many guises - in organizational charts, in the conversations employees have about their work, in reports and far more. But information in the form of a MIS has a special role, since an MIS is intended to be a model (an ontology?) of many aspects of the organization and many things external to it.

If there are many elements in the ontology and they are all connected, then there are multiple relationships between them. For instance, all clients are connected to one or more services (e.g. a child receiving social care may be in care (looked-after) and also on the Child Protection Register); clients are connected to practitioners; clients are connected to their data in information

systems, and so on. These relationships constitute the connectivity in the system.

Table 1 Entities of an organizational ontology

ENTITIES
Budgets
Objectives
Plans
Knowledge
Skills
Conversations
Office locations (sites)
Procurement
Expense claims
Legal duties
Objectives
Reports
Feelings
Beliefs
Values (to guide action)
Added-value (produced by services provided)
Performance indicators
Employee professional qualifications
Employee educational qualifications
Schedules
Projects
Programmes of work
Contracts
Negotiations
Marketing campaigns
Subcontractors
Employees
Desks
Chairs
Computer hardware
Computer software
Information
Databases
Clients
Services
Complaints
Teams
Stakeholders
Partner organizations
Meetings
Conferences
Policies

Datasets for testing the idea of random biased nets and complexity in social care

We have proposed that it may be of benefit to apply the idea of random biased nets to the social care domain, and also that there are many kinds of entity in the organizational structures that provide social care. It has also been argued that the connectivities between entities are an essential aspect of organizational structures. To examine whether these ideas can be usefully applied in social care research, one will need suitable data to test.

There is data available that could be analysed and that would save having to undertake an extensive data collection exercise. For instance, data collected via the SSDA903¹ statutory return in England provides a large dataset. It consists of a broad range of information about looked-after children, including demographic details, episodes of care, reason for becoming looked after, educational attainment, adoption procedures, whether in education, employment, or training, type of accommodation (e.g. fostering, residential homes, secure units), etc. This data has been collected for 150 local authorities for 3 years (on full data) and for further years for a 33% sample. Furthermore, the data is thought to be of good quality since, when uploaded to the central government website, it is subject to automated validation and correction. Thus, it seems that a suitable dataset available for testing this theory is, in principle, available.

Conclusions

In this paper, I have tried to outline complexity research and why it is relevant to organizations with responsibility for social care. An example - applying a technique of quantitative analysis from complexity to social care data was described and the results suggest that Zipf distributions associated with complex systems also occur in the social care

domain. One may conclude from this that it is worthwhile to explore further the mechanisms that cause these distributions.

Complexity research makes us think about the ontology of organizations - in other words, what things organizations consist of, and what structures connect the component parts. Organizations are composed of a surprising diversity of things – tangible, abstract, social, and psychological. This is true to an even greater extent for organizations that work together in partnerships. Appreciation of the complex relationships between elements in the system is an example of a ‘qualitative’ insight that complexity gives us.

Exploring complexity in social care may be beneficial not only in research, but also in the day-to-day management of social care organizations. Corporate IT systems used to manage our social care services and policies are a kind of model of reality. If such systems are designed to more accurately reflect the complexity of services and clients, we may be able to manage these services more effectively. Complexity is in its infancy, but many people predict that, in the future, tools developed in complexity will become commonplace - as routine as spreadsheets and word processor documents are today.

Note: This paper is adapted from part of a presentation to the SSRG Annual Conference *Joining up locally: Partnerships for better practice* held at Stamford Hall, University of Leicester, 16-18 April 2007. An earlier version of the discussion of Zipf distributions and social care survey data can be found in Downs & Johnson (2006); see also Pinnock (2004). The SSRG Workshop was a joint presentation by Mike Pinnock and Clive Downs.

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Endnote

¹ the SSDA903 statutory return is the main annual collection of data on looked-after children used to provide official statistics for England. Results are published annually, for instance in *Children Looked After in England (including Adoption and Care Leavers (2005-2006,))* downloaded June 5 2007 from:

http://www.everychildmatters.gov.uk/social_care/lookedafterchildren/research/.

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The shape of things to come – developing new approaches to commissioning public care

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Abstract

The White Paper, 'Our Health, Our Care, Our Say' suggests eight key steps that commissioners of care services need to achieve. Whilst few would disagree with any of the individual steps suggested, as a whole they potentially add up to a considerable change to commissioning and contracting as currently configured. This paper considers the implications of those changes, outlines a demand and supply driven model for considering future activities and suggests a number of key changes that need to be made to the roles of those commissioning public care.

Keywords: Commissioning, contracting, strategic needs assessment, demand forecasting, provider relationships, service planning, social care management

Introduction

In March 2007, the Department of Health published its *Commissioning Framework for Health and Well-Being*, following from the White Paper *Our Health, Our Care, Our Say*. It outlined eight steps for the delivery of effective commissioning:

- *Putting people at the centre of commissioning;*
- *Understanding the needs of populations and individuals;*
- *Sharing and using information more effectively;*
- *Assuring high-quality providers for all services;*
- *Recognising the interdependence between work, health and well-being;*
- *Developing incentives for commissioning for health and well-being;*
- *Making it happen – accountability;*
- *Making it happen – capability and leadership.*

Few in social care would disagree with the steps or the values that underpin them, yet the guidance potentially symbolises a watershed in the way that social care is purchased and delivered.

The case for change

As the Commission for Social Care Inspection (CSCI, 2006) notes:

An assessment of councils' approaches to commissioning has highlighted very mixed practice in analysing needs, demand and supply; in relationships with stakeholders; in market development; and in 'commissioning for quality' with involvement of local people. (p. 45)

The same report goes on to state:

Commissioning for many older people's services was primarily based upon historic patterns of service delivery and most councils were commissioning as single agencies and not in partnership with health, housing, independent and voluntary sector partners. (p. 63)

The Health Policy Forum (HPF, 2006) clearly believed that little was different within the health service when they argued:

NHS commissioning is starting from a low base in relation to designing and purchasing services in a way that properly takes account of people's needs

and demands. It seems that needs assessment in NHS commissioning has to 'move beyond public health'. That is not to say that epidemiological data analysis is not vital as part of health planning and commissioning but it is clearly no longer sufficient as the sole basis for making decisions about how priorities will be set and resources allocated through procurement and contracting. (pp. 21-2)

If Local Authorities (LAs) and Primary Care Trusts (PCTs) are to embrace the new approach desired by government then they do so at a time when commissioning and contracting is about to become much more complex. For example:

- The scale of demographic change that is about to occur for some authorities will mean their current configuration of services will be neither affordable nor sufficient to meet need. This is not only relevant in terms of a greater number of older people but is also true for physical and learning disability as increased longevity and longer survival of individuals with complex health and care needs has an impact.
- Service users in general and older people in particular, have been a relatively powerless voice in the past, given a culture that historically has emphasised being grateful for what you receive. The growth of equity and wealth amongst older people together with a desire for choice and improved quality is likely to drive demand for improved service provision. Some of this finds expression in the moves towards self directed care. However, whilst this has already had an impact in physical and learning disability in terms of older people it is not easy to interpret what impact this may have.
- Control over provision has also rapidly changed over the last twenty years from being LA dominated to being predominantly in the private sector. Some sectors of the market now exist

entirely outside LA care purchasing. There is also a gradual recognition that services contracted for by cost and volume do not necessarily deliver the outcomes that are needed.

- The impact that practice-based commissioning in health care may have has also yet to emerge. Clearly there will be a need to balance a desire for locally-based decisions as against the strategic role of the PCT and the need to achieve economies of scale.
- Social care in the past has spent comparatively little time focussing on understanding the 'whole system' in which it operates, whether it is understanding what needs are to be met, or what supply is to be put in place. This is in contrast to the private sector where companies often invest considerable amounts of time and money in understanding their customers and competition. If they do not, their product range becomes out of date, they cease to be competitive, shareholders lose confidence and eventually their business is jeopardised.
- Finally, with LAs no longer being major providers the managerial task has not only changed but, increasingly, knowledge of services is likely to be lost as well. In the future, provider relationships cannot be based solely on arms length contractual and legalistic arrangements, but will of necessity, be driven by commissioners requiring the very knowledge that providers will possess to effectively purchase services.

Many of the above issues are not new, yet the challenge for managers rests not in addressing them individually but in understanding what shape they collectively imply for the management of public care in the future. This paper offers a model based around a better understanding of supply and demand; an approach which activates the shift from being providers of services to

being enablers and facilitators across a much wider range of provision.

Overall, the task is more complex than the old production line approach to management, i.e. how do we manage the queue of potential service recipients or that particular service. The new approach to commissioning poses questions such as: how do we interpret and understand the demands of the public? What are the key decision points along the care pathway where people may potentially be diverted from long term-dependency? What needs to be the new relationship between service users/carers and commissioners? On the supply side, it is about how we influence, shape and grow care provision to match the demands of the community and what partnerships and arrangements are required in order to secure sufficiency of supply as against demand. Such changes clearly call for the development of new skills and thinking by those who act as commissioners of public care, together with changes to information systems in order to reflect the questions those managers will be asking.

The need for strategic thinking to drive commissioning

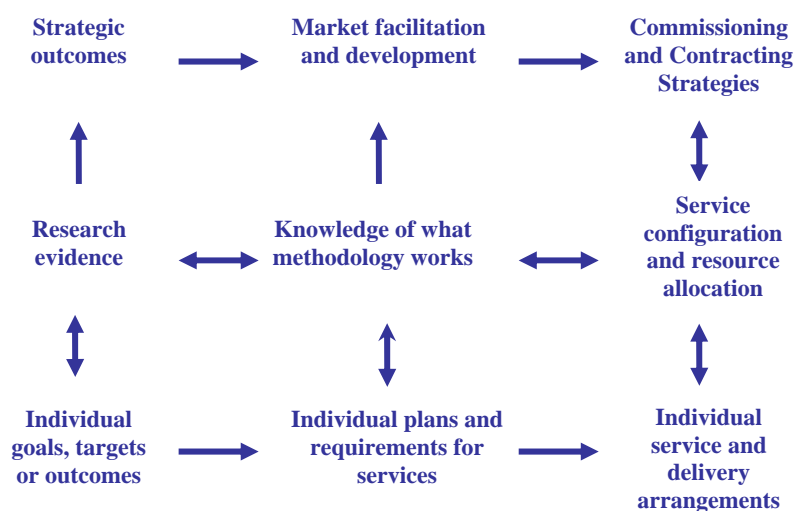
Traditionally, planning in the public sector has been on a year by year basis or at best on a three year cycle. Strategic commissioning calls for managers to take a much longer view. This should facilitate planning for demographic change, to enable commissioners to signal long-term intentions to the market, and to free-up thinking outside the constraints of existing service provision. This commissioning question - how is public funding to be best spent to ensure that supply is available at an affordable price to meet the needs of all of

the population can, in essence, be described through two activities:

- Understanding Demand – what are the desired goals for the population to be served and what is the rationale that underpins those goals and needs? These essentially are the outcomes that commissioners wish to see achieved.
- Understanding Supply – what services need to be in place to deliver the outcomes and what is the evidence that these services will deliver the desired effects? These are the outputs that need to be delivered or made available to meet the outcomes.

What is not clear from these statements is how these wider commissioning tasks fit with the individual provision of a service, particularly in an environment where an increasing number of service users may purchase their own services. The diagram below attempts to illustrate this relationship by showing how individual goals and services relate to strategic outcomes and outputs.

Figure 1 can be read in a number of different ways, either top down in relating strategic commissioning to individual requirements or bottom up in terms of individual needs and goals driving strategic aspirations and decision-making. Therefore, the bottom row could represent a direct payment or individual budget route to provision or a service that is contracted for, on an individual's behalf, by a local authority or PCT. Regardless of the purchasing mechanism, what resource is individually or collectively received, will be influenced by what outcomes it is expected the service should achieve and a knowledge of what does or does not work.

Figure 1 Relating individual contracting to strategic commissioning

For example, in exploring the relationship between individual goals and research, our expectations of recovery from a condition or illness are in part influenced by how knowledge and research have informed professional and public opinion alike. This in turn may be influenced by research which explores the impact that different treatment regimes have. As the diagram shows, some of the influences and processes are two-way, e.g. ‘service configuration and resource allocation’ both influences and is influenced by ‘what methodology works’. Whereas ‘what methodology works’ should affect how commissioners influence the market but not vice versa. Essentially, what is being suggested here are two key factors:

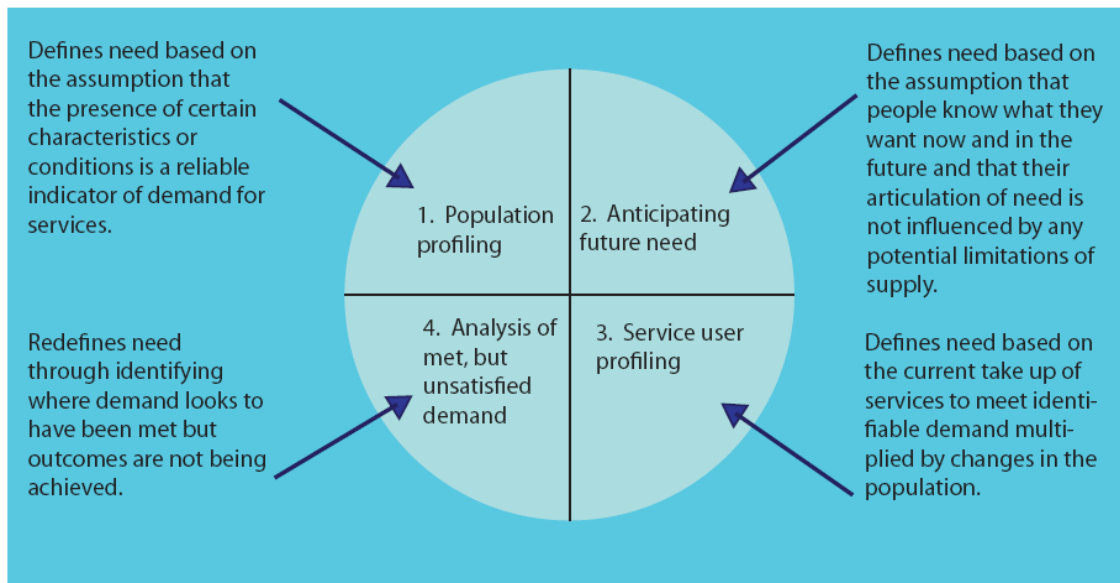
1. That research, knowledge, and evidence act as the ‘jam in the commissioning sandwich’ driving individual and organisational aspirations;
2. That effective commissioning and contracting needs to move from defining a set of organisational outputs (how many beds, places, etc.), to focussing on agreed outcomes (what can be achieved by the service provision, does the person get better?).

So, if services are to be purchased successfully and achieve outcomes desired by agencies and individuals, the key to success lies in the quality of ‘the jam’ or the knowledge available to us and our analysis of that information. This entails shifting commissioning away from changing existing service provision to a better understanding of demand and supply and how that knowledge gets used to develop appropriateness and quality within the market.

Understanding demand

The importance of predicting demand is heavily emphasised by the *Commissioning Framework for Health and Well-Being* (DoH 2007) which sees Strategic Needs Assessment as involving three main activities:

- A joint analysis of current and predicted health and well-being outcomes;
- An account of what people in the local community want from their services;
- A view of the future, predicting and anticipating potential new or unmet need. (p. 28)

Figure 2 The four activities of Strategic Needs Assessment

Some of the prediction of strategic needs can be delivered through effective analysis of population-based data. However, this does not translate into who comes to a Social Services Department (SSD) or a GP surgery. Predicting future demand requires a range of activities including assessing the views of current service users, carers and the wider population. There is also a benefit in reviewing the relationship between demand, service supplied and outcomes in those instances where it looks as if needs are being met and a service supplied but where, for a variety of reasons, the outcomes for the service user remain poor. Figure 2 illustrates these four elements of demand forecasting.

Population profiling

As indicated above, population profiling does not necessarily tell commissioners who will come forward for a service, but it does form a valuable backdrop for:

- Indicating the prevalence of conditions which may inevitably predict a social care response, e.g., dementia in people aged over 85;
- Understanding changing patterns of prevalence within a known population,

e.g. adults with a learning disability living longer and being subject to early onset of a number of old age conditions;

- Understanding strike rate, i.e. the numbers of people in particular circumstances or with particular conditions encountered by social care/health care/housing as compared to their prevalence within the population;
- Identifying general pressures that may exist in the future if current service provision is extrapolated based on population change;
- Exploring the relationship between where populations are located as compared to services and community facilities, e.g. drop kerbs for wheelchairs, shops, banks, etc;
- Helping to identify how many people there may be within particular target populations that a LA should contact if it is attempting to move from a reactive to a proactive service, e.g. number of carers, offering more than 50 hours care per week, where the carer is aged over 75.

To identify the above data requires the undertaking of five activities (re. older people, see CSIP, 2007):

- Identifying the current baseline population;
- Projecting that population forward;
- Identifying key characteristics within the population now and their potential prevalence in the future, where those characteristics may have a bearing on the likelihood of people requiring social care services, e.g. number of people who live alone aged over 85;
- Using estimates of prevalence from research studies and surveys to estimate the likely numbers of people within a population who may have a particular condition, e.g. dementia;
- Comparing populations to known service users and other performance data.

