Research, Policy and Planning
The Journal of the Social Services Research Group

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Editorial

Welcome to the new cover design, bringing the Journal in line with the updated SSRG logo and livery. We think you will find the articles in this edition equally refreshing and would welcome any comments you might have on the design and content, and any suggestions you have for the content of future editions.

We open this Spring edition with an article by Lesley Noaks on holistic approaches to early intervention. Drawing on empirical research undertaken as part of an evaluation of the 'On Track' early intervention programme she reviews the strategic shift in the promotion of partnership and the key factors involved in implementation of the programme. From this, other partnership projects may gain new insights into what works in delivering integrated services.

Michele Abendstern and colleagues discuss the literature review they undertook on the impact of the implementation of the Single Assessment Process (SAP) for older people. Issues that may help or hinder effective implementation of the SAP are identified and potential tensions between different policy aims are exposed. Issues in assessment practice which were historically contentious seem likely to remain relevant to the implementation of this policy.

Next, Rachel Winder and colleagues report the results of their qualitative interview study and consider why benefits uptake in the older population is lower than in other age groups. The valuable role of specialist benefits advice workers is confirmed and the need for more anticipatory approaches in identifying vulnerable adults is identified.

Janet Warren reports key findings from her doctoral research on young carers, identifying a group of children and young people not formally recognised in their role as carers. She highlights the need for greater professional awareness of the caring roles of children, earlier intervention and effective collaborative practices to ensure that all concerned receive the services they need.

Finally, Ian Shaw provides an historical overview of the complex interplay between social work, science and research. Looking at early social work, and identifying key changes and continuities in contemporary UK social work research and knowledge generation, the paper provides critical reflection on the relationship between social work, science and claims to expertise.

We are also pleased to include reviews of three new and important books. One is a research-based text on children and young people in care, the other two texts address current themes in generic social work practice.

As with previous editions, we have assembled a varied selection of articles and reviews which will be of interest to our wide readership of social care practitioners, trainers, managers and researchers. If you have thoughts about developing a paper about current issues in practice or theory, or would like to review a book, we would like to hear from you. Contact details and submission guidelines can be found at http://www.ssrg.org.uk/publications/rpp/index.asp.

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

Holistic approaches to early intervention: what works in delivering effective partnerships

Lesley Noaks, Cardiff School of Social Sciences

Abstract

This article reviews the strategic shift in the promotion of partnership working in the social care field. Drawing on empirical research undertaken as part of the evaluation of On Track, the article provides a review of the challenges of operationalising a partnership approach. The On Track project is a government funded, early intervention programme that required a collaborative approach. With an alertness to the potential for rhetorical claims in relation to partnership working, the article provides a review of the key factors that facilitated implementation of the On Track programme as a collaborative venture. It provides important insights for other partnership projects about what works in delivering integrated services.

Keywords: Strategy, multi-agency, partnership working, service users, facilitation, collaboration

A language of 'partnerships' has been borne. In contrast to a reliance upon rigid, autonomous bureaucracies, networks of diverse group interests have become the dominant ethic. They have been accompanied by a greater emphasis upon the desirability of a more holistic, rather than specialist, approach to social problems. (Crawford, 1997, p.25)

Introduction

Crawford's statement constitutes part of his mapping of key influences on U.K. criminal justice policy at the end of the twentieth century. He points to a rapid alignment, by both politicians and policy-makers, with the concept of partnership as the key route to tackling crime. Notions of collaboration became the dominant discourse in relation to preventing and addressing crime with a direct impact on both legislation and policy. The Crime and Disorder Act (1998) epitomised such trends, placing on a statutory footing the requirement in England and Wales for every area to establish a Community Safety Partnership. At the same time, the legislation required the establishment of Youth Offending Teams which incorporate a range of professionals (social workers, probation officers, educationalists, police officers) brought together to provide a more co-ordinated approach to youth offending.

Commitment to the principle of partnership was not restricted to crime related strategies and was more broadly adopted in the social care field. The importance of co-ordinated approaches between professionals and open channels of communication with the community has been highlighted in a series of public enquiries in the social care field (DOH 1995; Hallett, 1995; Laming 2003; Bichard – Home Office 2005). The report of Lord Laming's enquiry into the circumstances surrounding the death of Victoria Climbié called for a number of measures to be introduced to enhance working in partnership. These include:

Recommendation 8: The Management Board for Services to Children and Families must appoint a director responsible for ensuring that inter-agency arrangements are appropriate and effective. (Laming, 2003, p.372)

Recommendation 15: The newly created Local Management Board for Services to

Children and Families should be required to ensure training on an inter-agency basis is provided. The government inspectorates should evaluate the effectiveness of this. Staff working in the relevant agencies should be required to demonstrate that their practice with respect to inter-agency working is up to date by successfully completing appropriate training courses. (Laming, 2003, p.373)

The Green Paper *Every Child Matters* (HMSO, 2003), which preceded the 2004 Children Act, also has as one of its stated priorities "to break down organisational boundaries" (2003, p.10). The focus of this article is a review of the key factors that serve to promote effective partnership working. Drawing on the evaluation of the multi-agency On Track project the piece identifies the operational and strategic factors that facilitate and challenge partnership working.

The operational context to partnership working

The concept of partnership working is not new to either the social care or crime control fields. The Seebohm reforms of the 1970s, which produced large generic social services departments, were a response to the perceived overlap in the largely unco-ordinated social care provision. Typically, in response to public enquiries and tragic failures in public provision there have been calls for enhanced inter-agency collaboration and 'working together' (Butler & Shaw, 1996). By the latter half of the 1990s there had been something of a shift in the requirement for partnership working with the launch of a series of initiatives that were contingent on evidence of joint working. This included urban regeneration schemes; youth offending teams; community safety strategies and early years partnerships. A distinct feature of these developments was the increasing requirement for evidence of community

engagement and consultation although, in practice, the challenge has been to avoid partnership arrangements that are professionally dominated and have limited engagement with service users (Noaks *et al.*, 2004; Bullock *et al.,* 2006). A further feature of recent requirements has been an expectation of co-ordinated approaches across the public and independent sector. Crawford (1997) went as far as describing the recent promotion of partnership approaches as a 'quiet revolution' in the delivery of services in the social care field. Kampenaar (2001, p.15) describes this period as reflecting "renewed emphasis and enthusiasm in partnership working".

Operationalising the principles of partnership working

The key principle driving the contemporary collaboration movement is the perceived need for a more holistic approach to social problems. In the case of offending behaviours the significance of the inter-relationship between multiple risk factors, such as membership of a delinquent peer group, low levels of parental supervision and failure at school (Graham & Bowling, 1995; Wikstrom & Sampson, 2006) was crucial to the promotion of the collaborative movement. The commitment to the principle of collaboration went as far as making evidence of partnership a requirement of government funded crime prevention initiatives.

The On Track (OT) project, on which this piece is based, reflects the three core concepts of prevention, community and partnership that Crawford has defined as critical to the "major shift in paradigm" he describes (Crawford, 1997, p.25). Evidencing partnership in both planning and service delivery was a central requirement for OT projects. In that regard, On Track exemplifies change in the "nature and shape of the administrative structures of British governance" (ibid, p.55). The evaluation undertaken by the author (Noaks *et al.*,

2004) provides the opportunity to consider the implications of requiring and establishing such partnership approaches.