Anticipating future need

If the population data provides the baseline for Strategic Needs Assessment, then understanding current and future expectations amongst relevant groups provides definition or colour to that population data. However, engaging wider populations in making a contribution towards strategic commissioning is an activity often fraught with difficulties. In the past, for many authorities, consultation has centred on organisations or individuals with whom there is regular discussion about service provision. This has not always given a true picture of future need. Notwithstanding this problem, there is a wide range of potentially useful sources of information that may help in developing a picture of future need such as:

- General estimates of demand, e.g. housing needs surveys;
- MORI polls and other national surveys which explore attitudes towards health and social care;

- Research which looks at general population perspectives on services or future provision.

Ideally commissioners use a twin approach, supplementing findings from national research with locally-based work.

The Care Services Efficiency Delivery Programme (forthcoming on CSED Website) takes the above material a step forward and suggests a specific approach utilising focus group techniques for consulting with wider populations of older people. This approach was based on populations immediately prior to statutory retirement age and used two hour group sessions divided into four topics for discussion:

- To ask people to think fifteen to twenty years ahead and consider where they might be living, what financial resources they might have and what contact they may have with family, friends and neighbours;
- To ask the same questions but after people had been read a description of physical incapacity that might happen to them;
- To ask the same questions but after people had been read a description of moderate dementia that might happen to them;
- Finally, to ask people to reflect on the different perspectives of their future lives that had been talked about and consider what kinds of services they might need to assist them in the above situations regardless of who paid for that provision.

Service user profiling

Profiling current service users entails three potential activities:

- Quantitative profiling – who do we know, when do we know them, what

did they need and what did they receive, at what cost;

- Mapping – can we numerically assemble who is known along a care pathway exploring the relationship between initial contact and who then goes on to receive more intensive provision (care homes, hospital, etc.), who leaves the pathway or who remains at the initial point of entry;
- Qualitative profiling – what do current service users genuinely think of the service provided to them, did the service match their expectations, and what impact does it have on their quality of life.

Each of these three activities potentially poses problems. For example:

- Social Services Departments and Primary Care Trusts have a wealth of data about their service users/patients and yet most is in a format where extracting and analysing that data in order to help plan future commissioning is virtually impossible;
- Whilst mapping care pathways may be possible, identifying key points where decisions are made that change the course of the pathway may be much harder;
- Getting genuine feedback on service provision is not easy. For example, some people may be anxious that if they are critical of service provision then it may influence the way in which that service is delivered to them or limit its availability; some older people who have suffered falls or strokes may limit their own expectations of making a full recovery and consequently have lower perceptions of the volume or type of service required. Finally, users and carers are often aware of what services are around and consequently there may be a tendency to concentrate on quantitative demand and ‘cut to the

chase’ of discussing services, rather than genuinely measuring need.

Analysis of met, but unsatisfied demand

This final element of demand forecasting is the most complex to describe yet, perversely, it may give rise to the biggest potentiality for change through improved commissioning leading to a reconfiguration of provision. It represents not just unmet need, i.e. where a need has been identified but a service has either not been provided or does not fully meet what is required, but a wider perspective of where need looks to have been met (indeed all parties may have been satisfied with what was provided) but it did not alter the outcome for the service user or carer or fully meet their potential for recovery or rehabilitation. To uncover this less overt need involves questioning whether people’s existing needs really are being met, or whether the volume, nature and type of current service is achieving the outcomes which a service user might desire or should expect. For example:

- Are there needs being presented where targeted interventions could prevent worse outcomes but where this is not occurring, e.g. people coming into care homes where the provision of an alternative, community-based service could prevent this happening?
- Is the intensity of the service provided sufficient to achieve the outcomes desired, e.g. in stroke services do we know what intensity of rehabilitation is required for a particular individual to achieve maximum potential recovery?
- Are there unintended consequences to current service provision, e.g. does the provision of mobility aids, through encouraging dependency, actuallyacerbate diminishing immobility?
- Is the point at which intervention occurs the point at which it is most likely to deliver the best outcomes, e.g. are eligibility criteria effective

rationing devices or do they debar people from provision at a time when it may have the greatest preventative impact.

Answering the above questions is a crucial part of the analysis that needs to be undertaken in developing a commissioning strategy. It may involve challenging professional barriers and stereotypes, it is time consuming and often there is not the data against which such questions can be definitively answered. It may also have considerable inter-agency implications. For example, low levels of health service physiotherapy provision may negatively impact on a person's capacity to recover from a stroke which, in turn, may lead to diminished mobility, which may eventually require considerably increased social care provision. Equally, the absence of an early social care intervention may impact on health services in requiring a costly hospital admission. Effective joint commissioning requires a strong evidence base and the capacity to track back through systems to establish cause and effect across organisational boundaries.

Using the data

So far, Demand Forecasting or Strategic Needs Assessment has been discussed in terms of the information to be captured. Its aim is essentially to discern three distinct populations:

- Given populations - people the LA or the PCT are bound to know because those individuals and/or their carers require assistance either because of the nature of their condition or through their frailty;
- Target populations - those populations an organisation should know now because they are at high risk and poorer outcomes could be prevented if interventions were to take place in the immediate future;

- Vulnerable populations – populations where intervention now may be beneficial either in terms of future prevention or in terms of significantly improving the quality of an individual's life.

As has been illustrated by the range of activities, distinguishing between these three populations clearly takes time and effort by commissioners. Not all of the research necessary can be undertaken at one go and, in some instances, effectively recording and monitoring demand may require new processes for capturing and recording data.

Understanding supply

Commissioners and the market

In recent years the phrase 'Managing the Market' has been much used although increasingly recognised as redundant. Opposition has come from those who suggest that if a market is managed then '*ipso facto*' it cannot be a true market, through to providers who argue with considerable vehemence, that they have no intention of being managed by the public sector especially as, in the case of older people, a large part of their income comes from those who fund their own care. As a consequence, increasingly, the phrase used has moved from 'market management' to 'market influencing or facilitating' in order to describe the relationship that commissioners have with providers. The Department of Communities and Local Government (DCLG, 2006) goes one step further and describes three distinct areas of activity for modern commissioners:

- *Market intelligence refers to the accessibility at a local, regional and national level of market data covering areas such as current market activity, current and potential suppliers, and future opportunities, to inform strategic planning on both the supply*

and demand sides, as well as market research for individual transactions;

- Market dialogue refers specifically to the quality and frequency of interactions between stakeholders on the supply and demand sides, in interpreting and discussing this data, to better inform individual transactions and the medium and long term development of supply markets for local government services;
- Market shaping refers to collaborative action by public sector organisations and the supply market as a whole to develop markets in ways that support the delivery of key policy objectives at both local and national level. (p. 97)

Whatever terminology is used, clearly future commissioning is moving beyond ‘what do we buy, at what price?’ Figure 3 below suggests that market intelligence entails covering four areas; conducting a quantitative and qualitative analysis of what is available now, mapping out what best practice would look like and evaluating what resources are currently available as a benchmark against which to judge future costs and charges. Although normally included within considerations of demand, it may also be useful to consider carers on the supply side, given those instances where if carers were not providing a service it would

require a response from the LA or the health service.

Quantitative analysis

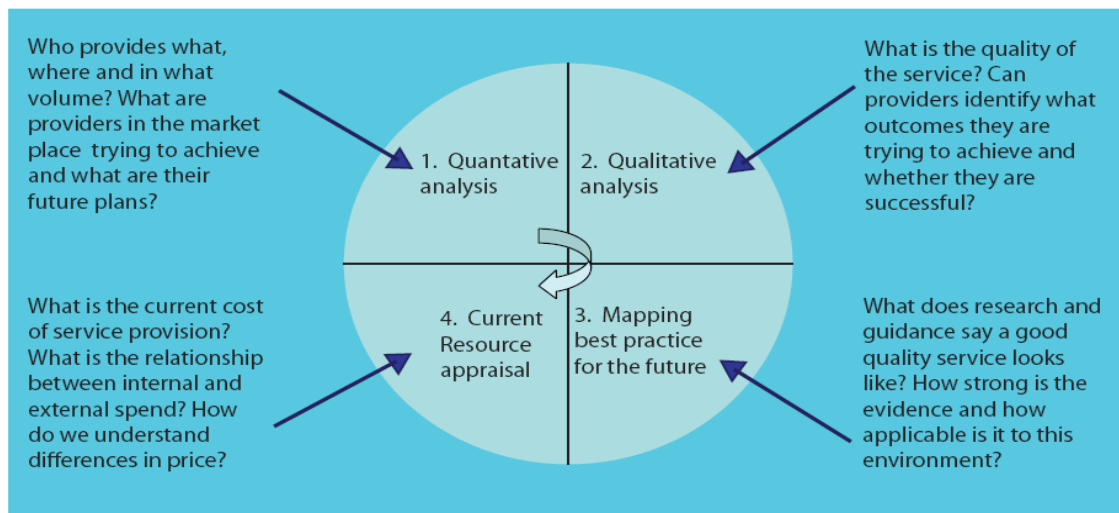
Nationally, the social care market is large and diverse. As the Audit Commission (2005) notes:

In 2004, an estimated 410,000 older people lived in residential and nursing homes across the UK. There are about 15,700 private, voluntary and LA care homes in the UK, providing care at an estimated annual value of more than £8 billion per annum. (p. 1)

The above is equally true of the third sector (IFF Research, 2007):

An estimated 35,000 third sector organisations currently provide health and/or social care in England and a further 1600 plan to do so in the next three to five years. The total funding for these services amounts to £12bn over the last year. This is a sizeable amount compared to the government’s £87bn budget for health and social care in England in 2005/06. (p. 1)

Figure 3 Mapping market intelligence



Although the above two reports describe the national volume of provision, the starting point for analysing local markets is about simply knowing what is available and where across the whole market, i.e. in-house services, voluntary and private sectors. It needs to identify shortfalls in provision and potential additional capacity. The data derived from this kind of review may be brought together and displayed in a number of ways. It may simply involve describing the name of providers or companies, what services they offer and how many places are available. Alternatively, the analysis could also provide type and size of service mapped geographically, like with like, services compared by price, levels of demand, comparison to what future types of service provision may be required.

Building on the supply map, commissioners need to have a clear view of what are the future plans of provider organisations and avoid making statements about the private and voluntary sector that are based on supposition rather than evidence. Sometimes this can include assumptions about future capacity to undertake tasks, both in terms of a lack of capacity or in terms of misjudging the direction that those organisations may be working towards. Finally, it is important in mapping the volume of supply to identify those areas where there is an over-supply of provision, either through vacancies, or through premises being used for a wider purpose than was intended. Judgements need to be made about pressure points, caused through potentially higher demand now or in the future (using the demand forecasting material), too high a price, or declining supply.

Qualitative analysis

If building the quantitative picture of the market is time consuming, building a qualitative view is both time consuming and difficult. Whilst qualitative views and opinions abound, little of that information is

assembled systematically or benchmarked against a set of standard criteria. Obvious sources for beginning this analysis are:

- CSCI inspections;
- Best value reviews;
- Complaints and letters of support about individual services;
- Anecdotal accounts from service users, carers and members of staff;
- Local and national consultative research.

Overall, the end product from this exercise should be a clear view of the qualitative aspects of current supply and on what this view is based. For each service this may mean making clear statements about what quality is to be expected, how has this quality standard been determined and how it is/was to be tested. Are there divergent views between commissioners, users/carers and providers? Are factors affecting quality temporary or permanent? Is there clarity about what the service is trying to achieve and is this based on outcomes or outputs? Both the quantitative and qualitative data could form part of the material that commissioners need to make available to the wider community as suggested by the *Commissioning Framework for Health and Well-Being* (DoH, 2007). It states that commissioners should enable:

any citizen – whether self funding or paid for by the state - to obtain good information and advice about local health, social care and well-being services. This should include information about whether services meet a minimum level of quality, how services compare to others in the area and whether they deliver value for money. (p. 19)

Mapping best practice for the future

Few commissioners in compiling their strategic approach appear to conduct a rational review of the research and best practice literature in order to help determine

what portfolio of services may be offered in the future. Consequently, change tends to be incremental or driven by factors that are not necessarily synonymous with best practice. In addition, there seem to be few attempts to engage with providers in a way that they could safely reveal their long-term plans and intentions. The emphasis, in many areas, on an arms length engagement with suppliers, does not always help this. Therefore, the end product from this activity should be:

- A model of good practice built on research and best practice examples, with a rationale as to how this provision would be better than that currently available;
- The start of a match between provision and the needs of users and carers.

Resource appraisal

Underpinning market intelligence is the need to gain a good picture of the current allocation of resources and to estimate the costs and benefits of current provision. Again, for most commissioners, whilst it is possible to identify what is paid for externally provided services and some unit costs of internal provision it is much harder to determine whether those services offer value for money or whether alternative forms of provision or re-configurations might offer a better service at a lower price. Some of the information that commissioners might wish to pull together at this stage includes:

- What is the financial range and mean for contracts for different service types?
- What is the distribution of resources as against service recipients?
- What are the cost differentials where services are commissioned as compared to being provided internally through a service level agreement? What is the explanation for these differences and does this deliver value for money?

- Are there any identifiable links between funding and outcomes?
- Are there providers that are financially vulnerable or markets that are under threat?

Some of the above material will be snapshots at a given date. However, this is an area where there is a strong need to understand trends in the market place, such as in contract values and turnover of suppliers. The end product from this exercise should be a succinct statement of costs of provision, both purchased externally and provided internally, together with the costs of commissioning and contracting as an activity. The statement should include an assessment of market strengths and weaknesses, trends or patterns amongst supply and areas of financial performance that could be targets for improvement.

Using the data

The above material suggests how commissioners gain market intelligence in order to inform their market dialogue. Bringing this knowledge of the supply side together with that on demand will entail answering further questions:

- What is the overview of the market in terms of who provides what and who pays or funds the use of that provision (remember this is the whole market not just that sector within which the LA or the PCT commissions)?
- Is there an over- or under-supply of certain services and on what is this based?
- What are the numerical trends in terms of volume and in terms of market share by key providers?
- Are services located in the right place now and in the future?
- What is the comparison between what is provided and what we know (from demand) about what people want?

- What are the costs, what are the trends in expenditure?

The starting point for analysis is always to focus on ‘what is the data telling us?’ For example, it is fairly straightforward to complete a visual map of current services but the key questions could be, “why has this pattern of services emerged and are there any shortfalls in current provision as a result of this type of evolution? Is there a danger of monopolistic supply? Is the availability of provision equitable across the authority?” In conducting the supply side analysis, the intention is to get as close to being able to link cost with activity with outcome. In most authorities, this is notoriously difficult given that data is often held in different systems and stored under differing categorisation. Tackling this may become part of the change agenda the strategy outlines.

Tackling the issues

The previous sections suggest activities to be undertaken by commissioners in order to map demand and supply in the social care market place. Mapping is not a one-off activity but a range of continuous knowledge acquisition tasks which, over time, build to inform commissioners’ understanding. The aim is to acquire the detailed knowledge necessary to influence the market to the benefit of actual and potential groups of users. Some of this will require commissioners developing new skills. This view has been recognised by the Department of Communities and Local Government (2006). They argue that:

...developing staff capacity in procurement will clearly be an important factor in driving improvement in the operation of local government services markets. However, as the demands on local government change, alongside the changing aspirations for its role, improvements in procurement capacity and capability alone may not be

sufficient to meet these demands. Other capacity constraints may also play a role, including:

- *The capacity for strategic commissioning as a core leadership discipline within local government;*
- *The need for improvements in capacity in understanding, analysing and influencing supply chains and markets to secure local and national priorities;*
- *The need for new ways of working and innovative strategy and delivery vehicles to support a strategic commissioning perspective. (p. 97)*

Examples of the kinds of skills that may be useful to future public care commissioners include:

- How to use local planning controls and mechanisms to influence access to land to promote or discourage the development of services;
- Developing a range of techniques, e.g. focus groups, polls, sampling methods, consultation events in order to better understand demand from a wide range of perspectives;
- The ability to develop local indicators of performance and the data sets that will provide commissioners with knowledge in the future that goes beyond who received what service, for how long, at what price;
- How to use seed-corn funding as an investor in order to influence the development of new services or to protect vital but vulnerable providers.

However, there are some dissenting views about the future role of commissioners and contractors. There is a suggestion that self-directed care, via direct payments and individual budgets, will in effect, abolish the local authority contracting task. Individual needs will be assessed from which, if eligibility thresholds are crossed, people will be offered an actual or a notional budget to purchase services from whomever

they wish. Roles of assessment, advocacy and brokerage remain but the contracting role at an individual and at a collective level will go. In this environment, even the strategic role of commissioning as envisaged in the guidance, may gradually vanish if the view is taken that the market will itself regulate supply to meet demand.

In reality, such a scenario seems unlikely. For example, many older people and carers want quality and choice but not additional responsibility on their part to achieve it, albeit that the scope of the service they receive is framed within a notional budget. Whilst some financial gains may be made through service users bringing new people to assist with care who were not previously in a carer role, such financial benefit is likely to be swiftly offset by higher costs through the inability of commissioners to block purchase services. Finally, whilst market forces may work well in other sectors in driving down costs, this may not be true in social care. For example, in the residential care of older people, where a private market has existed for a long time, there is little evidence that, through individuals purchasing their own care, the price has either been driven down or that the quality of care has been driven up.

The greatest likelihood is for a continued mix of contracting, with a higher proportion of service users directly purchasing their care but, at the same time, joint contracting continuing for those who do not opt for, or who cannot manage, alternative arrangements. This twin approach to purchasing would then be set in a context where the commissioner's task is to ensure that there are sufficient volumes of provision available at a high quality standard, whether individually or collectively purchased, and where such services deliver the outcomes that both users and commissioners desire.

Given the above, this positions commissioning managers in the future as

'investors' on behalf of the public. To achieve this, they will need to have authority to intervene at a senior level within organisations, to be able to negotiate with a wide range of providers, service users and carers, to have good analytical skills and to have a vision of the future, based on sound evidence, that they can drive forwards with a wide range of individuals and organisations.

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In the know: Knowledge Transfer Partnerships – encouraging the development of an evidence-informed approach to practice through a successful partnership between a University and a Local Authority

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Abstract

Wakefield Metropolitan District Council Family Services and the University of York are taking part in a two year collaborative Knowledge Transfer Partnership (KTP) project, the aim of which is to encourage a culture of evidence-informed practice and continual improvement within Wakefield MDC's Family Services as part of the Directorate's performance management framework, and to ensure that the Research Governance Framework (RGF) in Health and Social Care (Department of Health, 2001 & 2005) is fully implemented.

This paper will outline the key aims and objectives of the project, and explore the benefits of Knowledge Transfer Partnerships as a model for knowledge exchange. It will also describe the successful completion of the initial stages of the project, which included an RGF benchmarking project and the development of a communication and engagement strategy aimed at increasing awareness of the potential value of research and evidence-informed practice. The paper will also highlight examples of good practice which can be replicated in other Local Authorities.

Keywords: Research, evidence-informed practice, knowledge transfer, research governance

Introduction

The expectation that social care, education and health practitioners will use the best available evidence to inform their practice has intensified in recent years, as is clear in the range of recent policy initiatives that have stressed the importance of developing a 'sound evidence base' in relation to service provision (Department of Health, 2006). At the same time, there has been an increased emphasis on the effective governance of research, and in 2001 the Department of Health published the *Research Governance Framework in Health and Social Care* (RGF), which places a new requirement on Local Authorities to assess the quality and ethics of research before allowing access to service user and staff populations.

Against this background, Wakefield Metropolitan District Council (Wakefield MDC) and the University of York have entered into a two-year Knowledge Transfer Partnership, the aim of which is to fully implement the RGF and to develop a culture of research and continual improvement across Wakefield MDC's Family Services Directorate. The project has now been running for ten months, and this paper will highlight some of the key achievements and challenges from this period.

Knowledge Transfer Partnership (KTP)

Knowledge Transfer Partnership (KTP) is a UK-wide programme funded by 13 Government organisations led by the Department of Trade and Industry (DTI). Each project is part funded by these Government organisations, with the balance of the costs coming from the 'company'

partner. During 2007, the lead sponsor will change from the DTI to the Technology Strategy Board, and an additional 3 sponsors will join the KTP Management Board, bringing the total to 16 (KTP Management Board, undated).

Each partnership employs one or more graduates ('associates'), who are employed by the 'knowledge base' organisation, and seconded to the 'company' partner on a fixed term contract. The primary aim of any KTP project is to transfer knowledge from the knowledge base partner into the company partner in order to meet specific business aims and priorities. However, in reality, the transfer of knowledge is effectively a two way process.

This partnership is one of the very few examples of a public sector KTP, with the vast majority of KTPs taking place in private business and industry. However, the DTI are keen to reproduce the benefits of KTPs across the public sector, and this project may therefore provide valuable lessons and examples of good practice that can benefit future partnerships. In this sense, the value of this project lies not only in the potential benefits for those directly involved in it, but also the benefits it may offer to the wider sector.

Benefits/disadvantages of KTPs

In general, the benefits/disadvantages of Knowledge Transfer Partnerships can be categorised in relation to three areas:

1. Benefits/disadvantages to the company;
2. Benefits/disadvantages to the knowledge base;
3. Benefits/disadvantages to the associate.

1) Benefits/disadvantages to the company

An obvious key benefit is the knowledge transfer and better links with universities

and other educational institutions that the partnerships enable. In addition, many KTPs bring financial benefits to the company partner, and it is estimated that, on average, each partnership will result in over £200,000 increase in annual profits (Momenta, undated). However, this focus on the financial benefits of KTPs highlights one of the key disadvantages of the programme, which is that its language and structure are geared towards private profit-based industries: an approach which doesn't necessarily lend itself to public sector organisations. Whilst, undoubtedly, KTP projects may bring financial benefits to public sector organisations, the nature of these organisations means that the success of the project cannot be measured in monetary terms alone.

This is particularly problematic in terms of applying for funding for a KTP, as the application form asks applicants to clearly state what the expected benefits are in terms of profit. With regard to public sector organisations, it is difficult to predict these benefits at the time of application, and the application process does not recognise the potential for any non-monetary benefits. However, public sector organisations can be creative in the way that they answer this question, as there is no requirement to provide proof of any profits or losses at the end of the project.

A further potential disadvantage is that there is usually no extra funding available for KTPs, and thus if the project runs over schedule, it may place a financial strain on the company to complete it. Similarly, the sustainability of the project may also be affected due to a lack of any additional funding, and it is therefore vital to the success of any project that the issue of sustainability is carefully considered in the project plan.

2) *Benefits/disadvantages to the knowledge base*

Some key benefits to the knowledge base include opportunities: to develop business/practice-relevant teaching materials; identify new research themes and undergraduate and post-graduate projects; and publish high quality research papers, thus contributing to the Research Assessment Exercise (RAE) assessment and rating of their department (Momenta, undated).

With specific reference to this project, a further key benefit is the links that have been made with Wakefield MDC's Family Services Directorate (which includes the functions of adult and children's social services and education), which have the potential to offer increased opportunities in relation to practice learning and access to research populations.

3) *Benefits/disadvantages to the associate*

Undertaking a KTP project gives associates the opportunity to manage, with support, a challenging project that is central to the strategic development of the organisation in which they are placed. Associates are also encouraged to undertake personal development activities, and are enabled to do so through the provision of an associate development budget, and free access to business management and leadership skills training and an NVQ level 4 in Management. Associates are also permitted to spend 10% of their time on personal development activities.

A further key benefit is the triangular system of supervision, where associates receive academic and business related support through supervision with a representative of the company and of the knowledge base. However, this may also be a disadvantage if the company and knowledge base partners have competing priorities, as associates may be asked to

carry out conflicting tasks or be given conflicting advice which will impact on their ability to successfully complete the project.

Project outline

The primary aims of this project are to build upon the interim arrangements already in place within Wakefield MDC to ensure that the Research Governance Framework (RGF) is implemented, and also to stimulate the development of new research activity to encourage a culture of evidence-informed practice and continual improvement throughout Wakefield MDC Family Services.

The need for quality research has been reaffirmed through the publication of the Research Governance Framework (Department of Health, 2001 & 2005). The RGF requires health and social care services to register, approve and monitor all relevant research under a clear structure in relation to five key principles:

- Ethics;
- Science;
- Information;
- Health, safety and employment;
- Finance and intellectual property.

The main responsibility for Wakefield MDC is thus to assess the quality and ethics of any proposed research before allowing access to staff and service user populations.

In addition to promoting and enabling the effective governance of research, there is also an increasing emphasis within policy on using research evidence (amongst other types of knowledge) to inform practice. As Nutley *et al.* (2002) argue, although there is "nothing new about the idea that policy and practice should be informed by the best available evidence" (p. 2), the ideas and themes surrounding evidence-informed practice have "risen to prominence over the past two decades" (p. 2).

Furthermore, Humphreys *et al.* (2003) suggest that the evidence-informed practice debate is now taking place in a much changed arena, and that the rise in demand for evidence-informed practice needs to “be understood alongside the rise in other practices which are currently dominating this area ... in particular, the managerial agenda with its attention to performance targets, procedures, outcomes and value for money in a constricted resource environment” (p. 41).

It is thus argued that the effective use of research is crucial at the levels of both individual practice, in terms of aiding understanding and decision-making and assisting with the management of change and innovation in agencies, and also at the level of performance management, in terms of ensuring that research is integral to the overall strategy of the organisation in order to ensure the continual improvement of services. The primary aim of the project is thus to develop a means of embedding research as part of the Family Services Directorate’s Performance Management Framework in order to ensure that service delivery is effective and efficient.

The project also aims to incorporate an outcomes approach. Outcomes approaches usually focus solely on outcomes for service users. As Nicholas and Quereshi (2004) point out, a whole range of recent policy initiatives have “stressed the importance of maintaining a focus on outcomes when designing, delivering and evaluating social care” (p. 1). Outcomes approaches are also becoming increasingly integral to performance management, with the new performance assessment framework (CSCI, 2006) being based on the seven outcomes identified in the White Paper *Our Health, Our Care, Our Say* (Department of Health, 2006), and the five outcomes identified in *Every Child Matters* (Department for Education and Skills, 2003). In this sense, one aim of the project is to facilitate the increased and more efficient use of research

in order to develop services that are able to achieve desired outcomes for service users.

However, whilst the underlying aim of the project is to improve services, the direct impact of the project on services would be difficult to measure, and the impact of any service changes on outcomes for service users would be an even more challenging task. Thus, for the purposes of the project we will be focusing on outcomes for staff, as the project will aim to have a direct and measurable impact on the perceptions and skills of staff and the levels of research utilisation across the Directorate, and, correspondingly, outcomes for staff. The project also seeks to engage staff in developing these outcomes measures, in order to ensure that outcomes are relevant to both individual staff members and the organisation as a whole.

A key challenge for the project lies in Wakefield MDC’s recent restructure. At the application stage, it was anticipated that the project would be embedded within the former Social Services and Health Directorate. However, during the application process, the new Family Services Directorate was formed, bringing education alongside adult and children’s services under one Corporate Director. There is little doubt that the education sector can, potentially, benefit from the development of a research culture in the same ways that the social care sector can (see, for instance, Simons *et al.*, 2003). There has also been a recent drive within policy for “a more cumulative evidence base to inform decisions about policy and practice” in education (Sebba, 2004, p. 1), and it was therefore agreed that it would be logical and advantageous to roll out the project across the whole of the new Directorate in order to ensure a coherent and consistent approach to research. The full inclusion of education into the project does, however, pose a challenge that was not originally anticipated, and we will need to

ensure that we address this at each stage of the project.

The next section will describe the successful completion of some of the initial stages of the project, which included an RGF benchmarking project and the development of a communication and engagement strategy aimed at increasing awareness of the potential value of research and evidence-informed practice.

RGF benchmarking project

One of the first tasks of the project was to undertake an RGF benchmarking exercise. The aims of this were to: gather information about the RGF systems in place in a number of other Councils with Social Services Responsibilities (CSSRs); use this information to evaluate the current RGF systems in place within Wakefield MDC; and develop proposals for the improvement of Wakefield's RGF systems – drawing on examples of good practice from the other CSSRs.

Methods

Information was gathered from each of the seven CSSRs involved by talking to relevant members of staff, including those responsible for implementing the RGF, and examining their written RGF policies, procedures and application forms. We also felt that it was important to assess Wakefield MDC's RGF systems in relation to a wider, national picture of implementation, and we thus combined the information that we had received from the above CSSRs with information from the RGF literature, and information from the two national baseline surveys that were carried out in 2002 and 2005 (Pahl, 2003 & 2006). From this, we were able to develop the following list of Benchmarks to assess Wakefield MDC's and the other CSSRs' RGF systems against:

1. Systems to ensure that all staff are aware of the RGF;
2. Ensuring that all research is recorded centrally;
3. Independent ethics/methods reviews;
4. Managing/monitoring research;
5. Routinely notifying relevant staff about approved research;
6. Ensuring that levels of scrutiny are proportionate to levels of risk;
7. Systems to ensure that a sponsor is in place for all external research;
8. Checking that arrangements are in place to seek informed consent;
9. Checking that the research will meet the requirements of the Data Protection Act 1998;
10. Checking that the research meaningfully involves users and carers, and that it takes account of diversity and the need for appropriate methods of obtaining and disseminating information;
11. Checking that research applicants have examined existing sources of research evidence to ensure that their work will not duplicate that of others;
12. Checking that information is provided on how the research will be disseminated;
13. Checking that health and safety procedures will be observed, and that risks are minimised to both researchers and participants.

Recommendations

On the basis of this analysis, the following recommendations were made:

- Amending/developing Wakefield's RGF application form to ensure that it asks for information about:
 - The experience/skills of the lead researcher/their supervisor;
 - CRB checks;
 - How the project will conform to the requirements of the Data Protection Act 1998;

- Details of insurance cover;
- Service user/carer involvement in the research process and/or design of the research proposal and/or the process of analysing and disseminating the research findings;
- Issues of diversity and equal opportunities, including accessibility of the research methods and research findings. How will service users be enabled to participate in meaningful ways? How will they be compensated for their time? How will the research findings be presented to them?;
- Informed consent, and how it will be achieved and maintained throughout the project.
- Developing a communication and engagement strategy to ensure that all staff are aware of the RGF, and to ensure that staff are routinely notified about approved research;
- Establishing better links with the Corporate Research Team, and developing systems to transfer records to the SCIE National Research Register once it has been launched;
- Developing systems for independent ethics/methods review to include front-line staff, service users, carers, representatives from adult, children's and education service areas, and representatives from a University to provide specialist knowledge on research methods. Exploring opportunities to develop links with health in this area;
- Designing and implementing systems to ensure that research is monitored throughout the project.

Summary

The extent to which the RGF has been implemented across the CSSRs in this study mirrored, to a large extent, the national picture of implementation as illustrated by the two national baseline surveys (Pahl,

2003 & 2006). Thus, both locally and nationally, the vast majority of CSSRs have taken steps to ensure that the RGF is implemented to some extent (Pahl, 2006, p. 15). Wakefield MDC's RGF systems and structures also seem to be on a par with those of the other CSSRs in the study. Although the present RGF system has some weaknesses (robust systems for independent ethical and methodological review need more development), in other areas it seems to be ahead, for instance in terms of recording research centrally.

Once the recommendations from this study have been implemented, Wakefield's system will incorporate national and local examples of good practice, and will be well placed to achieve comparability with some of the more robust RGF systems that already exist. However, all the CSSRs' RGF systems had strengths and weaknesses, and many attributed these weaknesses to "lack of resources and time ... lack of support and information from DH, lack of specialised research staff within departments and problems in getting staff interested in the RGF" (Pahl, 2006, p. 3), again mirroring issues expressed by CSSRs in the 2005 national baseline survey (Pahl, 2006). Pahl (2006) recommends that in order to resolve these issues and improve RGF systems, there needs to be the development of national, centrally controlled measures which focus on financial support for RGF, a national lead for social care ethics review and provision of further training and information. Until this happens, implementation may therefore remain patchy in some areas, even in those CSSRs that have made a great effort to implement the RGF fully.

Communication and engagement strategy

The aims of the communication and engagement strategy are to: increase awareness of and knowledge about the RGF, and ensure that all staff are aware of their responsibilities under it; increase

awareness of the potential value of evidence-informed practice; develop strategies which aim to overcome barriers to research and give staff the skills, knowledge and ability to carry out and/or utilise research more effectively; increase the utilisation of research; and increase organisational commitment to the development of a research culture.

In addition, it is hoped that by engaging key stakeholders and securing their support at an early stage in the project, any resistance to the embedding of a research culture can be ameliorated. For instance, as Slovin (undated) suggests, successful changes in organisations are “predicated on all members of a team being active participants” in the change, and that therefore “every person must have a voice in support of progress, or changes will be resisted”.

The strategy identified, from the literature¹, the following key barriers to utilising or undertaking research in social care, education and health settings:

Lack of awareness of the RGF	Lack of training
Lack of time/workload pressures	Agency culture
Lack of resources	Lack of motivation
Lack of accessible research findings	Lack of awareness of the value of utilising/undertaking research
Lack of skills/confidence	Lack of organisational/managerial commitment

For each of these identified barriers, the strategy then outlined a number of proposed remedial approaches, which included:

1. Undertaking a staff research survey;
2. Holding a research and evidence-informed practice conference;

3. Developing an information pack to link research and evidence-informed practice with the General Social Care Council requirements for re-registration of qualified Social Workers;
4. Continuing to link research and evidence-informed practice with the Directorate’s performance management framework.

1) Staff research survey

The aims of the survey were to:

- Determine the proportion of staff that currently undertake and/or use research;
- See if there are variations in research use across different areas of the Directorate;
- Provide a baseline measurement of research use so that the survey can be repeated towards the end of the project as a means of measuring its impact;
- Determine what staff consider to be the barriers and enablers to using and/or undertaking research, in order to develop further strategies to overcome these barriers;
- Engage staff in developing outcomes measures;
- Begin to engage staff as part of the communication and engagement strategy.

219 questionnaires were sent out to staff, and 105 were returned – a response rate of 48%. This high response rate is likely to be partly due to the fact that the survey was anonymous. However, even when this is taken into account, the large number of completed surveys received is encouraging, and may indicate a good level of interest in research and evidence-informed practice.

The staff in the sample were selected purposively so that all relevant service areas were reflected in the sample (Commissioning, Performance and

Partnerships; Adults; Physical Disabilities and Older People; Safeguarding and Family Support; and Schools and Lifelong Learning). They were also chosen with regard to the following inclusion criteria:

- staff who have direct contact with service users;
- and/or staff who are involved in research;
- and/or staff who are involved in service planning.

These staff represent the area of the workforce that the organisation would wish to target for the development of an evidence-informed practice approach.

The results from the survey indicated that a high number of staff do already engage with research. For instance, 60% of the respondents said that they had taken part in research, 47% said that they had undertaken research, and 85% said that research helps to inform or shape their practice. However, the results may not be truly representative of the population, in that those who had taken part in research may be more likely to have a current interest in research, and may, therefore, be more likely to take the time to complete and return their questionnaires.