The On Track programme

On Track is a multiple interventions crime prevention programme targeted at children aged 4-12 and their families. It was initially established within the Home Office Crime Reduction Programme, which sought to deliver preventative programmes of crime reduction and evaluate the evidence for what works to reduce anti-social and offending behaviour.

The OT programme was premised on addressing links between offending behaviour and known risk or protective factors associated with the individual, family and/or community. The programme was established in 24 areas of England and Wales.

Delivery plans were required to show evidence of service development under the five core categories of:

- Home Visiting
- Family Therapy
- Parent Support and Training
- Home/School Partnership
- Pre-school Education.

At the same time, there was scope for local areas to develop a sixth category of specialist services. Such inputs were less prescribed and as such were more likely to reflect local needs and priorities.

Research methodology

There were four phases to the aspect of the research that studied partnership working:

Phase 1 - Participant-observation in steering group meetings and project based interviews in six OT areas. As well as the six coordinators the sample consisted of ten partners including four educationalists; two

voluntary organisation staff; one social services worker; one urban regeneration worker; one police officer and one parent. Everyone who was approached agreed to be interviewed. All bar one of the interviews were face to face and were undertaken in the project areas. In the remaining case a telephone interview was undertaken.

Phase 2 – a survey of steering group and operational group members (eight project areas). The main aim of this stage of the research was to gain a perspective from a broader range of On Track partners regarding the effectiveness of joint working. To achieve this, data was collected by means of a self-complete postal questionnaire. A response rate of 53% (134 out of 253 questionnaires that were distributed) was achieved across the eight projects.

Phase 3 – follow–up project based interviews with providers and service users (seven project areas). Follow up interviews were undertaken with 15 providers and 19 service users across seven of the eight areas. Face to face interviews were undertaken to achieve an in-depth perspective on the effectiveness of partnership working on the part of service providers and, most importantly, service users.

Phase 4 – consultation with other evaluation teams to gather evidence from the remaining 16 On Track projects.

In the reporting of results all of the project areas are anonymised and referred to as areas A-H.

Evidence of collaboration

From the initial launch of OT, the area-based strategic planning required evidence of multi-agency collaboration and active engagement with local communities. Projects had markedly different starting points in terms of the established level and quality of multi-agency collaboration and

engagement with the local community. In practice, projects could be placed on a continuum ranging from those which were in a position to draw on an established tradition of partnership working (some of which included partnership with service users) to those with more limited experience of this type of professional approach and little or no experience of working collaboratively with community representatives. Subsequent operational management groups also showed some diversity in the extent to which activities were driven by the partnership approach.

OT was reported by service deliverers to be a "somewhat unique" project in requiring partners to go beyond strategic planning and to work together to provide services. For most, their experience to that point in time had involved joint planning of services rather than joint delivery. In that regard, OT is illustrative of the factors that serve to promote effective partnership working. The evaluation offered the opportunity for a detailed review of the factors that facilitate and challenge effective partnership working. This paper provides a focus on the factors that supported best practice in partnership working. These included: early appointment of a project manager/co-ordinator committed to partnership working; supportive infrastructures evidencing an equal commitment; robust service level agreements; clear and open lines of communication; trust between professionals; and resourcing of partnership approaches, including training opportunities.

The research found that very few community users were part of the formal strategic or operational groupings that supported OT. Limited plans were evident to introduce service users to such strategic groupings. One area did include service users and another reported that service users were being offered training to play such a role but, in the majority of cases, the

strategic partnership work focused on co-operation between professional providers.

In the latter stages of the research, there was evidence of increasing engagement by projects with users and the adoption of innovative methods to achieve this. Some of those projects with no history of engagement with service users increasingly sought to move away from a top-down approach and develop OT in line with user priorities. This was acknowledged and welcomed by service users. In some areas there was evidence of service users who had engaged with OT moving on to take an increasingly active role in their community.

The research pointed to various ways in which the innovative working methods adopted by OT teams had contributed positively to the culture of partnership working in their locality. In particular, it was felt that the requirements for planning and delivery of OT services to be premised on partnership promoted joint working. The innovative approach to collaborative working adopted by some OT teams provided a good role model and was felt by some professional providers to have contributed positively to the culture of partnership in local communities. Such experience provides important groundwork for future collaborative ventures.

Transforming strategy into delivery

I don't feel that the management board has really got to grips with the issue of partnership. You know people turn up to the meetings mostly and contribute but don't have sufficient time to give to meetings and the following up of the meetings and taking issues back to their own agencies and I don't feel that has worked. (OT co-ordinator)

The transformation of strategy into operational practice was a key issue for the research. On Track was typically represented by respondents as requiring new

levels of organisational collaboration described by one co-ordinator as a working rather than a planning partnership. Another felt that the challenges of multi-agency working only became apparent "once you start working in partnership". They went on to say:

> *We've had pots of money in the past and everyone has said, 'thanks very much I'll have that money'. Once you've got the money you walk away from it and leave everybody to work it out. What we have tried to ensure here is that they don't walk away. That we keep bringing them back into the partnership arena and we keep saying, 'you have a responsibility to ensure that this is led by you' or that we make a collective decision about how the referral system is operated. And that's been a struggle. But it hasn't not worked.*
> (OT co-ordinator)

It was acknowledged by another co-ordinator that "there are different levels of partnership and the strategic does not always cascade down to the operational" and one co-ordinator felt that in the early stages of implementation the strategic partnership had limited impact on the operational day-to-day running of OT:

> *Partnership secured the posts and enabled those people to access professional supervision.*

Prompt appointment of a co-ordinator was seen to be a key factor in establishing an OT identity. In all six areas in the original research such an appointment was key to formulating the OT identity with possible partner agencies and users. In one of those areas that made a delayed appointment, having the framework for the OT infrastructure in place before the co-ordinator was appointed was described as "putting the cart before the horse". Despite the fact that a copy of the original bid was included with the co-ordinator's job application form they found that "it took

some time to get your head around it". In another area, which had experienced major shifts in responsibility for OT, the key stakeholders revealed gaps in their knowledge and understandings of the original OT vision and objectives.

A number of the interviewees saw the transformation of strategy into practice as a key function for the OT co-ordinator and their core team. One of the stakeholders described the co-ordinator's role as:

> *Trying to ensure that players are genuinely engaged, inputting what they originally agreed, disseminating and avoiding residents feeling done to.*

Another respondent described the need for a process of narrowing down general strategy to specific policies. They described the need for "the co-ordinator's vision to mould ideas". The challenge of this was acknowledged with a comment that "we are very different departments who work very differently".

Some providers felt that secondment of staff from other agencies into the OT team helped with establishing an identity:

> *I think it was a facilitating factor that people have worked hard with their parent agencies to try and make known what On Track does.* (OT Service provider)

Others were slightly more guarded about such an approach:

> *Well it's partnership with a small p. We are a partnership with our own specific roles but dip into each other.* (OT co-ordinator)

In this case the provider did not feel that they had achieved an adequate level of rebranding into an OT team.