Nonetheless, even when this is taken into account, the high numbers of people reporting that they have taken part in research appears inconsistent with the fact that a relatively small amount of research activity has been recorded in WMDC's corporate research database, or brought to the attention of those responsible for performance management and those responsible for planning and developing services. This would therefore indicate that a significant amount of research is taking place, but that staff are under-reporting their research or the systems in place for recording and sharing information from this research are inadequate.

In order to address this, a number of strategies have been recommended, for instance:

- Continuing to implement the RGF, which places an obligation on all CSSRs to identify research activity to ensure that research is not undertaken without being assessed against the RGF criteria. This will be achieved by continuing to advertise and promote the RGF to all staff.
- The RGF also requires CSSRs to maintain records of all research activity undertaken, and this will be achieved by maintaining a database for Family Services research, as well as submitting details of all research undertaken to WMDC's corporate research database and a national research database maintained by SCIE.
- Working with the Staff Development team to develop a system for the recording and sharing of information collated as part of a qualification/learning activity. For instance, establishing a 'library' for literature reviews that can be accessed by practitioners, and holding regular workshops where practitioners can talk to others about any research that they have carried out as part of their qualification/learning activity.

The results from the survey are also useful in identifying gaps in research resources and training. For instance, the resource that is available to the least amount of people is opportunities to work with researchers, and this was also something that was identified as a key resource that staff would like to be available. To some extent, this is likely to be addressed by full implementation of the RGF, as researchers will be obliged to share the findings of research with those involved (Department of Health, 2001 & 2005). In addition, a research conference is being organised (see below), which will give staff the opportunity to engage directly with

research staff from Universities, as well as colleagues who have experience of undertaking research. We will also be looking at the possibility of some members of staff being seconded to Universities for a short period of time, which could enable them to learn new research related skills and possibly take part in some research.

2) Research conference

Nutley *et al.* (2002) argue that one of the key requirements for improving evidence-informed practice is the “effective dissemination of evidence to where it is most needed and the development of effective means of providing wide access to knowledge” (p. 1). A conference which combines information about research with relevant examples of research will therefore allow us to promote evidence-informed practice and the RGF to a wide audience, whilst at the same time disseminate research findings to staff at all levels of the organisation. Some of the research examples will be presented by researchers, which will also provide an opportunity to develop “better, ongoing interaction between evidence providers and evidence users”, which Nutley *et al.* (2002) argue will also help to improve the uptake of research evidence (p. 9).

In addition, the conference will further demonstrate an organisational commitment to research, particularly as the Corporate Director of Family Services will be in attendance.

3) General Social Care Council (GSCC) re-registration information pack

The GSCC requires Social Workers to complete 90 hours or 15 days of study during their period of registration (3 years), and states that any failure to meet this condition may be considered misconduct, which would have implications for re-registering after this period. This study can include undertaking research that is related

to their practice, negotiating protected time to research latest policy and good practice developments in their field of practice, and reading a research article, report or document that leads to new insight or learning (GSCC, 2006).

Drawing on these requirements may therefore be an effective way of promoting and encouraging the use of research amongst social work qualified staff. It may also be an effective way of engaging qualified staff, as it is highlighting activities that they are already required to undertake, rather than asking them to undertake new activities in a climate of workload pressures and perceived lack of time for new initiatives.

In partnership with the Staff Development and Practice Learning Unit, we have therefore developed an information pack, which includes an outline of the GSCC requirements, recommendations on how to use research to contribute towards Post Registration Training and Learning (PRTL) requirements, and a log for staff to record their PRTL hours. The pack also includes fact sheets which offer information and advice to staff in the following areas: evidence-informed practice; sources of research; useful internet resources; tips for critically appraising research; tips for internet research; and the RGF.

4) Performance management

Locating the project within the Directorate’s performance management framework will also help us to ensure that research is fully embedded within the organisation. For instance, there is a requirement for each individual team to produce a team plan, indicating key performance targets and areas for development/improvement. We have amended the team planning template to include a section asking teams to outline any research they have undertaken, any research that they plan to undertake in the next financial year, and any research that

they have used to develop their services. This will help us to further promote the RGF and evidence-informed practice, as well as providing a forum for staff to begin to think about research and how it impacts on the services they provide.

Summary and what happens next?

Although the survey indicated a clear interest in research, and considerable levels of current engagement with research, the recommendations and strategies outlined above will help to further improve this, and ensure that the systems and structures are in place to facilitate a clear, consistent and comprehensive approach to research. This will be further enhanced by subsequent stages of the project, which will include further review and development of the RGF, including establishing an ethics panel, and developing a system of research mentors to champion research and evidence-informed practice across the Directorate.

The success of the project also depends, to a large extent, on research activity continuing to flourish beyond the lifetime of the project. The above strategies therefore aim to help ensure that the project is sustainable, and one of the key means by which this will be achieved is to ensure that change occurs at an organisational level, as well as at an individual practitioner level.

As Walter *et al.* (2004) suggest, there are three models for research use in social care, and the most effective means of enhancing and sustaining research activity may be to develop a ‘whole systems’ approach which incorporates aspects of all three models.

The three models are:

- The *research-based practitioner* model, in which it is the responsibility of the individual practitioner to keep up to date with research and apply it to their practice;

- The *embedded research* model, in which research is embedded in the systems and processes of social care, such as standards, policies, procedures and tools; and
- The *organisational excellence* model, in which research use is supported by developing a research minded culture across the whole organisation.

This article therefore acknowledges that a focus on individual practitioners is important, but insufficient in itself, and that it needs to be combined with an approach that also recognises that “the key to successful research use lies with ... delivery organisations: their leadership, management and organisation” (Walter *et al.*, 2004, p.xvii). Thus, as well as measures aimed at individual practitioners, there are also measures that seek to have an impact at an organisational level.

Endnote:

¹Sources used: Cooke *et al.* (2002), McCaughan *et al.* (2002), Nutley *et al.* (2002), Research Mindedness in Social Work and Social Care (2002), Rycroft-Malone *et al.* (2004), Small (2005), Thompson *et al.* (2005) and Walter *et al.* (2004).

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Safeguarding children in sport: a view from Rugby League - the policy process, participative cultures and local relationships

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Abstract

The national governing bodies of sport in the UK are now heavily involved in developing and delivering child protection policies. Research in this area is in its infancy. The impact that such policies have on sport and its participants is important to explore. This paper is based on the findings of the first phase of a research project which is evaluating the UK Rugby League's child protection policy. The article identifies the current 'state of play' concerning child protection policy in sport and advocates for a clear policy process for individual sports clubs; the development of a participative culture which 'voices' children within sports clubs and organizations; and the development of identifiable relationships between statutory authorities and sports bodies.

Keywords: Children, protection, sport, policy

Introduction

The national governing bodies (NGBs) of sport in the UK now have a mandate to produce, disseminate and embed child protection policies (Sport England/NSPCC, 2003). This departure indicates a significant point in the development of organized sport. One outcome has been that NGBs and their affiliated organizations have increasingly come into direct contact with bodies whose statutory responsibility or voluntary mission is the well-being of children. This has presented a considerable challenge for sport and as such warrants analysis. The authors are undertaking an evaluation of British Rugby League's child protection strategy with a view to developing a theoretical framework for 'good practice' in this area. This article draws upon findings from the first phase of an evaluation of Rugby League's policy process and extends the analysis elsewhere presented by the authors (Hartill & Prescott, 2007). Although the research focused on Rugby League, the findings have been set within British Sport's response to contemporary child protection policy imperatives. The article provides amplification and extension of the key findings from the policy research and, in so

doing, argues for clubs in all sports to use a clear, distinct policy model and to develop a 'participative culture' for children and young people. It also recommends the development of direct, clear and identifiable relationships between statutory authorities and sports bodies. The paper is above all concerned with when and how child protection policy is finally delivered at 'club' level.

Lasswell (1948) essentially argued that public policy should be seen as a form of public education (cited in Hudson & Lowe, 2004). It is a part of citizenship where people learn to engage with their society for their own improvement and for the betterment of society as a whole. The policy process needs to be explored at all levels, macro, meso and micro. In the context of child protection policy in sport a significantly large group of people are being engaged and educated in contemporary constructions of, and policies concerning, child protection and the safeguarding of children. Key issues therefore arise concerning the development and implementation of child protection policy in sport at the macro level where different countries are part of a global movement in

this context and indeed part of wider discourses of the globalisation and cultural politics of childhood. This article, however, focuses on the meso and micro levels of policy analysis. The meso level analysis here, often seen as the middle part of the policy process, concerns itself specifically with the development of child protection policies in sport and “the structure of the institutional arrangements in which policy is defined and eventually implemented” (Hudson & Lowe, 2004, p. 9). The micro level focuses on ‘ground level’ individuals and their role in the design and implementation of child protection policy and practice, at the heart of which is a structure-versus-agency debate.

Sport’s response to the child protection agenda

Child protection policy and sport can certainly be seen as part of changing child protection discourses within UK society and of the concomitant policy process in this field. Sport has ‘come late’ to the child protection arena and could therefore be in danger of just accepting traditional protectionist approaches to children’s welfare and indeed the current safeguarding of children agenda which can be seen as particularly protectionist in its intent (Parton, 2006). However, sport has the opportunity to forge ahead with developing a policy that clearly advocates for, and ‘voices’, children and young people. The ‘late in the day’ label that can be attached to child protection within sport does appear to support, to some degree, Lindblom’s (1959) view of the policy process as being incremental. It took a number of relatively high profile abuse cases before the issue was taken seriously. Here too is an example of a reactive approach to meeting children’s welfare needs which has been seen to be symptomatic of social policy for children in the UK in the past.

In sport, the recognition of child abuse as a problem can be seen to have arisen out of

feminist concerns about sexual harassment (Lenskyj, 1986; Brackenridge, 1987). Through the 1990s pressure mounted on practitioners and policy makers to implement change as the number of academic studies (Brackenridge, 1992, 1994 & 1996; Kirby *et al.*, 2000) and media reports (British Broadcasting Corporation, 1993; Spencer, 1995; Nack & Jaeger, 1999) on childhood sexual abuse in sport grew. In 1993 Paul Hickson, a former Olympic swimming coach, was convicted of rape and sexual assaults against female teenage swimmers previously in his care. This case attracted considerable media attention and proved to be a catalyst for more widespread calls for the reform of sport and how it treated children. Similar revelations of abuse followed in Canada (Robinson, 1998).

The Child Protection in Sport Unit (CPSU) was the significant outcome of this pressure for change (Boocock, 2002). This partnership between the NSPCC and Sport England falls under the remit of the Department for Culture, Media and Sport and is the most significant political response to concerns over child maltreatment within international sport (David, 2005). Nine fundamental standards for child protection, a three-tiered accreditation system (preliminary, intermediate, advanced) and a clear timetable for implementation¹ are linked to central funding for English governing bodies (Sport England/NSPCC, 2003). The preliminary level relates to the development of a child protection policy and a plan for its implementation; this has been achieved by the Rugby League, and the majority of centrally funded sports. However, “it is known that some NGBs [National Governing Bodies] initially failed to meet the required minimum standards” (Brackenridge *et al.*, 2005, p. 260).

The *Strategy for Safeguarding Children and Young People in Sport, 2006-2012* (Sport England/NSPCC, 2006) follows up these ‘Standards’. As the recent *Change for Children* agenda in the UK has

demonstrated, there is often a role for organised sport where social policy initiatives are introduced to address child welfare. Culture, sport and play organisations have a unique role to play (DfES, 2004) and, as Brackenridge *et al.* (2007) recently concluded, “youth sport ... may now have assumed the status of the ‘sixth social service’” (p. 205) where sport is constructed as a ‘purity system’. However, Brackenridge *et al.* also note the ‘transformative effect’ such policy developments have had on “ethical reflection in sport” (2004, p. 334). Thus, child protection policy may be viewed as a necessary and welcome addition to the world of organised sport.

Questionnaire: the method

The authors have undertaken the first two phases of an evaluation of the UK Rugby Football League’s child protection policy (RFL, 2003) and the findings reported are concerned with the initial response to a child protection agenda from amateur and professional clubs across the UK (Hartill & Prescott, 2005). The study focused on what happened when the policy reached the organizations and individuals who were expected to work with it. A critical analysis of the policy process, that is the impact of the development, dissemination and early implementation of a child protection policy in the context of a specific sport, Rugby League, was produced.

Data collection was via postal questionnaire to all rugby league clubs with a junior/youth section affiliated to the RFL (N=205). Follow-up telephone calls to all non-respondents produced an overall response rate of 37% (N=75). While the respondents were not representative of all levels within the RFL they were the specific individuals held responsible for the implementation of policy at club level, in other words, designated child protection officers (CPOs)². This was a sample survey and the respondents were a representative group in

the contexts of sport, rugby league and their specific role as CPOs. The research deliberately focused upon the thoughts, feelings and opinions of the CPOs with regard to the impact of the policy on themselves and their club.

A thematic analysis of the data was undertaken (Gomm, 2004) and the questionnaire results were coded in the sense of employing a technical process of indexing the data to indicate what themes appear and where. Clearly, the themes suggested themselves as a result of repeated reading of the data. This grounded the themes, and their interpretation, in the data whilst still acknowledging the imposition of structure on the findings. The research findings generated a spotlight on two particular areas of the policy process: first, the presentation and delivery of the policy; and second the impact in individual clubs of that presentation.

Discussion of findings

The discussion here provides a sharper focus and an extended analysis of the first phase findings. This focus is on three areas: the policy process and the impact of a child protection policy; the development of a participative culture and the ‘voicing’ of children and young people; and sports clubs’ external relationships with local authority safeguarding bodies.

The response from one club CPO illustrates some of the difficulties faced by those in rugby league sensitive to child protection issues:

I am regularly dismayed to hear comments that such policies are the thoughts of ‘do gooders’ and there are no such problems in junior rugby league.

The RFL policy states: “All clubs must identify a designated person to be titled the Club Child Protection Officer to handle child protection issues” (2003, p.16).

Although some clubs had not appointed a CPO 12 months after the launch of the policy, findings indicated that clubs had generally responded in a positive manner.

Presentation and adoption of the policy

The manner and format in which policy and guidelines are presented to individual members of sports clubs is a critical indicator of the legitimacy and importance afforded to the policy by the club. Unfortunately, some time after receipt of the policy, over a fifth of the respondents said they had not presented the policy to their members. Further, whenever the policy had been presented directly to club members, with one exception, it was in the context of either a general meeting or a meeting exclusively for coaches or limited numbers of club personnel.

A key concern arising from the data was that child protection should not be 'slipped' into the general agenda, sometimes as an 'AOB' [Any Other Business] item. A typical response was that the policy:

Has been an agenda item and is located in central office file.

This does suggest a lack of prioritization that, it has been argued, occurs through fear of creating a 'moral panic' and frightening away potential players, their parents and coaches (Hartill & Prescott, 2003). This does construct child protection or at least the policy as only one of a number of competing issues in a context that has no previous record of considering such matters.

'Specialist' meetings for selected personnel do not encourage ownership of the policy by all members of the club and, importantly, do not involve children. The issue of 'gatekeepers' who fail to facilitate the dissemination of knowledge is problematic. For example:

I distributed the essentials of the policy document to the coaches only.

Children's individual and collective voices are expected to be included in all processes affecting them (Children Act, 1989; UNCRC, 1989) and the promotion of participation is underpinned in England by such initiatives as Quality Protects (1998) and *Every Child Matters* (2003). Awareness at club level is crucial to the achievement of children's rights, in any sporting context. Annual general meetings and other formal meetings do not make any allowance for children's participation and, even if they did, children and young people would be unlikely to offer their views without appropriate participatory and/or advocacy provision being put in place.

Increasing the sports community's awareness and knowledge of issues of child protection is a key feature of the policy process and the impact of the policy on Child Protection Officers' knowledge is therefore of no little importance. Measurements of this are inevitably subjective because CPOs were asked to say whether the policy had added to their knowledge about the problem of child abuse. Some respondents may have identified an increase in knowledge that, in reality, did not occur while others may have underplayed the increase. However, the question did allow CPOs to express how they had perceived the usefulness of the document.

Nearly half of the research respondents felt that their awareness and knowledge of child abuse had either been increased or reinforced. The following examples are indicative of this:

Opened my eyes to the different ways children could be abused even without violence.

Some people think child abuse is sexual, it has made them more aware of other

types of abuse, e.g. shouting and name calling – bullying.

Brought the obvious and not so obvious signs to the front of our minds with a better ability of how to deal with problems as they arise.

The Rugby League's policy states, "ideally, they [CPOs] should have a background in working with children" (RFL, 2003, p. 16). Therefore, it was not surprising to find a reasonable degree of awareness amongst identified CPOs. However, some concern arose when responses explicitly stated that the policy document had had no impact on their awareness/knowledge or that the management of the Rugby League was overreacting in some way:

Don't think it has impacted on our knowledge in any way.

[The policy has] increased awareness but I do feel this is a bit of a sledgehammer to crack a nut situation in Rugby League.

CPOs were then asked about how the policy had impacted upon their club. It is reasonable to suggest that as 'gatekeepers' these designated CPOs are in the best position to determine whether the policy has been well received by club officials and members. Such information is crucial when considering relatively 'closed' environments, such as private sports clubs. Overall, the majority of responses from individual rugby league clubs were positive. The Rugby League community has begun to accept, and in some cases embrace, child protection issues as part of the fabric of their sport. This is an encouraging step forward as it represents a break from the silence which has shrouded child abuse in sport (Kirby *et al.*, 2000) perhaps particularly in male-dominated, 'manly' sports such as Rugby League.