Good practice in multi-agency partnership working

The evaluation of OT provided the opportunity to identify good practice in relation to effective collaboration. Dissemination of such findings is important as multi-agency delivery models are increasingly deployed. In that regard the research pointed to the significance of effective communication and co-ordination as a key means of transforming strategy into delivery. Such co-ordination proved to be important both within OT teams and between OT and other mainstream services. As OT expanded, internal co-ordination became increasingly challenging. Investment of sole responsibility for such co-ordination with the co-ordinator/manager became insufficient. As teams expanded and increasingly moved toward delivering the multiple interventions model that a more holistic approach required, maintaining co-ordination proved to be beyond the remit of a single individual. In area D, the co-ordination responsibility was vested with an individual. However, when this person left their post, co-ordination collapsed, highlighting the potential fragility of such an approach. It proved important for projects to put in place infrastructures and systems to operationalise co-ordination. Evidence of best practice in this regard included:

- Establishing co-ordination teams to deal with allocation of referrals and case reviews;
- Accessible written information, for example service level agreements;
- Multi-agency staff development sessions (but important that these are supported by written information);
- A shared OT base/location (although even this is insufficient without formalising the opportunity for liaison);
- Appointment of intervention co-ordinators with designated

responsibility for co-ordination of service delivery.

Without such practices there was a sense of interventions working in isolation rather than as part of a co-ordinated holistic package. Fieldwork with project managers and others involved with service delivery pointed to some over-estimation of the level of co-ordination. For example, fieldwork for the impact research (Atkinson *et al.*, 2003) identified that some providers were unaware if those to whom they were providing a service were receiving other OT interventions. It is difficult to see, in such circumstances, how service users could experience OT as a co-ordinated programme.

As well as the measures identified above, projects have demonstrated some innovation in attempting to tackle the co-ordination issue. Project E has, for example, established an OT website that providers are actively encouraged to visit and leave messages on at regular intervals. Projects had also put in place co-ordination meetings and team development days, although several providers acknowledged the potential workload issues in achieving effective co-ordination and the danger of an overly bureaucratic approach:

> *It's been really difficult I would say with partnership. I can say that - the facilitation of it is messy, it's a bit muddled because – I mean we've got this system now where if I need an education element brought in if I'm working with a family I have to make an internal referral to the education team I can't just go to a partner, to a colleague and say "I've got this issue with a school can you visit the school"… I can't do that it has to be an internal referral to education as I mentioned which should only be given in a Thursday afternoon caseload management meeting.* (OT Service provider)

The view was expressed that individuals needed a training input to achieve effective partnership working. The required radical shift in working methods needed to be acknowledged and an appropriate training input provided:

> *We've had recruitment and retainment problems and initially I believe some people just could not make the change into a new role. You've got to leave everything behind and try and form some new way of working and work with others and it can be hard and I know some people found that very, very difficult and there's the element then of personalities, knowing somebody's previous role, where they've come from, and I've never worked in that before and I've found that very difficult.* (OT Service provider)

Shifts in working practices

Partnership working in general is perceived to have brought about a radical shift in the profile of workloads and working methods, particularly for senior managers. Evidence of the positive benefits that derive from the work of OT will be vital in encouraging such staff to adjust workload to accommodate new approaches. One service provider described partnership as "a way of life and central to effective delivery of core services". This reflects some of the shift in policy and prioritising of partnership approaches described earlier. The police officer in the first sample reported how their entire role involved some form of partnership working and how strategic collaboration received greater priority than their operational inputs. Another respondent highlighted that organisations were at a relatively early stage in what was a radically new working approach. For some areas, attendance at such meetings was particularly resource intensive but a key requirement to operationalise holistic solutions. The organisational issues highlighted as requiring further attention were:

- The lack of community engagement in partnership arrangements. The focus was mostly on multi-agency working with direct involvement by service users extremely limited. Something which might be described as a 'rhetoric of communitarianism'.

- The lack of organisational infrastructures to support partnership working. One area graphically described the bureaucratic difficulties that proved impossible to surmount in advertising a joint post that cut across several local agencies.

Several respondents reported that significant amounts of their time were invested in multi-agency forums in marked contrast to their role five years ago when little or no such inputs were evident. Booker (2006) has commented on how the integration of Children's Services has brought with it issues for the professional identity of staff, with managers needing to address overlap in function, rivalry and competition.

Achieving an emerging culture of partnership working

Interviews with service providers pointed to various ways in which the innovative working methods adopted by OT teams had provided a good role model and contributed positively to the culture of partnership working in their locality. Typically, blocks and challenges related to a need to work across professional boundaries. Reference was frequently made to initial suspicion and misgiving and the need to work through that to build trust:

> *I think it's encouraged people to look at other ways of working and other ways of doing things and to trust us enough really to let us do that and start working at an earlier stage with children and families. In relation to health visiting and Sure Start, there were a few problems in their relationships and we stuck our*

heads above the parapet, it was a bit like 'oh no, what are this lot going to be doing.' Again, it has been very much the strength of the team members, that they have been able to work through that. (OT Service provider)

Multi-agency truly is a reality in On Track. It wasn't always the case. People were initially guarded and needed to build trust. (OT co-ordinator)

Often services talk about working in partnership but miss the fundamental principles of what that means. We aim to model those principles whether or not we are talking to families or professionals. Hopefully people will have a sense of how effectively that can work. That it's about negotiation, problem solving and creativity. (OT co-ordinator)

For some, the OT approach itself was seen to be innovative with related positive ramifications for evolving partnership arrangements in the locality:

We are a partnership not an organisation. On Track isn't just one of the agencies. It is seen as a partnership venture. (OT co-ordinator)

Most providers felt that OT had met its aspiration to deliver services grounded in a partnership approach. One co-ordinator commented that OT's efforts had made working in partnerships "more accessible and acceptable". Such co-ordination was essential to achieving a more holistic solution to social problems.

Lessons learned on creating effective partnerships

The evaluation of OT has provided the opportunity to consider the factors that have facilitated implementation of the programme as a collaborative venture. The 12 factors set out below will have generic relevance for a range of policy domains including health, education and regeneration schemes:

(i) The significance of the role of the co-ordinator and the stage at which they were appointed. The challenge of operationalising partnership working required a relatively high level of appointment. The status of the co-ordinator/manager was significant and management experience vital. Strong leadership and a commitment from the top to partnership working were seen to be critical.

(ii) The time lost in developing action plans that mostly preceded the appointment of the co-ordinator and their core team. Such a strategy worked against seamless strategic planning - many had to play catch up, key personnel had moved on and some agencies claimed no recall of original commitments in relation to OT. This was a structural problem in that money for the appointment of co-ordinators was not made available until after action plans were approved. Those projects that took up money made available for the appointment of external consultants to write bids, report delay in local partners identifying with the OT programme. Our recommendation would be for money to be made available for the appointment of programme co-ordinators at an earlier stage. This would have facilitated ownership of the programme, made for continuity in planning and saved time and resources in the longer term.

(iii) More acknowledgement of the need for a project start-up phase. Expectations regarding when service delivery would begin were unrealistic. One co-ordinator described the OT model as "complex" and felt that time spent on laying the foundations was vital. The need for such planning, including developing service level agreements, was not acknowledged and the discourse quickly shifted into suggestions of delay in delivery. Several respondents also felt that insufficient time was allowed for community consultation in the initial

planning phase. The time scales were felt to be too short to allow for genuine community consultation with the consequence that projects delivered little more than tokenistic efforts. One respondent considered that:

> *there was little time for informed discussion and to consider where On Track fitted in the bigger picture. The process was rushed and there was not enough time to see where it fitted with other initiatives. Without this it felt like a knee jerk response.* (OT Service provider)

Another felt that short time-scales meant that it was 'opportunist' as to which agencies were part of the initial consultation process. This was felt to have an ongoing effect on an agency's understanding and connection with OT and negatively impacted on its engagement with providing data for the evaluation. Broadly, projects reported limited acknowledgement on the part of the Home Office of Huxham's (1996, p.6) finding that "collaboration is inherently more time-consuming - and hence resource consuming and costly".

(iv) Acknowledgement of the importance of support networks for co-ordinators. In some areas, co-ordinators were isolated, with the future direction of OT overly reliant on a single individual. Management infrastructures and some delegation to other senior staff were important. Some of the individual pressure of the position is reflected in the turnover in staff and the negative impact on service delivery once those individuals leave.

(v) The importance of time spent on devising inter-agency service level agreements. This can look like a lack of activity and output but those areas that gave early attention to this have experienced less in the way of delay in the longer term. Area B, which described not having a local culture of using such instruments, has experienced ongoing uncertainty and related

delay regarding working practices. This has negatively impacted on their ability to retain staff. Service level agreements can also be beneficial in the face of a lack of continuity in strategic planning. They can be a valuable tool in a climate of strategic shifts and deflection of policy and overall direction. Information sharing was seen to be a crucial issue in facilitating collaboration and the need for agreements to be formalised in service-level agreements.

(vi) The significance of task groups as a strategy for transforming the strategic into operational policy. Such groups provide an important tier in service delivery and are more amenable than large steering groups to input and participation by service users.

(vii) More resources and support for community based partnership groupings. The research uncovered a need to acknowledge the shift in role experienced by professional groups and, where appropriate, provide training on working effectively. Training might also incorporate guidance on working with service users. Such inputs evidence a commitment to genuine community engagement.

(viii) Avoiding rhetoric. Several respondents felt there was a measure of rhetoric regarding governmental commitments to partnership working with a lack of awareness of the practicalities of implementation. The challenges that were felt to be particularly overlooked centrally were time constraints – including, as indicated above, insufficient time to undertake effective consultation and for mutual understanding and trust to be established in partnership forums. One respondent suggested that the government had a:

> *Notional idea of partnership and not the faintest inkling of what it implies. In practice it is time consuming and that is not supported financially by central government.* (Service provider)

(ix) Sharing of skills and expertise and a willingness to be honest regarding gaps in knowledge. Threats to effective collaboration were felt to be the predominance of an insular perspective with "people still fighting their corners, often linked to budgets" (Partner provider). Trust between professional groups and with service users was felt to be a vital component:

> On Track has pulled together a group of different professionals with a different ethos in how they work. This has had implications for confidentiality and information sharing. This has been a challenge within a multi-agency team but in the same respect it has added different perspectives on how to work together. (Service provider)

For multi-agency practice to work effectively, professionals had to be prepared to work beyond their own professional boundaries. Personal commitment to partnership working was felt to be particularly important but this needed to be backed up by organisational features, such as service level agreements.

(x) Efficiently-run meetings. Opportunities for decision-making will encourage participants to attend. Overly-large meetings are a constraint on decision-making with the danger that there is merely a reporting function rather than critical discussion and debate (see previous point regarding task groups). Effective chairing of such meetings needs to be supported by clear and accessible minutes. In sum, the focus, size, membership and administration of such meetings all proved to be critical factors.

(xi) Build into the infrastructure opportunities for communication across agencies and with service users. Face to face opportunities for sharing views and perspectives were seen to be crucial in operationalising partnership. It was acknowledged that time constraints can mean this is not always feasible. Other innovative options include project websites and active encouragement and training for partners to use the web on a regular basis.

(xii) Location in an accessible and user-friendly base. The atmosphere should be conducive to both service users and professionals. Regular use by the community was seen as important in establishing an OT identity. One of the projects well-served in this regard received 40% of their referrals directly from members of the community visiting the centre.

Conclusion

> Partnership is not a cheap option. To work effectively it needs time and resources invested. (Service provider)

While acknowledging that effective partnership working can be resource intensive a majority of the research participants identified considerable positive benefits deriving from joint working. Respondents suggested that OT provides a unique example of strategic partnership translating into collaborative service delivery. They also point to the increased prevalence of partnership working as a mode of delivery. In that regard, the lessons learned from this piece of research will have implications for other collaborative projects.

Experience shows that effective partnership working does not occur without opportunities being formally factored into organisational infrastructures. This is acknowledged by the Laming Report (2003) and endorsed by this research. Where effective partnership working does take place it can be extremely positive for the co-ordination of multi-disciplinary service delivery and seamless planning:

> The profile of the school has been raised and parents are choosing the school for

its support services among other things. (Service provider)

It's a privilege to work so closely with experts in other fields. (Service provider)

The multi-agency approach can only be a positive thing as repetition is less likely to occur and expertise will be used to the most effect. (Service provider)

From the outset, partnership working was at the core of planning and delivery of OT. Effective collaboration was critical in meeting the challenge of implementing multiple interventions in a holistic and co-ordinated manner. This paper shows evidence of how this is being successfully achieved in some areas but with others having some way to go in achieving required levels of collaboration. This evidences the challenge of operationalising a collaborative approach and the need to avoid assumptions that genuine partnership approaches will happen without a focus of energy and effort.

Recent government policies for children and families in the U.K., particularly promotion of Identification, Referral and Tracking and the 2004 Children Act, clearly demonstrate that multi-agency collaboration is seen as the way forward. In that regard, the experiences of OT are highly relevant.

Effective co-ordination of services required commitment from the top and an open and receptive stance in relation to diverse professional groups. Bringing together professionals in new collaborative ventures often entailed some initial wariness. Factors that served to overcome any initial resistance included joint training and regular multi-agency meetings. Such meetings served to establish team policy and build a team identity. It proved important to foster a culture of partnership working. Without such an ethos, professionals tended to work in parallel rather than collaboratively.

The groundwork required to establish effective professional partnerships is time consuming, a particular issue for public services under pressure. Explicit acknowledgement of the increased workload, particularly for middle and senior managers, is vital. In sum, achieving effective collaboration is costly in employee time and needs to be appropriately factored into job descriptions. The positive benefit of such endeavour is a more co-ordinated approach in regard to service delivery. Where the goal is also to achieve partnership with community representatives, the research demonstrates that this will only be achieved once effective collaboration is secured amongst key professionals.

While achieving effective collaboration is resource intensive, OT staff commented that working effectively in partnership, as well as enhancing service delivery, was also an important tool for achieving enhanced staff morale. Interestingly, those projects who had achieved most in their efforts at collaboration spoke about their approach going beyond multi-agency work to a more holistic approach: "I don't see them as representatives of other agencies but as colleagues" (OT service provider). There was a concern, however, to stress that this is not a static event but an ongoing process that needs to maintain momentum and continue to draw in professional and lay members of the community:

I think really everyone has got to know what is going on and sort of communicate. Otherwise, it just doesn't work does it? You end up dealing with separate people and nobody knows what the other person is doing. (Service user)

On Track has created opportunities for partnership working, ensured ease of access to other services and enabled quick and easy problem-solving between agencies. The crucial factor in the On Track method of working is that partnership leads to clear lines of

communication with common ground, even though service providers' differences in working practices may stay in place. (A professional partner representing a voluntary agency in Area H)

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Notes on Contributors

Lesley Noaks was a practising social worker in the child care and mental health fields in the period 1973-1989. She worked in both the statutory and independent sectors. Since 1989 she has been a researcher/lecturer in social work and criminology in the Cardiff School of Social Sciences, Cardiff University.