Embedding knowledge, awareness and policy concerning child protection into practice with children and young people in sport clubs has to be seen as a significant venture. There is evidence of some scepticism on behalf of the rugby league clubs' CPOs with regard to the efficacy of a child protection policy in the 'safe world of their clubs'. The workload and key responsibilities of the people involved, in the context of their largely voluntary capacity, need to be taken into account. It has to be acknowledged that multiple roles increase burdens of responsibility. An approach that does not overtly and practically prioritise child protection policy might be identified as a 'reductionist approach' and this has been shown to be a dangerous position to take (Brackenridge, 2001).

The written policy is clear about procedures to follow after the disclosure of abuse and the duty to inform local statutory bodies is pre-eminent in this. Recently, there has been considerable development in terms of child protection practice with the advent of safeguarding boards and the current emphasis on interagency co-operation, interdisciplinary training and a more ecological approach to meeting children and young people's needs in vulnerable situations. Sport England (2006) identifies partnership working as a key strategy in its approach to safeguarding children. However, the research suggests that clubs do not consider it particularly important to develop 'early' relationships at a local level with teams or individuals responsible for child protection assessments, training and professional practice.

Overall, three key areas arise for consideration:

1. A policy process model for individual clubs – 'the club schedule'

A range of issues emerged from the research with regard to policy process, and therefore,

ultimately, practice with children. Generally, quality assurance, monitoring and evaluation need close scrutiny. Child protection policy needs to be systematically monitored as part of each sport's responsibility and each club's response within that is of critical importance. Sport England states that individual sports have to demonstrate that, "arrangements are in place to monitor compliance with child protection policies and procedures and with recruitment and selection policies and procedures" (2003, p.13). This requires a clearly structured feedback process which an individual club policy process model can facilitate.

It is a cultural change that is required. A more formal and disciplined model of policy implementation may be part of the catalyst for such change. Even if a policy process model is only a very small part of a cultural shift then it is worth adopting. It may be part of such change because a model addresses the issue of seriousness with which safeguarding children is viewed by Rugby League and other sports clubs and is part of that educative process originally identified by Lasswell (1948) for public policy. The importance of a clear process model is further supported by Brackenridge's (2001) argument, identified earlier, that any reductionist approach to child protection is dangerous. The role of child protection officers in Rugby League has to be prioritized and the policy process plays a major part in emphasizing their position and responsibility. The importance of producing a defined process model is also reinforced by the need to embed the integrity of adult responsibility towards children and young people in all individuals, clubs and in 'sport' itself.

In order to improve the impact that child protection policies have within sports clubs, it would be more effective to produce a process model that provides a clear schedule for presentation, training and implementation within every individual club

(see Hartill & Prescott, 2007). This is likely to both improve knowledge about child abuse and increase child protective behaviours within organizations. These objectives have been identified as achievable, particularly in the context of a two-way communication process that delivers the policy and is able to explore such issues as motivation and intention (Howse, 2003). Further, knowledge and protective systems require regular reinforcement and re-emphasis.

2. A participative culture: 'voicing' children

The opening up of a space for children to legitimately contribute to issues that have an impact upon them goes to the very heart of a children's rights agenda (Goddard *et al.*, 2005) which appears to be gaining a foothold within sport policies. Many authors have characterized this world, or elements of it, as a patriarchal, heterosexist, performance-driven domain where violence and sexual violence is legitimated (e.g. Curry, 1991, 1998; Messner & Sabo, 1994; Brackenridge, 2002) and as such displays the qualities and characteristics of an institutional setting conducive to the abuse of children (Etherington, 2000; Brackenridge, 2001). It is clear that such a setting has provided little space for children's voices to be legitimated (Brackenridge *et al.*, 2007). The socio-cultural analysis of sport over the past twenty or so years identifies a wide gap between the cultural character of organised sport and the child-centred philosophy of the UN Convention on the Rights of the Child (1989). Therefore, it is crucial that child protection policy is presented as a process that *fundamentally involves* children. It is apparent that this is generally not the case, despite the fact that Standard Six of the National Standards at least clearly identifies that "mechanisms [should] exist for young people's views to be heard" (CPSU, 2007, p.10). Rugby League and organised sport in general should produce guidelines and enforceable procedures to

engage children and young people in decision-making at all levels. This would underpin sports' child protection policies with constructions of childhood and youth that see children and young people as extant, competent social actors.

The impact of the child protection policy on Rugby League club members appears to be uneven. This unevenness can be seen in both the breadth of impact (across all clubs) and in its depth (the reactions of individuals to the policy). This is not necessarily surprising; however, a steadier impact can be achieved if those at the heart of the policy actually become its real focus. As *Every Child Matters* (2003) suggests, it is by placing children and young people at the heart of the process that their needs can be voiced. Such an approach can have the most influence on the credibility and impact of policy that concerns them. As previously argued, Rugby League and indeed all sports organizations could respond to this by establishing children and youth councils/committees (Hartill & Prescott, in press). Representations could be made to these councils on issues that might affect children within that organization. This would enable children's opinions to be considered at committee level and representatives of these councils should be invited to sit on committees at all levels of sports organizations including governing body and local club level.

Sport England states that one of the key outcomes of its new six-year safeguarding strategy is that, "children and young people engage in decision-making in sport" and that "sports bodies will have a commitment to empower children and young people by advising them of their rights and how they should be treated" (Sport England, 2006, p.7). The clear articulation of such an ambitious objective within sport is highly desirable and represents a clear response to the spirit and demands of the Convention (UNCRC, 1989). Sport England/NSPCC make no explicit reference to how the

involvement of children will occur (within the five areas identified as key to achieving policy outcomes) but guidance on how children will actually be empowered through sport needs to follow; the suggestion for increasing children's involvement could therefore be seen as one (established) way of working towards policy objectives in a way that individual clubs are able to immediately engage with. It is also important to note in this context that participation alone does not necessarily achieve change or improvements in policy decisions. Research has identified that even within participatory climates children and young people are not always convinced that they are listened to nor are they fully aware of the purpose of their involvement (Gunn, 2006). Sport has an opportunity to get behind the national and international rhetoric of participation to uncover practical ways to lead children to the heart of policy making rather than just providing a vague 'space' for them somewhere in the policy process. If Children's Councils are to have substance rather than rhetoric within sport, sports clubs and their governing bodies need to give serious consideration to the development of a 'participative culture' within their policies and practice.

In support of this suggestion there is a wealth of research and literature concerning theoretical perspectives, policy and practice focused on children and young people's participation (Lansdown, 2001a; Kirby *et al.*, 2003). Managerial support and, indeed, vision may be the first but not the only requirements. Ways to embed the principle of participation in minds as well as policy and practice need to be given careful thought. Sociology and the law have produced constructions of children and young people as both independent social actors with their own culture and characteristics as well as the subjects of rights and entitlements (UNCRC, 1989; James & James, 2004). Importantly, in the specific context of child protection policy in sport, participation should be seen, in a

holistic sense, to not only improve confidence, self esteem and well-being but also to better protect:

More fundamentally, however, the recognition that children have agency and competences demonstrates that they can and do make a positive contribution not only to their own welfare but that of others. (Parton, 2006, p. 183)

Sport is likely to embrace traditional approaches to the adult-child relationship where adults protect and control, and children listen. If children are to be part of a policy debate this dominant discourse will have to be challenged because it constructs children and young people as incompetent and not knowledgeable (Davis & Edwards, 2004). Participation needs to be seen as having different levels and dimensions and the complexity of power relations within this must not be ignored. It has been argued that even organisations that embrace “a child liberation philosophy find it difficult to find a clear and meaningful starting point” for participation (Brady, 2007, p. 33).

It has been clearly identified that barriers do exist in terms of many adult attitudes and pre-conceptions concerning children’s rights, in general, and participation in particular. These are often hidden within organisations (McNeish, 1999). Given the concern with the lack of awareness of child abuse identified earlier in this paper, adult attitudes in Rugby League and sport in general towards participation do need to be carefully explored.

Sport can and should embed in its philosophy, policy and practice what has been seen as a new model of children and young people as social actors. Doing so will complement and “... reinforce governments’ increasing recognition that children are competent citizens whose views should be sought and enacted in legislation, policy and practice” (MacNaughton, *et al.*, 2007). As those authors suggest, even for

the youngest of children, this envisages an equitable and collaborative adult-child relationship. The aim should be to make children and young people’s participation part of the fabric of the formal and informal ways that sports clubs and organisations make decisions (Kirby *et al.*, 2003).

3. Local community relationships

UK Government strategies under the current ‘Children’ and ‘Youth’ agendas encourage all organisations involved with providing services to children, including sport, to team up in new ways, share information and work together, to protect children and young people from harm and help them achieve what they want in life. Every local authority is expected to work with its partners to find out what works best for children and young people in its area and to act upon it; the government identifies the local community as an important part of this process (DfES, 2004). As identified earlier, local authorities and partners need to ensure there is a good level of participation of children and young people in the design and delivery of services to ensure they reflect their needs.

It is argued that keeping the *Every Child Matters* outcomes framework in mind helps to focus on how services can better be brought together around the child, young person and family. Sport England (2006) has identified this, however, if “the outcomes are to be really effective in driving change, it is important to be clear what they mean in practice and how progress towards them will be measured” (DfES, 2004). The outcomes framework acts as a basis for agreeing local priorities and planning local change. The development of what has been described above as ‘early’ relationships at a local level with teams or individuals responsible for safeguarding children is clearly indicated here. Immediate relationship-building between sports clubs and professionals in the local community is recommended in the

context of sport's developing child protection agenda.

Conclusion

Brackenridge (2002b) found that, in 1999, 39% of voluntary sports clubs in one English Midlands county had a child protection policy, from a sample of 130 clubs across 19 different sports. We found that, in 2004, 85% of our sample of English Rugby League clubs (voluntary and professional) had a (newly appointed) child protection *officer*. This represents a major development within organised sport in the UK with regard to child protection. As Brackenridge predicted: "the introduction of a set of NGB standards for child protection by Sport England should have a considerable impact on the future uptake of both codes of practice and policies for child protection at club level" (2002b, p. 109). However, each CPO role is only as effective as the individual that takes it on and each policy is only as effective as the people who implement it. The manner in which a child protection policy is developed, presented and prioritised is a central issue for every sports club.

The planning process for child protection policy bears critical analysis. Planning can be viewed as an attention-shaping activity and not one that is purely concerned with an instrumental approach to the policy process (Habermas, 1984). It can be argued that more attention might have been paid, in the planning of the Rugby League's policy, to the more subtle effects that shape and mediate policy processes. It is important to note that key messages that concern awareness and understanding of child abuse and the means to safeguard children may be diluted or distorted through weak communication systems. A means to develop a deeper 'communicative competence' could be explored by future child protection policy planners; the individual club policy process model (the 'Club Schedule'), participative cultures that

embrace children's councils and the development of clear relationships with Local Authorities are three ways of facilitating this. The development of a policy process model and children's councils can be seen as specific methods by which individual clubs can achieve at least one of the outcomes/objectives set down in recent sport policy (Sport England/NSPCC, 2006) whilst clearly working within the 'principles' of that policy. The development of clear, local relationships with child protection professionals would be a robust response to Sport England's recent "commitment to work in partnership with parents, guardians and others to increase their knowledge of the theory and practices of safeguarding children" (2006, p.7).

The need for, and complexity of, cultural change in the context of child abuse and the nature of the adult-child relationship which lies at its heart must neither be ignored nor underestimated. Only the broadest community of interest is sufficient to impact on a social problem of this kind. Sport can have a key role to play in this community given that its practices and texts are cultural agencies able to work on its participants and consumers in an ideological way. Sport, now more than ever, wields considerable ideological power over its participants and consumers (Sugden & Tomlinson, 2002). Nation states, organised religion and global corporations have not been slow to recognise this fact. However, to date, the egalitarian promise of sport, frequently extolled, has barely been realised. The mission statement of Sport England's (2006) policy strategy is to, "lead the way in keeping children safe from harm". If sport is truly to assume a key role in this community, the grass roots of sport that are its lifeblood, must be more aware of and more supported in the task of prioritising children's interests *through* sport, rather than assuming that sport will (and is designed to) serve children's best interests *per se*. Such an assumption, which exemplifies the domination of a welfare

discourse rather than a children's rights discourse within policy, has been identified as potentially dangerous and, at best, non-protective of children and young people (Lansdown, 2001b). Policy strategies should focus much more on children as creative human agents and participation processes should be part of the routine experience of all children (Williams, 2004). An underpinning philosophy is required that embraces the authentic empowerment of children and young people in "the complex human activity of policy making" (Gunn, 2006, p. 135). Effectively, the participation of children and young people in the policy process must become part of sport's organizational culture (Wright *et al.*, 2006).

Endnotes:

¹ 'Intermediate' level must be achieved by March 2007 and 'Advanced' level by March 2008.

² The Rugby League's policy document currently uses the term 'child protection officers' whilst Sport England's accreditation scheme 'Clubmark' refers to 'child welfare officers'.

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Researching the support needs of Pakistani families with disabled children in the UK

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Abstract

Pakistani families living in the UK form one of the most disadvantaged sections of the society. Key issues faced relate to poverty, high unemployment, ill health, low levels of English proficiency, rising 'Islamophobia', men feeling misunderstood and misrepresented, and a lack of faith/culture appropriate facilities. When a disabled child is born, additional issues are added to this already challenging situation. These include a significantly higher incidence of disability, high costs of raising a disabled child, being less likely to receive benefits, poor access to health and social care, negative attitudes towards disability within the community and a high incidence of depression and anxiety among primary carers.

Although a considerable body of research-based evidence has been available for well over a decade, no significant improvement in service provision to these families has been seen. The paper suggests that a critical paradigm of research, with emancipatory goals, is needed and that participatory action research be used to help Pakistani families gain better understanding of their own support needs and to provide better skills to be able to ensure that these needs will be met more effectively within the family, in the community and through mainstream services.

Keywords: Pakistani, disabled children, critical emancipatory research paradigm, participatory action research

Introduction

This paper is based on an interactive workshop I conducted at the *Inclusion and Exclusion 2007* Conference organized by the Race Equality Foundation and the Social Services Research Group on 29th January 2007. The participants of the workshop brought a wide range of experience of working with black and ethnic minority families with disabled children and included a Pakistani mother of disabled children.

The paper also consists of a literature review around the situation faced by Pakistani families* with disabled children in the UK, a discussion of the possible reasons why little improvement in their situation has occurred despite the awareness of the issues brought about by this research, and a proposed way ahead in research approach and methodology. During the workshop,

participants were given the opportunity to share their experiences and views on challenges faced by the families and on reasons for research not having had as much impact on service provision as desirable, before findings from the literature on both these issues were presented. Having first secured their consent, participants' input and feedback have been incorporated in the paper. The paper was written at the end of the first phase of my PhD studies, whilst the research proposal was being finalized.

Pakistani families in the UK

When reading relevant literature about the Pakistani community in Britain, the first factor that stands out which has an impact on many of the other issues that will be described in this article, is the disproportionately high percentage of Pakistani families living in poverty: 60% are

low-income families before housing costs, rising to 68% after housing costs, compared to 20% of the total population (National Statistics Website, 2002). An associated problem is the very high unemployment rate, which is twice the rate compared to the white population for men and three times for women (Equal Opportunities Commission, 2004). In addition, Pakistani people, especially men, are less likely to have a professional qualification or degree (Equal Opportunities Commission, 2004). Those men who are employed are more likely to work unsocial hours due to shift work in restaurant and retail jobs, thereby affecting the role of fathers in their children's upbringing, as they are rarely at home from the time the children come home from school until they go to sleep (Khan, 2006a, p. 7).

There is also a higher incidence of ill health among Pakistani people, with the incidence of self-reported ill-health being double and the incidence of disability across the life span being one and a half times that of the white majority population (National Statistics Website, 2004).

Limited English proficiency also impacts on Pakistani families. Modood (1997, p. 60) found that, overall, 78% of men and 54% of women speak English fluently or fairly well, rising to 96 and 84% respectively for 16 to 24 year olds and dropping to 56 and 28% for 45 to 64 year olds. The proportion of those speaking English well increases with the length of settlement in the UK, although those who arrived at a younger age are more likely to develop good English. Another important factor is the 'residential density effect' - people living in neighbourhoods with larger numbers of Pakistani people being less likely to speak English well.

Khan (2006b, p. 2) reports from her research with Pakistani men that they see the rise in 'Islamophobia' in recent years as an important factor in hindering integration in society, leading to more alienation. The

men added that they felt misunderstood and misrepresented in society and that they struggled to redefine their role in the family, as the traditional roles of being the 'provider' and 'authority' figure were lost. In addition, the men in this study considered the lack of faith- and/or culture-appropriate provision of social and leisure activities for youth and families to be an important threat to developing positive family relationships (p. 3).

Workshop participants highlighted the isolation of the Pakistani community from the white majority community, ascribing the reason for this mainly to a lack of knowledge and understanding of Pakistani culture by the majority population. They observed that this led to a lack of participation in the political and wider community spheres. Another important observation they made was that information about accessing care and benefits is often not provided in a way that lets people know their rights. This was seen as an additional problem to poor English proficiency and not merely a result of it. Finally, both overt and indirect racism were seen as pervasive problems for Pakistani families in all spheres of society, hindering access to education, health and social services and to employment.