Address for Correspondence

Dr Lesley Noaks
Cardiff School of Social Sciences
Cardiff University
Glamorgan Building
King Edward VII Avenue
Cardiff
CF10 3WT
Wales

Email: Noaks@Cardiff.ac.uk

Implementing the Single Assessment Process for older people in England: lessons from the literature

Michele Abendstern, Paul Clarkson, David Challis, Jane Hughes and Caroline Sutcliffe

Personal Social Services Research Unit, University of Manchester

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Abstract

With the introduction of the Single Assessment Process (SAP) in England, in 2004, the government aimed to address the shortcomings in the assessment of older people with health and social care needs. The SAP promoted a person-centred approach, multi-professional working and the standardisation of assessment practice. By reviewing the literature on assessment from the mid-1980s to the present, this article identifies issues that may help or hinder effective implementation of the SAP. In addressing assessment from the viewpoint of different stakeholders, potential tensions between different policy aims are exposed. It is suggested that achieving the aims of the SAP will be a complex process, with historically contentious issues in assessment practice remaining relevant to the implementation of this policy.

Keywords: Comprehensive assessment, multi-disciplinary assessment, older people, Single Assessment Process

Introduction

The assessment of the needs of older people is an issue of international concern (Otis & Butler, 1997; Carpenter, 1998; Byles, 2000; Kane & Kane, 2000; Jorg *et al.*, 2002; Campbell & Ikegami, 2003; Howe & Kung, 2003; Challis *et al.*, 2004). In England recent attempts to improve assessment practice are enshrined in the Single Assessment Process (SAP) (Department of Health, 2001, 2002a), a government policy designed to address some of the concerns about the quality of assessments for older people raised by reports and research subsequent to the community care reforms of the early 1990s. A number of reports have identified variability in both the content and quality of the information collected in assessments; poor categorisation of needs and problems; lack of clarity regarding the purpose of assessment; a lack of differentiation of assessment according to need; and a shortfall in appropriate health care inputs to the assessment process (Department of Health, 1993 a, b, 1996; Audit Commission,

1997; Social Services Inspectorate, 1999). At the same time research also highlighted uncertainties over the scope of assessment and how it was conducted, with marked variability in both the form (the way in which assessments were conducted and which staff were involved in them) and the content (what information was sought about needs) of assessments by UK social services departments, leading to inconsistency in practice (Caldock, 1993, 1994a, b; Lewis *et al.*, 1995; Stewart *et al.*, 1999; Parry-Jones & Soulsby, 2001).

The SAP represents a recent attempt by central government in England to address such weaknesses. Its underlying principle is to provide a framework for assessment making it more integrated between different settings and between different professional groups. The policy aimed to: place the individual at the heart of the assessment process; raise the standards of assessment; develop a more standardised practice, and reduce duplication by developing greater multi-disciplinary and multi-agency communication and understanding

(Department of Health, 2001, 2002a). The nature of assessment and what are conceived to be its different purposes such as need identification, effective information collection via the promotion of inter-professional practice, and strategic service development may, however, be viewed in different ways by the different stakeholders involved, as outlined in Box 1. This makes it likely that implementation of the SAP will be a complex and difficult process.

The aim of this article is therefore to explore, via a literature review, how the different stakeholders in the assessment process conceptualise and understand assessment. The review is structured around the three major stakeholder groups - older people and their carers, the different professional groups involved, and policy makers – and focuses on key themes reflecting the aims and intentions of the SAP. At the service user level, the notion of person-centred care, including user participation, and the concept of 'need' considered through the prism of different professional cultures, are discussed. At the professional level, collaboration between different professional groups and different professional views of standardisation are considered. Finally, at the policy level, the promotion of efficiency and the structures required to support inter-agency and professional assessment practices described in the literature are outlined. By these means the complexities, potential obstacles to effective implementation, and tensions between different policy aims of the SAP are drawn out. By raising awareness of past practices and experiences it indicates that lessons may be learned which can support the effective implementation of the SAP.

Box 1 Purposes of assessment from the viewpoint of various stakeholders

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Service users:
- Information on services, options for care
- Ideally empowers older people to have control over decision making process
- Early screening for medical disorders
- Comprehensive appraisal of functional capacity, disability, psychosocial needs, environmental situation, vulnerability and carer's needs
- Diagnosis by clinicians of specific disorders
- Eligibility for services, especially social care
- Information and advice

Professionals:
- Informs care planning, enabling identified needs to be matched to services
- Determines eligibility for services
- Prioritises access to services
- Informs allocation of resources
- Provides information on unmet needs
- Provides information for planning new services
- Provision of data for performance monitoring and quality assurance

Policy makers:
- Application of eligibility criteria
- Targeting of service in response to identified need
- Aggregation of information to monitor performance
- Information to plan new service
- Cost containment by regulating access to services

Sources: Lawton (1986); Terri & Lewinsohn (1986); Payne (1989); Kane (1990); Leutz *et al*., (1993); Philp & Dunleavy (1994); Hughes (1995); Otis & Butler (1997); Kane & Kane (2000).

Parameters of the review

The review had the specific purpose of highlighting issues relevant to SAP implementation. The areas of enquiry were therefore chosen *a priori* to reflect both the key attributes of the SAP as described in the Department of Health Guidance (Department of Health, 2002a) and as a means of identifying any distinct views of assessment held by the various stakeholders involved. A broad strategy for literature searching and for locating relevant studies was adopted. Literature concerned with issues pertinent only at a local level was excluded. To provide acceptable scientific quality for evidence, only peer reviewed articles were included amongst the published papers.

The literature search was undertaken on refereed journals, books and government documents from immediately before the community care reforms of the early 1990s to the present. This period was chosen because of the important developments occurring at that time, which have a bearing on the present conduct of assessment in England. Both UK and non-UK sources were considered so as to highlight important issues arising from developments in assessment processes in other countries. The US and Australia, for example, have operated more formal standardised or integrated assessment procedures than the UK. The literature from these countries was therefore drawn upon to throw light on the potential impact of similar attributes within the SAP, thus highlighting some of the potential obstacles to its effective implementation.

Searches were undertaken on a range of electronic databases (Social Science Citation Index, Medline, PsycInfo, Cinahl, Sociological Abstracts, EconLit) with key search terms refined during this process to include: 'the assessment of care needs', 'community-based assessments' and 'assessments of older people for health or social care services'. Grey literature was accessed via specific databases (Caredata), research organisations (The Joseph Rowntree Foundation, The National Institute for Social Work) and the internet. The literature reviewed is broad in scope, with some studies referring to issues related to assessment only tangentially, for example in relation to the integration of health and social care. This is indicative of the fact that assessment is a fundamental part of the wider health and social care system.