This brief overview indicates that Pakistani families are significantly disadvantaged in many areas of their lives, as compared to their white majority counterparts. The next section will show that their situation worsens considerably when a disabled child is born into the family.

Pakistani families with disabled children in the UK

Although a number of the problems described in this section are shared with white majority families with disabled children, they have been described because they impact particularly heavily on Pakistani families. Chamba *et al.* (1999)

found that ethnic minority families with disabled children were relatively more disadvantaged as compared to the white majority population and that, among them, Pakistani and Bangladeshi families were worst affected.

The first important observation is that a number of studies report a significantly higher prevalence of childhood disabilities in Pakistani families. For example, Morton *et al.* (2002), in their Derby-based study, found a three times higher prevalence for severe learning disability, six times for hearing loss, four times for sight loss and ten times for genetic causes of disability (p. 89). The latter is also evident in the national study of Progressive Intellectual and Neurological Deterioration (Devereux *et al.*, 2004), which found that 19 % of all reported cases occurred in Pakistani families, whereas the total Pakistani under-16 population constitutes only 1.8% of the UK total (p. 11). The authors suggest that consanguinity is likely to be one of the reasons for this difference in prevalence, with approximately a quarter of cases being children of parents who are related, most of whom are Pakistani (p. 10). A complicating factor in this respect is that genetic guidance for families from ethnic minorities is particularly difficult, and many families do not receive adequate information and guidance after their first disabled child is born, which increases the chances of more than one child with the same genetic disorder being born into the same family (Morton *et al.*, 2002, p. 92). However, it is important not to overemphasize the issue of consanguinity as this leads to an unhelpful tendency to blame families for having disabled children. It needs to be kept in mind that “families which are already poor are more likely to have chronically sick or disabled children” (Reith, 2001, online). As Pakistani families are three times more likely to live in poverty than the general population, this is likely to have a significant impact on the incidence of disability as well.

In the UK, the average cost of raising a disabled child is three and half times higher than the cost of raising a non-disabled child and the available benefits do not cover the difference (End Child Poverty and the Council for Disabled Children, undated). Chamba *et al.* (1999) found that, among ethnic minority families, fewer parents were receiving benefits and, if they did, they were less likely to be awarded at the higher rates. Parents who did not speak or understand English were even less likely to receive benefits (p. 5). As mentioned above, poor English proficiency is a common issue in Pakistani families.

In their study, Bywaters *et al.* (2003, p. 507) report that Pakistani families found it particularly difficult to gain access to health and social services. This was not due to their failure to try to access services for their child, but due to full information not being made available, which was often compounded by the language barrier experienced by many of the families. In addition, the services offered were not always in line with what the families needed. Chamba *et al.* (1999, p. 22) report that many families encounter insensitivity from service providers regarding their religion and culture. This was particularly important in the case of respite services, where needs like a Halal diet and modesty must be addressed before parents feel able to hand over the care of their child. On the basis of my own experience of working in a multi-disciplinary child development team, I have observed a great deal of misunderstanding about both Islam and the Pakistani culture, even among colleagues who were open-minded and willing to serve them as well as possible.

Although negative attitudes towards disability can be seen in all sections of society, they may possibly be more overt in the Pakistani community. The first issue relates to the faith based explanation of the cause for the child’s disability. Although Bywaters *et al.* (2003, p. 505) found that

only a minority of parents in their sample referred to God when asked about the cause of their child's disability, the concept of it being God's will, testing or punishment is nevertheless a recurring theme. In my experience both in the UK and in Pakistan, families often refer to God when they speak about their child's disability and how they deal with it. Although these beliefs about the causes of disability are quite common in the Pakistani community, they are not based on the Qur'an. Al-Munaizel (1995) describes how the Qur'an affords equal human rights to disabled people and that Muslims are encouraged to associate with and care for disabled people as a moral obligation. Morad *et al.* (2001) give a number of examples of the improved services for, and position of, disabled people in early Islamic societies and suggest that negative attitudes seen in contemporary Muslim societies and communities cannot be attributed to the teachings of Islam. Similarly, Bazna and Hatab (2004) concluded from their detailed study of the Qur'an that physical impairments are morally neutral, i.e. they are neither curse nor blessing, but just a part of the human condition, thus removing any stigma and barrier to inclusion (p. 25). Bywaters *et al.* (2003) point out that religious beliefs may be an important element in the coping mechanisms of families and should therefore not be off-limits for service providers who do not share the same beliefs (p. 508). My own experience confirms this and I have often been able to encourage Pakistani families to rediscover what their faith teaches them about disability, helping them to feel more positive about their child.

Nevertheless, in practice, Pakistani families with disabled children face many negative attitudes in their own community. Workshop participants emphasized the cultural impact of having a disabled child, often leading to the mother being blamed for the child's disability. Even if the mother is not blamed for the disability, she is often still seen as a 'victim', and told that she

must carry this burden in the hope that she will eventually be rewarded for it in heaven. These views lead to a sense of shame and isolation, as well as to a lower likelihood of receiving emotional or practical support from her husband, extended family or community. This lack of support perhaps serves to challenge the stereotype of caring minority ethnic families, which is sometimes used by professionals as the reason for the limited provision of services for these families (Chamba *et al.*, 1999, p. 15; Katbamna, *et al.*, 2004, p. 398). Chamba *et al.* found that, compared to mothers from other ethnic groups, Pakistani mothers were least likely to receive high levels of emotional and practical support from their partner. Hatton *et al.* (2004, p. 68) also found low levels of support from spouses in their sample of South Asian families. In addition, they found that support from the extended family was even less frequent, with almost 68% reporting 'no help' and 21% reporting 'a little help'. Reasons for this were that extended family members were too busy, not interested in the child, did not know help was needed, or could not cope with the child. Parents were often reluctant to ask for help (p. 74). Help from friends outside the extended family was even less common and parents tended to feel uncomfortable talking about their disabled child to their friends (p. 77). When asked about support from local communities, parents reported negative attitudes, stigma and a consequent lack of support. Support from religious organisations was not forthcoming and parents, generally, did not take the initiative to try and obtain support from this source (p. 79). Only around 10% of parents had sometimes received help, but 44% had found them unhelpful and 46% had found them unavailable for support services (p. 79). Some parents expressed the view that "our Muslim people aren't doing enough to help Muslim people ... Pakistani Muslims need a push" (p. 114).

In light of the above, it is not surprising that there appears to be a high incidence of psychological distress, including depression and anxiety, among primary carers (most often the mothers) of Pakistani disabled children. Emerson *et al.* (2004) found an incidence of 70% of carers suffering psychological distress versus 47% in the general population. In Hatton *et al.*'s (2004) study, more than 45% of Pakistani parents were affected by depression and almost 35% by anxiety. Parents attributed this to having to care for their disabled child without support (p. 149). The authors point out that this higher rate is unlikely to be due to ethnicity *per se*, but is more likely to arise from the higher level of social deprivation they experience (p. 81).

This review of the literature clearly shows that, not only are Pakistani families relatively more affected by poverty and deprivation in general, they also have higher chances of having disabled children, which increases and compounds this disadvantaged position even further. It could be said that families (of any ethnic background), as a whole, are 'disabled' by the unjust society in which they find themselves, as parents and siblings of the disabled child, subject to stigma, marginalization and discrimination in much the same way as the child (Fazil *et al.*, 2002, p. 238). Pakistani families are particularly vulnerable in this respect as they have a number of characteristics that make society regard them as 'other' - ethnicity (colour, culture, language, originating from a former colony) and religion (the 'dreaded', highly misrepresented Islam).

Nature of research studies and their impact on the families

The research studies on which I have drawn for the literature review, which to my knowledge are the only studies that have been published to date, have yielded a wealth of findings, which clearly show the complex web of marginalization in which

many Pakistani families with disabled children are caught. However, although this has been known from research findings dating as far back as the mid 1990s (e.g. Beresford, 1995), more recent studies (e.g. Hatton *et al.*, 2004) suggest that little progress has been made in either defining the specific support needs of this group more precisely, or in meeting these needs.

These studies have either been large-scale, using questionnaires (Beresford, 1995; Chamba *et al.*, 1999), or smaller, qualitative studies that have mainly employed interviews (Fazil *et al.*, 2002; Bywaters *et al.*, 2003; Hatton *et al.*, 2004). Although the study on which the papers by Bywaters *et al.* and Fazil *et al.* are based described how action research had been used (Fazil *et al.*, p. 389) to ensure the 'right' questions were being asked in the interviews, the research participants did not participate at the level of co-researchers, but rather their feedback was used by the researchers to refine the research tools. A similar approach was taken by Hatton *et al.* (2004), although they do not describe it as 'action research' (p. 169) and acknowledge that their study "falls short of recommendations made for participatory research (which is) a way of doing research that includes people at the receiving end of the study as joint researchers". All of these studies were carried out within traditional research paradigms.

Significantly, Bywaters *et al.* (2003, p. 508) note that none of the families in their study appeared to be aware of the disability rights movement or to be in touch with any organisation for families with disabled children. They point out that this should be a challenge for these organisations to take up, so that ethnic minority families, who currently appear to perceive disabilities mainly from an individualistic model, may become more aware of the social models of disability, which conceptualise disability as being caused by political and social barriers as much as (or more than) by the individual

person's impairments (UPIAS, 1976, pp. 3-4).

The participants of my Conference workshop suggested the following reasons for the limited impact of research findings:

- engaging with service users from ethnic minorities is too challenging for many service providers;
- service providers are not questioning critically enough why current services are under-used by people from ethnic minorities and therefore not taking the initiative to access research findings;
- there are only fragmented attempts to improve services and not enough 'champions', i.e. high profile advocates of racial equality in health;
- there is a lack of political will at higher levels;
- there is a perception that providing more appropriate services will only cost money and not bring financial gain;
- academic studies do not translate into policy, as the findings are often not formulated in practical terms;
- there is a low level of involvement of people from ethnic minorities in planning and evaluating services because, on the one hand, they are not invited often enough to be involved and, on the other hand, they are less likely to have the confidence and skills to do so due to their marginalized position in society at this time.

Although this list of reasons echoes many of the findings from the literature review above, it remains a disturbing collection of issues. The main theme seems to be a lack of willingness at all levels: of politicians to create fairer laws; of service-providing organizations to be informed by research findings and by representatives of ethnic minorities when they plan and implement services; and of individual service providers to be committed to the highest quality of care of their service users regardless of their

ethnicity. By the same token, it appears that the only players who have not been challenged to take on an active role in improving the situation are the families with disabled children themselves. Furthermore, the research has followed traditional research paradigms. Hence it has described the disadvantaged position of Pakistani families with disabled children with the aim to improve service provision, rather than challenging or addressing the oppression faced by the families directly. A critical emancipatory approach to research is therefore needed: one in which the research participants take more control over the research process, reconsider their situation from a social model perspective and gain the skills to start addressing their own challenges, rather than merely describing them. This should enable people to take a more active role in improving policies and provisions: the following section outlines this proposed way forward.

The need for a critical emancipatory research paradigm

The critical research paradigm distinguishes itself from the more traditional positivist (quantitative) and interpretive (qualitative) paradigms in that it focuses on social and political influences on human thought and action and starts from the assumption that social structures have historically served to oppress certain groups in society. Research undertaken within the critical paradigm therefore has emancipatory goals and seeks to bring empowerment to oppressed groups (Henn *et al.*, 2006, pp. 15-6).

With the birth of the social model of disability, which locates the problem of disability in the social and political structures of society rather than in the disabled person, the demand for an adequate research approach to match this radically different view of disability also arose. Stone and Priestley (1996, p. 702) explain that "the focus of disability research will have less to do with the ability of disabled people

to ‘cope with’ or ‘adapt to’ their situation and more to do with the identification and removal of physical and social barriers”. In the disability studies literature, this alternative approach has generally been described as ‘emancipatory disability research’. Some of the key characteristics of this type of research are: (1) the control over the research focus and process lies with the participants as much as possible; (2) the lead researchers are accountable to the disabled community; (3) a social model of disability is adhered to; and (4) the research should have some meaningful practical outcome for disabled people (Barnes, 2002, online). It is difficult to find any literature that prescribes specific methodology and methods that should be used in the pursuit of emancipatory disability research (Mercer, 2002, p. 245), although Barnes (2002, online) points out that it has generally been associated with qualitative, rather than with quantitative data collection strategies. However, he goes on to say that quantitative strategies may be useful too and that “it is not the research strategies themselves that are the problem; it is the uses to which they are put”.

Participatory action research

Participatory action research is congruent with both the ethos of the social model of disability and with the key characteristics of emancipatory disability research and I therefore believe that it can be used as an effective method to achieve the goals of emancipatory disability research. Participatory action research can be described as “an emancipatory practice aimed at helping an oppressed group to identify and act on social policies and practices that keep unequal power relations in place” (Herr & Anderson, 2005, p. 9). Reason (1994, p. 6) explains that participatory action research starts with concerns for power and powerlessness and aims to confront the way in which the established and power-holding elements of societies world-wide are favoured. Secondly

the lived experience and knowledge of people, often oppressed groups, are directly valued and central to the process. The two major aims are to produce knowledge and action that are directly useful to the participants and to empower people through the process of constructing and using their own knowledge, a process described by Paulo Freire (1970) as ‘conscientization’. Another important feature is the commitment of the researcher and of the participants to the processes of genuine collaboration. For this to happen, dialogue is very important because it causes the subject-object relationship of traditional science to give way to a subject-subject one, “in which the academic knowledge of formally educated people works in a dialectical tension with the popular knowledge of the people to produce a more profound understanding of the situation” (Reason, 1994, p. 7).

In order to achieve the emancipatory goals of participatory action research, the nature and level of participation of the participants is extremely important. Cornwall (1996, p. 96) presents a useful continuum of modes of participation, ranging from the research being done **on** people, to the research being done **by** them, i.e. Co-option (on), Compliance (for), Consultation (for/with), Co-operation (with), Co-learning (with/by) and Collective action (by). The highest level at which an outside researcher can engage with the participants is at the level of ‘co-learning’. Keeping in mind that the participants in participatory action research studies tend to be members of a highly marginalised section of the population, it takes both time and facilitation skills on the part of the researcher to enable participants to reach that level of participation and, through this, emancipation. As Reason (1994, p. 18) states: “There are a whole range of skills required for participatory research which are very different from those of orthodox research, and which include personal skills of self-awareness and self-reflexiveness; facilitation skills in

interpersonal and group settings; political skills; intellectual skills; and data management skills". Maintaining a high level of participation is only possible if the researcher constantly reflects on the status of their relationship with the participants and if the participants are aware of the desired nature of their relationship and encouraged to monitor and give feedback on it too.

The process of participatory action research – and all other types of action research – consists of a spiral of cycles, each of which consists of planning, action, observation of the impact of the action, and evaluation of that action and its impact (Kemmis *et al.*, 2004, p. 3). This is a dynamic process in which these four aspects are not seen as static steps, but rather as moments in the action research spiral. In the process, the aim is to bring together discourse and practice through constructive (planning and acting) and re-constructive (observing and reflecting) processes, so that improvements in practice and understanding can be made systematically, responsively and reflectively (Kemmis *et al.*, 2004, p. 7). Before embarking on the first cycle of the action research spiral, the process begins with a general idea and the sense that some kind of change is desirable. The idea of improvement prompts a reconnaissance, or exploration, of the current situation, in order to understand it better. On the basis of this reconnaissance phase the initial plan of action is decided and the first cycle of the action research spiral has begun (Kemmis *et al.*, 2004, p. 3).

Will it work?

Successful participatory action research studies carried out with South Asian participants in the UK have been described in the literature (e.g. Bowes, 1996; Chiu, 2003). However, I have not been able to identify examples of participatory action research involving Pakistani families with disabled children/members, who face

oppression due to ethnicity as well as disability issues. Nevertheless, successful development projects using participatory approaches have been described (Singh, 2005) and valuable lessons can be learned from them. My own experience of using participatory methods in project planning, in the evaluation of community-based rehabilitation projects and in teaching and researching in inclusive and health education in Pakistan also makes me optimistic about the possible outcomes of participatory action research with Pakistani participants.

At the time of writing, I have gained the cooperation of two local mosques in inviting and encouraging families to come forward to participate in a study which aims to identify the support needs of Pakistani families with disabled children and how these needs can be met more effectively; and to explore how engaging the research participants in undertaking participatory action research in groups of men, women and children can facilitate their active role in achieving these aims.

In gaining access to the community I have found that my previous experience has been very helpful. My nine years in Pakistan and five years of working with South Asian families in the UK not only give me a good knowledge of Urdu, the Muslim faith and the Pakistani culture, but also give people the confidence that I understand them relatively well. Secondly both my professional background in occupational therapy and my experience in using participative approaches in other professional roles have prepared me well to take a facilitating rather than a directive approach to working with the research participants. Finally I believe that not being a Pakistani myself may be an advantage as I do not fit into the social hierarchy and therefore have no fixed 'status' within the Pakistani community. This means I am likely to be perceived as impartial. In addition there is no culturally defined role I

am expected to fulfil and I am therefore no threat to the honour of families in engaging with both the male and the female family members as a researcher. In personal communication Pakistani women have expressed the view that it would have been extremely difficult for a Pakistani female researcher to engage the men meaningfully, but that I stand a good chance of doing so, due to my non-Pakistani nationality and professional background.

In order to 'make it work' it will be important to keep in mind the culturally specific power relationships that are evident within the sample of participants. By working in separate male and female groups an opportunity is created to bring about change within existing power structures. By having meetings for all participants to exchange their findings and ideas people will be able to begin to challenge issues from the inside where they form an identified threat to the health and well-being of the disabled child and/or other family members. Starting to develop the conditions in which communication can improve and positive change can occur is a process that needs to be controlled by the participants as much as possible. Although it is likely that initial developments will focus on relationships within the families, they should prepare participants to be able to describe their needs more effectively to, and negotiate more effective support from, service providers.

Conclusion

This paper has highlighted the situation of Pakistani families with disabled children in the UK and discussed what approach to research might be most effective in addressing the persistent problem of their needs not being met effectively. I have argued that a critical research paradigm is most likely to enable participants to take on a more active and assertive role in policy and service development. Though at the time of writing I can only be optimistic

about the potential outcomes of this approach, reports on this work in progress will become available in due course.

Footnote:

* In this paper the term 'Pakistani families' is applied to all families of Pakistani origin, regardless of their current nationality, or whether they are first, second or later generation immigrants.

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Changing relationships: services for disabled women experiencing domestic violence in the UK

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Abstract

It is estimated that between one in three and one in four women experience domestic violence at some point in their lives, and there is some evidence to suggest that disabled women are likely to experience longer periods of violence than non-disabled women. Given shifting government policies and professional arenas in the UK, it seems likely that disabled women and social workers will interconnect around domestic violence more often in future. Based on findings from a small local study (which aimed to identify the appropriateness and accessibility of disability and domestic violence services for women), this paper shows some of the difficulties as well as the potential for social workers working with disabled adults. It provides an overview of the literature on the identification of barriers facing disabled women accessing domestic violence services, then goes on to present some of the findings from the disability agencies and services. Addressing these dilemmas in a discourse which recognises domestic violence as a crime, this paper offers some opportunities for changing relationships between disabled women, domestic violence services and social workers.

Keywords: Domestic violence, disability, relationships

Introduction

It is estimated that in the UK between one in three and one in four women experience domestic violence at some point in their lives (Home Office, 2000 & 2003) and publicity about this issue continues to grow (Home Office, 2006). Domestic violence is about "men's violence against women within existing relationships and postseparation" (Hester, 2000, p. 150). British Crime Survey findings indicate that women who report that they are in 'poor health' have suffered more than twice the rate of domestic violence than those that report that they are in good health (Walby & Allen, 2004) and that disabled women experience more incidents of domestic violence than non-disabled women. It is likely that many of these women (particularly those with children) will have had contact with

social services or known social workers (Fawcett, 2000) and been involved in assessments (Preston-Shoot, 2003). Furthermore, given that social workers' focus of work is increasingly to 'help' disabled people 'live at home' (Department of Health, 2003 & 2004), it seems likely that disabled women and social workers will interconnect around domestic violence more often in future.

Disabled women who were actively involved in the feminist activism against domestic violence - leading marches, setting up refuges, writing and other work in the 1970s and early 1980s - were not always 'identified' as such (and many found it liberating to be accepted as women in their own right, not being called 'disabled'). However, Morris (1996) has claimed that non-disabled feminist academics' exclusion

of disabled women's experiences from research on domestic violence has often been based on prejudice and discrimination, and argues that this is also reflected in agency approaches. This paper attempts to address these points. It is based on a report from a pilot study, commissioned by Middlesbrough Domestic Violence Forum (MDVF), which aimed to identify the appropriateness and accessibility of disability and domestic violence services (including any gaps in current provision) for women in the area (Radford *et al.*, 2005). An additional reason for the study related to a local incident, the domestic murder of a disabled woman in Middlesbrough in 2002. During the investigation of this crime, it came to light that the murdered woman had not been in contact with any local domestic violence agencies (Radford, 2002).

The paper begins with an overview of the literature on the identification of barriers facing disabled women accessing domestic violence services and then provides a brief search of the literature around social work, disability and domestic violence. The paper then goes on to present a small section of the results from the pilot study¹, focussing on some of the data from disability agencies and services. Adding this local knowledge to the national and international research highlights some of the difficulties in balancing workers' desires to maintain clients' independence and privacy with their concerns about adequate protection. Addressing these dilemmas in a discourse which recognises domestic violence as a crime, offers a crucial starting point for social workers – one which could herald a changing pattern of relationships between them, disabled women and domestic violence services.

Given the relative lack of UK research literature in this area, this review draws primarily on studies from North America and Australia, where more research has been undertaken with disabled women and on investigating barriers to services. Whilst

it is understood that the legal and 'welfare' systems in North America and Australia are organised differently from those in the UK, and therefore statistical and interpretative parallels cannot be made directly, there are a number of useful concepts and relevant issues to draw on. In line with feminist approaches to the study of domestic violence and the social model of disability, this literature review focuses on recent studies and practice-based literature which take a less victim-blaming approach and put the voices and experiences of disabled women in the foreground.

Disabled women's experiences and the impacts of violence

In relation to domestic violence, in common with non-disabled women, the literature indicates an overall pattern of power and control, which escalates over time. However, disabled women often find that their disabilities are used against them by non, or less, disabled violent men as a further means of control and dehumanisation. The research indicates violent men use prejudices about people with disabilities combined with patriarchal assumptions and ideologies to humiliate their partners and destroy their sense of self-worth, which may already be low as a consequence of previous disabling life experiences, such as social isolation (Erwin, 2000).

Sexist and heterosexist normative ideologies combined with disablist attitudes and assumptions are illustrated in accounts from disabled women in a study from Western Australia, (Cockram, 2003). This study showed that, in common with non-disabled women, disabled women's accounts illustrate that they may make several attempts to escape the violence and get protection. As with other women, the decision to leave can be triggered by increasing episodes of life-threatening violence and/or recognising its impacts on children. Strategies used by the abuser to

increase their social isolation and deny them access to money, transport or communication with others, as well as locking them in the home, can make escaping even harder (Cockram, 2003).

Disabled women's accounts also indicate that they frequently face institutional and social barriers when trying to get away. For example, women may be in contact with professionals who fail to ask about domestic violence, making it difficult for women to seek help (Lapidus *et al.*, 2002). Further, disbelief from others including family members, neighbours and agencies such as the police, may be a key factor that prevents women from escaping the violence (Helfich & Simpson, 2006). Saxton *et al.* (2001) found that where women had to rely on partners for personal care, this increased the difficulties women had in leaving an abusive relationship. Other barriers were the inadequacy of domestic violence and disability services in providing the appropriate care and support that women may need once they have escaped from the violence, and the focus by agencies on a woman's disabilities rather than on the violence they have experienced from a partner (Erwin, 2000; Nosek *et al.* 2001; Cockram, 2003).

The Leeds Inter-Agency Project (LIAP) found that when disabled women did approach domestic violence services:

they were viewed first and foremost as disabled women. The fact that they were experiencing violence was not seen as a priority. (LIAP, 2005, p. 16)

LIAP also found that disabled women believed that these services would not be accessible to them as disabled women (LIAP, 2005) and that women "who disclosed violence and abuse to disability services were often told that they could not be helped, as that was not the organisation's expertise" (p. 16). They also experienced 'patronising and negative attitudes from the

professionals' who 'took over' and denied them choices and decision-making. Further, some women did not feel able to disclose experiences of violence because they felt it would not be treated 'confidentially'.

Most women in the consultation organised by Women with Disabilities, Australia (WWDA) (2004) had many similar concerns. WWDA has also contributed to the debate around 'neglect' as a form of domestic violence, which is often omitted from many mainstream domestic violence definitions. WWDA defines neglect:

Neglect refers to the harm caused by failure to provide adequate support, food, shelter, clothing or hygienic living conditions. It also includes failure to provide adequate information and education in the use of poisons, alcohol, drugs. For women with disabilities neglect may include leaving a woman in soiled clothes for 'punishment', or leaving her for extended periods in bathtubs or beds, or forcing her to eat at a pace that exceeds her ability and comfort. (WWDA, 2004, p. 8)

But as WWDA (2004) point out, the pervasiveness of neglect, in this context, makes its inclusion in definitions of violence difficult. It may be useful for social workers to think of neglect as another form of controlling behaviour in an overall pattern of domestic violence where physical violence or threats are used. It is also crucial for social workers to be aware of their own potential to compound the problems for disabled women by misinterpreting, minimising or dismissing their experiences, or by patronising them or making decisions for them. Morris (1996) draws parallels between the ways society takes power and choice from disabled women and domestic violence survivors. She argues that like domestic violence survivors, disabled women are not passive victims to be pitied, but survivors who cope, struggle and resist oppression.

In relation to learning disability services in the UK, McCarthy and Thompson, (1996 & 1997; McCarthy, 1999; Thompson, 2000) identified a number of failings in relation to residential community provision, particularly in relation to a tolerance of sexual violence against learning disabled women. Whilst recent changes in the law in relation to sexual offences in the UK, should make it easier to prosecute rape and sexual assault against women with learning disabilities², these are aimed at dealing with offences from staff and therefore do not deal with the main problem of women with learning disabilities being assaulted by their male partners or 'boyfriends' with learning difficulties. Furthermore, in the UK, attrition studies on rape and sexual assault have shown that complaints made by women with learning disabilities or mental health problems are least likely to be investigated by the police (Kelly *et al.*, 2005).

Social work, disability and domestic violence in the UK

Outside the UK there seems to be a reasonable record of addressing domestic violence issues in social work (for example Solokoff, 2005; Buzawa *et al.*, 2007; Eastman & Bunch, 2007), and more recent studies do occasionally address disability issues (Milberger *et al.*, 2003; Baldry *et al.*, 2006; Brownridge, 2006; Olsvik, 2006). This does not seem to be the case in British social work literature. Research about social work and domestic violence in relation to disabled women (or children) seems to continue to be negligible in volume. There are a few examples of social work research and practice in relation to domestic violence but, with the exception of this work (Radford *et al.*, 2006), very little has been published relating directly to disability or 'impairment' and domestic violence since Mullender's work on social work 'in health and adult care settings' (1996, p. 107). It is even more difficult to find information about domestic violence

and disability in official policy or practice guidelines. A recent³ search of four of the UK's social work websites⁴ (whose roles are to develop knowledge about good practice, promote high quality learning and provide invaluable routine professional support and advice) led either to material about children and young people and adjacent issues, or to North American sites about domestic violence.

It is not surprising therefore, that there is little information about disability and domestic violence in British social work practice or research. Mullender and Hague (2005), in their paper on service user groups, draw out the parallels between attitudes to disabled people and domestic violence survivors, with tendencies to pity and protect rather than involve and empower. However, more social work texts are including sections or chapters on domestic violence and do occasionally refer to health or disability. For example Taylor-Browne's chapter (2005) helpfully points out that 'health professionals' find it difficult to ask women about domestic violence (p. 95), but does not discuss services for, or needs of, disabled women.

As indicated earlier, it is assumed that social workers' growing involvement with many disabled people and their carers in their assessment and other work, might bring them into contact with these agencies and might place them in a position of influence. Social workers' most common role in current British practice is as assessors and regulators of services, and this is likely to be particularly so in the emerging multi-disciplinary and inter-agency settings. Currently in England, inter-agency, multi-agency and multi-disciplinary working is developing in relation to services for adults and services for children (Department of Health 1998; Department for Education and Skills, 2003) and the Home Office has encouraged similar initiatives in relation to domestic violence since 1990⁵ (Hague & Malos, 1998). These developments could

place social workers in a key position to influence disability services, and improve the experiences of disabled women who experience domestic violence. However, although government policies continue to encourage improvements and develop strategies to address domestic violence as “core business – not an optional extra” (Local Government Association, 2006, p. 5), the involvement and role of social workers remains undefined. The only potential area for social work, currently defined as being primarily the responsibility of “the director and lead member for children’s services and Local Safeguarding Children’s Boards” (p. 7) is related to child protection work.

In contrast to these local and national strategies and policies, which appear to overlook or side-line social work, there are examples of research and practice that place social workers in key positions. A number of recent studies that have adopted a closer and more detailed approach to research and practice with women who have experienced domestic violence, suggest a variety of potential social work roles. Cavanagh (2003) clearly demonstrates women’s responses to abuse and violence as dynamic, involving a ‘repertoire of responses’ to survive, reduce and resist men’s attacks. Humphrey’s *et al.* (2005) explore more complex analyses and responses to domestic violence and substance use and Hester (2005) highlights other problematical professional and policy discourses which social workers might address in:

- *seeing as separate issues violence by men towards women and violence by men towards children;*
- *construing a gap between ‘violent men’ and ‘fathers’ so that violent fathers become invisible;*
- *blaming mothers for lack of contact between children and fathers; and*
- *not incorporating children’s voices and perspectives.* (p. 176)

Enosh and Buchbinder (2005) explore autobiographical methods for research and practice with women in constructing memories and narratives of violent experiences and Hague *et al.* (2003) demonstrate the crucial position of ‘domestic violence survivors’ as service users, to be “both heard and heeded ... in service planning, provision and delivery” (p. 2).

On the whole, however, the literature suggests that neither policy makers, service providers, professionals nor disabled women themselves have a great deal of confidence in the appropriateness of services for disabled women experiencing domestic violence. This raised a number of questions that the study attempted to address and results showed some contrasting evidence, including the improved accessibility of Middlesbrough Refuge (Radford *et al.*, 2005).

Methodology

Ethical approval was obtained and the study was undertaken at the beginning of 2005. Representatives of member agencies of MDVF and Cleveland Disability Forum (CDF) were contacted by phone and email, and invited to participate in the survey. Twenty out of the 25 members of CDF participated, most had charitable status and many relied almost entirely on voluntary workers and funding. Those providing information were offering services to between 40 and 10,000 clients. They had different practice responsibilities and policy experiences, and adopted a variety of approaches. For example, the WRVS has over 60 years’ experience, whereas the Shaw Trust was established in 1982, during the International Year for Disabled Persons. One of the participants in the research, and a key player in this area, was the Cleveland Disability Forum which co-operates and consults with the voluntary sector, Local Authority, statutory bodies and all who plan

and provide services/facilities to those with disabilities.

Using semi-structured, telephone-interviews, 20 participants, representing disability services and agencies were interviewed, using a semi-structured framework. Of the 20 participants, twelve were from voluntary agencies and eight were from statutory agencies (health and social services). Most of the twelve voluntary agencies offered a range of services. One provided crisis and financial help, two offered advocacy and information services, three provided counselling, two provided training and nine offered various kinds of day facilities or domiciliary support. The eight statutory agencies included six multi-disciplinary teams, four of which included social workers. They focussed mostly on assessments with day facilities or domiciliary support, though one also provided adaptations and two provided residential facilities. The individuals who took part in the telephone interviews were mostly paid workers (13), two of whom were social workers, but one student and four volunteers also participated.

Results

The results reported here relate to the 20 disability agencies' understandings about domestic violence and to their policies, procedures and training provisions in this regard.

Definitions and estimates

On the whole, participants from the disability agencies were confident about defining disability and willing to estimate numbers or percentages of different forms of disabilities. Their client base (as a whole, not referring to clients disclosing domestic violence) was varied, and included deaf and hearing-disabled people, blind and partially-sighted people, wheel chair users, mentally ill and learning disabled people⁶. Participants were less confident about

defining or estimating experiences of domestic violence but, despite none of the participants' knowledge of any 'official' or 'agency' definition of domestic violence, many of them seemed reasonably aware and had a general understanding of the issues. One or two felt their knowledge was poor or limited (and a small number included child abuse in their descriptions), but most of them were eager to seek help from elsewhere.

Participants were not asked to calculate or estimate any correlations between different types of disability and domestic violence, nor make any other comparisons or analyses. However, some participants offered their analyses and understandings. Only two people spoke of domestic violence as a gendered phenomenon within the context of patriarchal social relations, though most implied this awareness by referring to 'mostly men' as perpetrators and 'mostly women' as 'victims'. Almost all referred to the different and sometimes overlapping forms of abuse and many knew about shame, secrecy and silence:

I have personal experience of domestic violence - it comes in many shapes and forms ... People forget the mental attachment, for example non-verbal threat, fear, wondering about when it's going to happen next, not knowing ...

As far as the participants were aware, none of the agencies kept statistics about domestic violence and only six of them were able to estimate what proportion of their women clients experienced domestic violence. The estimates of these six participants varied considerably (from less than 1% to 60%), although it is not entirely clear whether they were estimating the number of clients disclosing domestic violence, or estimating the numbers they suspected were experiencing it. Two participants gave the numbers they knew of saying, for example "two or three in eight years", but most had "no idea" or "knew of

none". A few participants pointed out that they had never asked about domestic violence, and some conceded that although it probably did occur, it was too difficult for them to conjecture. However, despite their admitting to having limited knowledge/experience of domestic violence in their agency, some of them attempted to estimate specific forms of domestic violence in relation to their particular clients.

Participants were asked about clients' experiences of physical, emotional and sexual violence and financial abuse, and also about withholding medication/aids (a form of domestic violence identified in the literature). Ten participants thought that "some" clients experienced physical violence and one person estimated that this might be as many as 50% of clients; however, five participants thought that none of their clients experienced physical violence. With regard to emotional violence or mental cruelty, eighteen participants thought that this was "likely in many families" and two people thought that around 80% of clients experienced it. Six participants thought clients commonly experienced sexual violence. There were marked differences between participants' estimates relating to experiences of financial abuse. Four people thought this was common, including one participant who said this was "the most common form" and another who estimated that over 60% of their clients experienced this. However, five participants felt that this did not occur. Participants also thought that the withholding of medication or aids was uncommon and only one person estimated that around 20% of clients experienced this. It is impossible to know whether the large differences between respondents' estimates reflect personal or societal myths and stereotypes about disability, or are indeed based on workers' practice wisdom and considered calculations about particular service users and specific disabilities.