Assessment at the service user level

Assessment at this level is characterised by the way assessments impinge on the older person who has approached or been referred to health or social care agencies. It is the most frequently debated aspect of assessment. Here, the SAP aims to promote assessments that enhance 'person-centred care', leading to care delivery that upholds the values, wishes and preferences of older people and involves them as active partners in the process of assessment and service planning (Department of Health, 2001, 2002a).

A person-centred approach to assessment is not new. Such an approach was advocated in the policy guidance *Caring for People: Community Care in the Next Decade and Beyond* (Cm 849, 1989) in the form of 'needs-led' assessments. However, the literature suggests that this concept was at times misunderstood by social care professionals who regarded 'need' largely in terms of those needs expressed by the service user (Bradshaw, 1972), whereby the latter's definitions of their needs were privileged over both professional opinion and service availability (Parry-Jones & Soulsby, 2001). Case law legitimised the view that 'need' could be considered in the light of available local authority resources (R. v. *Gloucestershire County Council, ex parte Barry* [1997] 2 WLR 459), resulting in some disaffection by local authority assessors who were concerned that their

traditional advocacy role was becoming compromised by their requirement to act as gate-keepers of scarce resources (Caldock, 1993; Richards, 1994; Twigg & Atkin, 1994; Nolan & Caldock, 1996). The literature suggests that the tension between wishing to provide services on the basis of user-defined need and having to take account of agency eligibility criteria in framing decisions about need remains a real conflict for practitioners (Parry-Jones & Soulsby, 2001; Preston-Shoot, 2003).

Much of the literature on this topic draws a sharp distinction between assessment seen from a professional viewpoint, where the assessor is deemed as an expert in identifying users' needs, and that from the user's viewpoint, where the older person's preferences and wishes become paramount. Several studies have suggested that despite an expressed commitment to listening to and taking account of the perspective of the service user, professionals were unable to do this when these perspectives differed from their own (Ellis, 1993; Barnes & Wistow, 1994; Glenister, 1994; Clark, 1996; Myers & McDonald, 1996). Professionals in these studies tended to operate what Smale and Tuson (1993) termed a 'questioning' or one-way model of assessment whereby the professional is regarded as the expert and the service user as the passive recipient of care. In contrast, an 'exchange' model of assessment is advocated whereby the service user is recognised as the expert in their own lives and the professional and service user are considered to have "equally valid perceptions of the problems and can contribute to their solution or perpetration" (Smale & Tuson, 1993, p.7; see also Lloyd, 2000; Preston-Shoot, 2003). Such an approach can be seen to rest upon a rights-based conception of community care, in which the service user's experience is used as the basis for entitlements to particular services (Oliver, 1996) as well as reflecting the underlying concept of the 'patient as

expert' recognised in relation to particular disease groups (Lloyd, 2000).

Although signalled explicitly in Standard Two of the English National Service Framework for Older People (Department of Health, 2001) as being central to the SAP, it would seem that person-centred care has been largely regarded as a value that acknowledges the rights of older people to determine their own ends rather than a concrete practice involving the use of particular skills (McCormack, 2003). The involvement of older people as active partners in the assessment process, considered fundamental to a person-centred approach within the SAP (Department of Health, 2001), is one means of operationalising this concept. Here the literature suggests the need to balance a responsibility to protect the most vulnerable people in society (Stevenson, 1996) with the recognition of the desire and right of older people to participate in the assessment process. The literature suggests that only lip-service has been paid to the concept of user participation by professionals (Croft & Beresford, 1992; Cahill, 1998) with participation often regarded as an end in itself rather than an important linkage to other goals (Qureshi, 1999). There is also evidence in the literature suggesting that older people have often been perceived as uninterested in active involvement (Beisecker, 1988; Waterworth & Luker, 1990; Barnes & Prior, 1995; Jewell, 1996) However, this view has been challenged by others (Myers & Macdonald, 1996; Eales *et al.*, 2001; Roberts, 2002; Chapman *et al.*, 2003; Clark *et al.*, 2004), who have suggested that the apparent acquiescence and passivity of older people in the assessment process found in some studies may be the result of factors such as feelings of powerlessness and ignorance in the face of complex and confusing systems (Hardy *et al.*, 1999); asymmetry of power between practitioners and service users (Meethan & Thompson, 1993, McWilliams *et al.*, 2001; Carr, 2004); disillusionment based on

previous negative experience (Croft & Beresford, 1992); and older people's views being subordinated to those of family members or professionals (Roberts, 2002).

Safeguarding a person-centred approach to assessment will require an understanding, by those implementing the SAP, of the relationship between 'rights' and 'needs' as defined by service users and professionals. This will necessitate more precise definitions as to the purposes of assessment on each side of the 'exchange'. Whilst it has become popular to support the concept of participation as representing a move towards an 'exchange' model of assessment, it is also important to identify limits and consider those who, for reasons of frailty and ill health, may not be in a position to take control of, or even participate in, the assessment process. Concurrently, the potential difficulties involved in limit setting in terms of who makes these decisions and how they are scrutinised must be considered. The Mental Capacity Act (2005) provides an example of how this issue is being addressed by legislators. The literature suggests that people with cognitive impairment have until recently been viewed as lacking the mental capacity to take part meaningfully in discussions about their quality of life and have consequently been excluded from negotiations about their care needs (Albert, 1997). A number of published studies have challenged this standpoint (Mozley *et al*., 1999; Barnett, 2000; Wells & Dawson, 2000; Wilkinson, 2001) whilst the Mental Capacity Act (2005) has enshrined in law the notion of the "presumption of capacity" and a requirement to provide appropriate support to enable people to participate in decision making processes about their care (DCA, 2007, para. 1.2). The purpose of assessment from a person-centred perspective, including greater participation of older people in the assessment process, may therefore conflict with the role of assessment as a professional decision-making tool used in conjunction with

criteria relevant to the aims of health and social care agencies.

Assessment at the professional level

Assessment from the professional viewpoint raises further debate concerning how and in what form information is generated. Variations in both the extent and nature of information elicited by professionals during assessments have continued to raise concerns, despite initiatives aiming to standardise assessment content and ensure the coverage of a broad range of domains (Carpenter, 1998; Martin *et al.*, 1999; Stewart *et al.*, 1999; Parry-Jones & Soulsby, 2001). Two aims of the SAP are particularly pertinent in attempting to overcome these difficulties (i) the reduction of duplication of information gathered by different professional assessors, itself an aim dependent on more effective collaboration between them and (ii) the standardisation of practice across the country, an aim intended to ensure that assessments cover a broad range of domains so promoting consistency between agencies and within and between localities (Department of Health, 2002a).

Professional collaboration

A major obstacle to sustained, effective collaboration between professional groups, highlighted by the literature, is a lack of shared vision regarding both the purpose of assessment and how it should be undertaken. This issue can in part be summarised in terms of the 'clinical/social divide', and whilst there is evidence that this divide is neither as static nor clear-cut as is sometimes suggested, with community nursing in particular spanning the divide (Worth, 2001), the literature does indicate that professionals continue to lean towards either one model or the other, depending on their professional orientation (Dalley, 1991; Worth, 2001; Royal College of Nursing Scotland, 2003). Although debate before the community care reforms signalled the need for community care assessments to operate

in consort with both primary and secondary health care (Browning, 1992), the distrust that existed between the sectors meant that this largely failed to materialise (Hunter, 1994; Wistow, 1994); a consequence being that UK community care assessments tended to neglect specialist health care information (Challis, 1999). By contrast, in Australia, the development of Geriatric Assessment Teams following the 1986 Nursing Homes and Hostels Review (Department of Community Services, 1986) formalised multi-disciplinary assessment practice, including primary and secondary health and social care (Kendig *et al.*, 1992; Challis *et al.*, 1995). The Australian experience demonstrates how structural reform to assessment at a national level could lead to greater integration at the professional level. However in England, by giving the lead responsibility for the coordination of community care assessments to local authorities (Cm 849, 1989; Department of Health, 1990), the community care reforms failed to bridge the divide between health and social care and, in particular, neglected the contributions of secondary health care professionals. Such large scale reform, and particularly the manner in which it was implemented locally, has obvious relevance to a national policy such as the SAP. Despite efforts to reduce duplication, by promoting collaborative practice in assessments (Department of Health, 2002a), the literature testifies to potential difficulties at a local level, including the distrust of professionals over the motives of such activity (Dalley, 1991).

Standardisation

Standardisation of the process and content of assessment is a fundamental aim of the SAP as a means of promoting its operation in a similar and consistent way across the country and between professional groups. By this process it aims to achieve both 'territorial justice' (Davies, 1968; Department of Health, 2002b) and the ability to aggregate assessment information in order to inform performance management and service development (Kane & Kane, 2000).

As detailed above, the literature suggests that the purpose of assessment is viewed diversely by different professional groups involved in assessing older people. With regard to standardisation, a distinction can again be drawn between the medical profession, where standardised tools and scales have long been in routine use (Burns *et al.*, 2003) and social work, where such tools have been less widely acknowledged and little used (Abendstern *et al.*, 2006). Where they have been employed by the latter, evidence suggests that their value was compromised by local adjustments being made to them (Glasby, 2004). These difficulties may be due to a level of circumspection regarding standardisation within some professions, notably social work and nursing, where an open-ended assessment model (the antithesis of a standardised approach) has been seen as an important characteristic of their professional role (Qureshi, 1999; Worth, 2001). Standardisation has been regarded by these groups as leading to a mechanistic and bureaucratic process, denying individuals their 'voice' and pre-judging users' and carers' priorities (Nolan & Caldock, 1996). In the absence of standardisation, however, there is evidence in the literature of judgemental assessment practice (Ellis, 1993), based on individual 'practice style' (Ozcan, 1998) and variation according to the professional identity of the assessor rather than the needs of the service user (Runciman, 1989). The result has sometimes been a degree of variation in assessment information that is over and above that expected from the variations in the circumstances of older people in a particular locality (Stewart *et al.*, 1999).

Such professional differences to the approach and view of the purpose of assessment may continue to raise issues for

the implementation of the SAP. The guidance does acknowledge these potential difficulties regarding differing professional views, noting that standardisation should "support existing good practice [and be] useful to those practitioners responsible for its day-to-day operation" (Department of Health, 2002a, Annex A). The guidance is not prescriptive regarding how standardisation of assessment content and practice should be achieved. Whilst it lists the domains that comprise the SAP, it comments that not all domains will always be required to be completed. The Guidance also endorses the development of local tools and emphasises the importance of local implementation processes relevant to existing local good practice. A tension is evident here between support for local implementation initiatives which are sensitive to local circumstances and a desire to promote a standardised national approach to the implementation of the SAP.

The existence of the SAP as a government policy is acknowledgement of the inefficiencies of previous assessment practice, both in terms of duplication and its consequent costs to public agencies (see Gershon, 2004), and in the less than optimum outputs from the resulting mix of services – an issue arising when the "scale and depth" of assessment is not proportionate to need (Department of Health, 2002a, p.1). Notions of efficiency and cost effectiveness have underpinned previous policies, particularly the community care reforms of the 1990s. However, as noted above, a tension is evident in the literature in that efficiency has been considered by some professionals as an undesirable aim, being linked purely with cost minimisation, and perceived as in direct conflict with a person-centred approach (Qureshi & Nicholas, 2001; Martin *et al.*, 2004).

Promoting efficiency

The identification of the likely difficulties in promoting efficiency through the SAP is assisted by examining policies that have articulated similar goals in relation to the practice of assessment. An analogous policy, raising similar issues concerning the promotion of efficiency, is that of the implementation of care management in the early 1990s. Care management is important in this respect because, in its assessment phase, it aimed towards a differentiation of assessment according to need and a coordinated approach to assessment, aspects similar in important respects to those of the SAP.

Studies undertaken during the time of the introduction of care management in the UK found it was often a predominantly administrative process, at times involving the use of generic assessment tools, and failing to target those most in need (Challis, 1992, 2004; Lewis *et al.*, 1995; Stewart *et al.*, 1999). One aim of care management was to overcome some of these problems in relation to assessment. Intensive care management studies, carried out in a number of settings in the late 1980s and early 1990s (Challis & Davies, 1986; Davies & Challis, 1986), showed gains for very vulnerable older people, in particular in relation to improvements in their wellbeing and reductions in carer stress, with these gains largely being achieved at a lower or similar cost than normally expended (Challis & Davies, 1986; Knapp *et al.*, 1992; Challis, 1993; Challis *et al.*, 1998). Key elements of this model were "a differentiated response to need; appropriate targeting; devolution of budgets; continuity of involvement of care manager with service user and appropriate links with specialist health care expertise" (Challis, 2004, p.233). These features, however, were not translated into mainstream practice following the introduction of care management across social services authorities in the UK which bore little

relation to the intensive care management studies, thereby meaning that potential benefits of the policy may not have been realised. The SAP, similarly, advocates changes to assessment based on previous research evidence (Department of Health, 2001). However, experience derived from the introduction of the care management arrangements suggest that the benefits in the assessment process may be slow to materialise unless local implementation is allied more precisely to the factors underpinning gains in efficiency. Such debate has consequences for the SAP, which advocates differentiation in assessment as one means of promoting efficiency, in particular for the policy's implementation locally. A further important element of assessment viewed from this level is the establishment of structural support to enable more effective professional collaboration to take place.

Structural support for collaborative practice

Studies have demonstrated that more effective outcomes for older people arise from formal mechanisms which integrate the assessment approaches of different professionals (Hunter *et al.*, 1993; Challis *et al.*, 2004; Clarkson *et al.*, 2006). Donald and Bown (2003), for example, found that a multidisciplinary assessment panel, incorporating a geriatrician, care manager, community psychiatric nurse, district nurse, physiotherapist and occupational therapist, for those being considered for admission to long-term care, ensured a more appropriate and consistent categorisation of care for older people, compared with recommendations made by care managers alone. Challis and colleagues (2004) found that integrating the assessments of care managers and specialist clinicians, through a reporting process between them, resulted in improvements in medical information passed to and used by care managers in their work. This, in turn, resulted in less deterioration in older people's physical

functioning, less contact with nursing homes and emergency services and cost savings, particularly to the NHS.