Agencies were also asked about disclosures, and about when or where this might happen. Although ten representatives confirmed that this had never happened (as far as they were aware), others said domestic violence was frequently disclosed either during the admission/initial interview stage, or later, as relationships with staff built up over time, often in the context of 'life history' work. One participant said that domestic violence was occasionally reported by telephone (as part of their 'safe and well check' procedure), and another participant explained that their clients participated in training about violence and personal safety, which includes domestic violence, and was a regular point for disclosures. This was a significant finding and led into discussion of how disability agencies responded to disclosures (whether this information was just noted in people's files or reported as 'crime') by asking about policies and procedures.

Domestic Violence Policies and Training

Only two agencies screened their clients for domestic violence (as part of a risk assessment during the admissions process) and none collated information about disclosures or incidents (though some recorded such information individually on clients' files). Only seven agencies had some kind of domestic violence policy in place, for example 'referring on' to another agency, and only two had specific policies. Most incorporated domestic violence under more wide-ranging policies, for example relating to 'Vulnerable Adults', National Care Standards, bullying and harassment policies. In order to identify how these policies might work, participants were asked what support services were offered. Most agencies (13) talked about referrals (mostly to social services), but generally they revealed a wide range of good and less good policies and practices.

Only seven participants said that they or their colleagues had undertaken domestic

violence training, and some of that was as part of other training programmes, for example child protection training. One or two of these few agencies had had a range of training, but on the whole the training was non accredited, provided in house or by the National Health Service (NHS) or a local government department. Twelve agencies reported that they had no training at all about domestic violence and two participants were doubtful about the relevance of domestic violence training and one representative said:

it wouldn't benefit me in any way, shape or form.

Although only one view, it serves to highlight the importance of professional accredited training for all agencies, one of the key recommendations of the study's final report (Radford et al., 2005).

Discussion

Although the respondents were able to define disability and readily able to estimate (if not quote) numbers and 'categories' of disabled people in their groups or agencies, they were less experienced and confident about their knowledge of domestic violence and most agreed that domestic violence training would be beneficial. Similarly, although many were enthusiastic about the subject and willing to acknowledge their own and their agencies shortcomings in this area, on the whole they had no knowledge (and certainly no consistent record) of the extent of domestic violence and were unable to identify domestic violence policies or facilities.

Overall, the experiences of disabilities agencies were very mixed. Some reported that they never received domestic violence disclosures from clients and others reported "very few". In contrast one agency estimated that as many as 50% of clients had experienced physical violence and 80% cruelty, neglect or emotional violence, though it is unclear whether these figures refer to

disclosures or to cases where staff suspected domestic violence. It is important to note that agencies which undertook screening and kept statistics about domestic violence reported higher figures than agencies which estimated numbers.

Unfortunately the population of women with disabilities remains undefined and this is particularly problematic in relation to vulnerability and risk. For example, the risks faced by women with mobility problems are likely to be different in kind to those faced by women with mental health problems; the vulnerability of women with learning disabilities might be very different from those who are blind or who have communication difficulties. It seems likely that the type of domestic violence, and the appropriate interventions, may also reflect these factors. Any offer of help or support should take the different dependence needs into account, especially around issues of neglect and abuse. On the whole, disability agencies seemed to describe emotional abuse and controlling care as "neglect", rather than framing it in the prevention, protection, justice and support discourses of domestic violence. This highlights a tension between the welfarism of the medical model of disability and the human rights approaches of domestic violence discourses.

It is important not to stereotype disabled women as being all the same, nor as helpless victims of men's violence, and to avoid concentrating on discussions around dependency and vulnerability. One way to do this is to focus on disabled women's experiences, and particularly on what they say in relation to agencies and to their 'carers'⁷. This might be particularly revealing in relation to the very different estimates by agencies about disabled women's experiences shown earlier. Disabled women do not want services based on 'guesstimates', nor to be treated as special 'tragic cases', they want equal treatment and inclusion in adequately provided and appropriate services. Whilst

power and control tactics may operate differently in certain contexts and there may be a wider range of perpetrators for disabled women, social workers should be stressing the commonality of their experiences with non-disabled women in relation to domestic violence and building our relationships around such allegiances.

This research is one of the few recent studies to engage with this issue, and although local, its findings are of national significance. It has shown that little is known about the prevalence of domestic violence among disabled women, nor about their carers, and suggests that although training would be welcomed by most, it might not address all of the political and personal complexities that are involved. As social workers become more involved with disabled adults they need to shift their relationships away from a pattern of ambivalence – on one hand desiring to maintain clients’ independence and privacy whilst on the other intervening and protecting their ‘vulnerabilities’. Social workers must work within the domestic violence discourse, recognising it as a crime and distinguishing between perpetrators (who need criminal interventions) and survivors/victims (who need support) (Home Office, 2006). Social workers must move away from the ‘family violence’, ‘dysfunctional families’ and couple counselling discourses of the past and replace their qualifying education, on-going training and current practice with models that emphasise gender relations, disablism and poverty (Mays, 2006), allowing them to make new relationships with their clients that are built on genuine consultation with disabled women and with women who have experienced domestic violence.

Endnotes:

¹ The pilot study consisted of two parallel surveys of member agencies of (i) Middlesbrough Domestic Violence Forum (MDVF) and (ii) Cleveland Disability

Forum (CDF), offering support services in the fields of domestic violence and disabilities respectively). By surveying agencies affiliated to both forums, it drew together insights and experiences of agencies that have operated alongside each other for a number of years, but with only limited interaction between them.

² The Sexual Offences Act (2003) provides a clearer and more comprehensive framework (and guidelines) for different agencies and professionals, for example clarifying issues surrounding consent in rape and sexual assault cases. The government has also introduced guidelines on procedures for protecting ‘vulnerable’ adults (Department of Health, 2000).

³ Summer, 2006.

⁴ Social Care Institute for Excellence (SCIE), Higher Education Academy - Social Policy and Social Work (SWAP), British Association of Social Work (BASW), Association of Directors of Social Services (ADSS).

⁵ Multi-agency working has been in place in the Middlesbrough area since 1992.

⁶ Other disabilities were also referred to in smaller numbers: autism, cerebral palsy, Downe’s syndrome, Angelman’s syndrome, epilepsy, global developmental delay, ADHD, Arthritis, Parkinson’s disease, M.S., epilepsy, dyslexia, brain injuries, stroke, Huntington’s disease, HIV, amputees, deep vein thrombosis, hepatitis, disfigurement, old age, infirmity, elderly, dementia/confused, Alzheimer’s disease, diabetes, fractured femur.

⁷ An area that was beyond the remit of this pilot study, but hopefully to be part of a second stage.

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All three authors are researchers with strong records of research and publication in the fields of domestic and sexual violence. All have histories in feminism and are actively involved in promoting justice and protection for women and children and challenging gender violence in their practice.

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Book Reviews

Costs and Outcomes in Children's Social Care: Messages from Research

Jennifer Beecham and Ian Sinclair

London, Jessica Kingsley, 2007, pp. 144,

ISBN: 9781843104964, £16.99 (pbk.)

In social care services, there is a continuing focus on measuring service volume, activity, quality and service outcomes, along with professional drivers for evidence based practice. In this 'evidenced-based' environment, the knowledge derived from both research and participative practices can be used to assist professionals in their practice. Therefore, this collection of research reports provides a timely and accessible source of knowledge with particular relevance to services for children and families.

The book has a focus on research that investigated planning and commissioning in children's services. The authors draw upon 14 research studies, 13 of which were part of a Department of Health research programme examining the *Costs and Effectiveness of Services for Children in Need*, which pre-dated the *Every Child Matters* initiative. Through analysis of the findings of these research studies, the authors examine the costs of service provision and consider how far services are effective in improving outcomes for children.

The book is made up of seven chapters, the first of which offers a broad introduction and includes the national policy context for the studies and the core questions that were addressed. Thus whilst each of the research studies was different, the core concerns were closely related; with key questions focussing on what money is spent on and what makes a service 'work'. The second chapter is particularly helpful in enabling the reader to appraise the research methods for themselves, as it details the research

design and how some of the complex issues of assessing costs and making economic evaluations were addressed. Thereafter, chapters three through to six use the knowledge gained from the research studies to explore particular aspects of costs and outcomes in children's social care. For example, 'the ideal and the reality' of service delivery; service costs and variations in cost, early intervention and preventative services; and services for children who may need care, are in the care system, or are care leavers. In the concluding chapter the authors summarise the book and the studies reported therein, suggesting that there are some key questions that arise from this work. In particular they recommend further development in the forms and quality of future research and inquiry. They also raise questions about different aspects of the efficacy of preventative, early and late intervention services. Finally the authors discuss the 'operating challenges'. Whilst conceding that more evidence is needed, they stress the importance of promoting quality of provision above structural change.

This large size, soft-back book is written and structured in a very clear and accessible manner. Within the chapters, there are helpful 'summary boxes' that not only provide summaries at the end of each chapter, but also highlight important aspects. Whilst the 'messages' are aimed at a wide audience, they are particularly relevant for local policy-makers, commissioners and managers in social care services for children. That said, practitioners and students will also find this book useful as one element of the knowledge base that can support and evidence the development of good practice with children and their families.

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Social Work: a Companion to Learning

Mark Lymbery and Karen Postle (eds.)
London, Sage Publications, 2007, pp. 320
ISBN 9781412920025, £20.99 (pbk.)

Like much of the public sector, social work seems to have been subject to a relentless process of regulation and reform in recent times and this looks set to continue for the foreseeable future. Of course, practitioners on the ground welcome changes which will improve conditions for professionals and outcomes for service users and their families. However, at times, the phenomenal rate of upheaval can make practising social workers feel unsure as to their role and can make social work seem daunting to those seeking to join the profession. Re-configurations, cross-sector working arrangements and new management and performance regimes have all had to be absorbed by practitioners, leaving many confused as how to maximise the contribution they make. In this edited volume, the contributors set out to assist the trainee and practising social worker to make sense of the changing shape of British social work.

In keeping with the strong sociological basis of social work practice, the book begins by mapping important aspects of the *context* of social work. For example, Jordan describes the 'external forces' which shape the interaction between service user and service provider, and the importance of practitioners actively engaging in the political dimensions effecting experiences. This chapter sets a critical tone which is sustained throughout much of the book. The authors attempt not just to inform but also to challenge the reader. So, for example, Hugman's account of the underpinning values of social work is at pains to emphasize the need for ongoing critical engagement with complex moral questions. The opening section proceeds with discussions of the roles of 'sense of self', user involvement and research in practice. The rise of interprofessional

education is also presented and critiqued. Finally, an argument for greater international learning is presented.

Part three looks at the social work profession's legal basis. It details some of the skills and responsibilities required of practitioners. Although overall I appreciated the book's concise approach, I felt an exception might have been made for some of this section. Certainly the twelve pages on 'assessment, planning, intervention and review' would need to be augmented by further reading by any social work student. Despite this, I felt that section two provided a reasonable plea for ongoing good practice whilst acknowledging the constraints on practitioners. The discussions of partnership and practice-learning present important but familiar material. However, I found Rafferty & Steyaert's discussion of the role of technology raised new and important questions.

Part four begins with a discussion of the organisational context of social work and the importance of continual professional development. Although the distinctiveness of the book's substantive sections started to seem a bit tenuous by this point (perhaps inevitably) I enjoyed the user perspectives on partnership working and the slightly controversial suggestion that social work supervision borrow from models developed in the health sector. Key concepts such as 'managerialism' are then discussed and the volume finishes with both a glimpse into the future and a re-statement of the importance of seeing the service user at the centre.

Overall, there is no doubt that this book will contribute to the learning and reflections of students and practitioners alike. Indeed, many of the issues raised and discussed have a relevance to those working in the 'caring professions' more generally. At the same time, much of the content feels like a starting point rather than a definitive guide. This is not surprising given the constraints of word length and the breadth of material

covered. Overall this volume has much to recommend it.

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Intervention and Support for Parents and Carers of Children and Young People on the Autism Spectrum: A Resource for Trainers

Barry Wright and Chris Williams
London: Jessica Kingsley, 2007, pp. 256, ISBN: 9781843105480, £29.99 (pbk)

The number of children identified as having an Autism Spectrum Condition (ASC) has increased dramatically over the last couple of decades. It is now estimated that between 0.7-1% of children in the UK have a condition on the spectrum and this has led to increasing demand on services to provide assessment, post-diagnostic support and advice to parents.

The Autism Spectrum, its complex diagnostic classifications and myriad behavioural manifestations can be confusing even to experienced practitioners - so providing clear, concise and useful information to parents and carers is a challenge. Yet helping parents through the initial shock and confusion in the post-diagnostic period can help them to develop their own confidence and skills to manage the challenge of bringing up a child with an ASC.

This book aims to provide an 'off the shelf' manual for practitioners intending to run post-diagnostic groups for parents and carers of recently diagnosed school-age children with Autism, Asperger Syndrome and related conditions.

The authors assume that group facilitators will have significant experience and knowledge of the autism spectrum. For

those who feel they need additional background reading they suggest that the manual should be read in conjunction with their previous publication *How to Live with Autism and Asperger Syndrome: Practical Strategies for Parents and Professionals* and the relevant sections of this sister publication are referenced frequently throughout the book.

The book describes in detail how to set up and deliver the group programme. The course consists of 11 sessions. The initial sessions cover the characteristics of children with autism spectrum conditions, how they perceive the world and how problem behaviours may relate to particular autistic characteristics. The final sessions aim to help parents develop a problem solving approach to managing these behaviours. The authors suggest group sizes of 5 to 20 participants with 12 to 15 being their ideal group numbers.

The authors suggest that with minor adjustments the programme could also be used to train educational staff or care workers who are providing support to children with autism spectrum conditions.

Each chapter deals with one session and includes all the resources needed to run the session. There are figures for overhead projector acetates, handouts and suggested homework activities. The early sessions have more emphasis on information delivery but also include activities for the participants to consolidate learning points: so, for example, in the session on language and communication, participants are invited to mime various activities in small groups and then consider how much non-verbal communication aids comprehension in typically developing children (and adults).

The last 3 sessions of the course are the most ambitious and, I suspect, the most appreciated by the course participants. They focus on specific behavioural strategies that can be useful in managing problematic

behaviours and include desensitisation, reinforcement schedules, externalising, distraction, consistency, time out, traffic lights and visual timetables. There is also a session devoted to the use of visual guides and social stories, two particularly helpful approaches for children with social-communication disorders. These latter sessions on behavioural management do call for additional therapists to work with individual families on developing their own profile of useful strategies.

The manual ends with the obligatory 'pre-' and 'post-' group evaluation forms and the results of evaluation of their own groups which have been running since 1999.

Running parent groups is a time consuming but rewarding activity and this manual will be extremely valuable to anyone planning their own group. The sessions are well structured, providing psycho education but also opportunities for parents to share experiences with other families who have faced similar difficulties. This latter aspect of group work is something that parents often particularly value.

My only hesitations about the programme were its length, 11 sessions at 2 hours per time is a very significant commitment, and I also felt that some of the handout material was quite lengthy and might be off-putting to any parents with specific literacy difficulties. Having said that, the course is very comprehensive and the authors stress that it should be approached flexibly and sessions adjusted to meet the needs of each group.

Having run similar groups in the past, I can only say I wish this resource had been available to me at the time - it would have saved a great deal of preparation time and provided a highly practical guide to a novice group facilitator. Therefore, if you are regularly involved in providing services to children with autism spectrum conditions and their families or are thinking of running

a group for parents to help them understand and manage their children's difficulties, then this book may be for you.

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What are SSRG's objectives?

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

Who belongs?

SSRG is open to anyone who subscribes to the objectives of the Group. Members are drawn from a wide range of professional groups and organisations sharing a common interest in the work of the caring services.

How is it organised?

SSRG operates at two levels, nationally and regionally. National SSRG comprises a committee of elected and selected officers, elected members, co-opted members and regional representatives whose principal tasks are to promote the objectives of the group at national level, and to co-ordinate its activities. Regional Groups, of which there are eleven, including Scotland, Northern Ireland and Wales, exist to provide a focus for members' activities in their local area.

What does it do?

National SSRG publishes a Journal and a Newsletter which are distributed free to all members, and a wide range of other publications on issues in the social and health care services. It maintains working links with central government departments, the Association of Directors of Social Services and other professional bodies and organises an annual three day workshop on a topical theme in social and health care services research, and occasional day conferences, for which members receive generous discounts of fees. It also co-ordinates the work of Special Interest Groups which provide members with an opportunity to contribute to the formulation of SSRG responses to national policy initiatives and current issues in the social and health care services.

Regional Groups organise regular meetings focusing on the research, planning and development of the social and health care services, seminars featuring guest speakers on important topics, and occasional day workshops. The Regional Groups also provide mutual support for members and a forum for the exchange of ideas and information.

Equal Opportunities Policy

It is the policy of SSRG that no SSRG member, job applicant, employee or any other person working with, or in contact with, the organisation receives less favourable treatment, nor is disadvantaged by conditions or requirements imposed, on the grounds of their age, colour, disability, gender, ethnic origin, marital status, nationality, race, religion, sexual orientation, responsibility for dependents, political affiliation or membership of a trade union. It is the aim of SSRG to actively promote this policy, and to ensure that the contribution of research, information, planning and evaluation in social, housing and health care services is sensitive to this issue.

Research, Policy and Planning is the Journal of SSRG

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