Translating the potential benefits of such collaborative studies into policy development or mainstream practice has proved difficult. For example, in hospital discharge, Marks (1994) commented on the consistency of research findings, going back over twenty years, documenting the breakdown of discharge procedures, despite government guidance and a number of schemes at the local level. One of the lessons from implementing collaborative schemes in this area is the value of coordinating the diverse functions and assessments of different professionals. In the UK examples of such a strategy in this area include a dedicated discharge co-ordinator (Houghton *et al.*, 1996), a liaison nurse (Peters *et al.*, 1997) and the full involvement of the hospital multidisciplinary team (Bull & Roberts, 2001).

These findings provide valuable evidence for those implementing the SAP in relation to developing operational structures, procedures and guidelines which integrate the assessment processes of key professionals at particular key episodes in an older person's care. The literature suggests that developing appropriate structures is important for systematic implementation. This involves moving away from 'force of circumstance', when professionals are obliged to collaborate through shared tasks (Dalley, 1991), which, although potentially leading to greater professional understanding, is vulnerable to an over reliance on individual commitment to the process (Sheard & Cox, 1998). The role of information technology to enhance multidisciplinary assessment practice is also an important aspect of operational structure implicit in the SAP guidance (Department of Health, 2002a). Information technology offers an "electronic bridge to overcome the temporal-spatial difficulties associated with

traditional forms of collaboration" (Reeves & Freeth, 2003, p.89) and may supersede the goal of co-location aimed for in recent years. Installation alone, however, will not guarantee success (Department of Health, 1995; Warburton, 1999; Cameron & Lart, 2003; McNally *et al.*, 2003). It is a necessary but not sufficient condition. Structural divisions will need to be addressed further for such collaboration to bear fruit (Warburton, 1999; McNally *et al.*, 2003; Reeves & Freeth, 2003).

Conclusions

A review of assessment across health and social care testifies to the considerable complexities involved in delivering a 'joined up', standardised and participatory assessment process for older people. It also demonstrates that critical issues relevant to the implementation of the SAP are not new but have been considered by commentators from a variety of backgrounds over a substantial time period. Several issues stand out and are summarised in Box 2 as constituting the principal lessons from this review. Implementing the SAP in the medium to long-term is likely to be a complex process involving challenges for all concerned. The changes envisaged will tend to be filtered through interpretations

and implementation of policy at the local level (Lipsky, 1980). Throughout this process, long standing and deeply embedded professional practices, traditions, beliefs and structures will need to be addressed; a key issue here being the differing professional values and roles of those involved in the assessment of older people.

Without a shared understanding across professional groups there is a danger that professionals will continue not to accept the assessments made by others, so duplicating information collection and therefore jeopardising the efficacy of the shared tools and systems envisaged as part of the SAP. Joint working protocols and training programmes may offer a means of addressing this. However, Barr (2003) has suggested they need to be carefully designed if they are not to compound stereotyping and negative attitudes held by professionals. The development of information technology offers the potential for a new style of collaborative practice with the capability to develop strong networks without the need for co-location (Reeves & Freeth, 2003), but its design will require thought if it is to strengthen rather than undermine a joint approach to assessment required by the SAP.

Box 2: Summary messages from the literature

> - *On person-centred care*: Professionals are committed in theory but find it hard to give up control in practice. Approaches to involving older people in their assessments need to reflect the heterogeneity of older people.
>
> - *On standardisation:* Hostility from some professional quarters remains a reality. The purpose of standardisation needs to be clarified for all professionals alongside valuing professional judgement.
>
> - *On multi-disciplinary working*: Structures are needed to support the necessary 'meeting of minds' for integrated approaches to assessment to work more effectively.
>
> - *On efficiency:* Still perceived with suspicion by professionals as a purely cost cutting exercise rather than being aimed at improving outcomes. Assessment efficiency involves both savings of time and expense involved in avoiding duplication and a more optimum mix of services resulting from the assessment.

A single collaborative approach, involving multiple agencies but co-ordinated by the social services care manager was an original intention behind the community care reforms (Department of Health, 1990; McNally *et al.*, 2003). The evidence is, however, of such a pivotal approach not being fully established and, instead, multiple separate assessments, often with little sharing of information, being undertaken. If such a collaborative model of care management, as envisaged by the reforms of the mid-1990s, has not fully emerged across localities, it seems likely too that an integrated assessment practice, as proposed by the SAP, will be similarly difficult to realise. One reason for this may be the inherent complexity of a policy which seeks to change professionals' *behaviour* rather than merely the pattern of resource allocation and distribution (Wildavsky, 1979). For local agencies to more effectively realise the aims of the SAP will require changes in the practices of professionals, which in turn will require local management to implement structures offering incentives for professionals to change the way they operate. However, one difficulty with the introduction of the SAP is its lack of prescription as to which agency should take on a co-ordinating role, which is likely to result in further uncertainty and even duplication. External prescription may therefore be required to direct agencies as to their respective responsibilities for coordinating the different 'stages' of assessment (Department of Health, 2002a). In the long term, judging the impact of the SAP and whether it has achieved its aims will require knowledge of the manner of its implementation, which, in turn, will need to take account of the debates considered above.

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Notes on Contributors

Michele Abendstern PhD, BA, CQSW, PG Dip, is a Research Associate at the Personal Social Services Research Unit, University of Manchester. Her previous employment includes social work, care management and historical research. Her research interests are in the development of services for people with dementia and the integration of health and social care.

Paul Clarkson PhD, MSc, is a Research Fellow at the Personal Social Services Research Unit, University of Manchester. He previously worked as a social worker in psychiatric and acute medical settings before research posts in London and Leeds. His interests are in performance measurement in long-term care of older people; assessment in community settings and the use of routine data to evaluate practice.

David Challis PhD, MSc, BA, Cert PSW, CQSW, Cert Ed, is Professor of Community Care Research and Director of the Personal Social Services Research Unit at the University of Manchester. He has undertaken the development and evaluation of a series of studies of community based care for older people which provided alternatives to hospital and nursing home care. Currently he is responsible for national studies of care coordination in older people's services and evaluation of assessment procedures in England.

Jane Hughes MSc, BA, DSW, CQSW, is a Lecturer in Community Care Research in the Personal Social Services Research Unit,

University of Manchester. Currently her principal research activities are centred on services for vulnerable older people living at home.

Caroline Sutcliffe BSc, MSc, joined the Personal Social Services Research Unit in Manchester as a Research Associate in November 2000. Her research interests include quality of life and dementia care in older people, and care management arrangements.

Address for Correspondence
Michele Abendstern
Personal Social Services Research Unit
Faculty of Medical and Human Sciences
University of Manchester
Oxford Road
Manchester
M13 9PL
Telephone: 0161 2756851
Fax: 01612755790.
E-mail: Michele.Abendstern@manchester.ac.uk

Receiving specialist welfare benefit advice within Social Services: a qualitative interview study of older people and their carers

Rachel Winder[1], Suzanne H Richards[1], Katrina Wyatt[2] and John Campbell[1]

[1] Primary Care Research Group, Peninsula Medical School, Exeter, EX1 2LU
[2] Peninsula Medical School, Exeter, EX1 2LU

Abstract

Benefits uptake in the older population is low compared to other age groups, and improving access to, and uptake of, welfare benefits advice is a key goal of UK health and social policies around active ageing. As there is little information on older people and/or their carers' experiences of receiving specialist welfare benefits advice within social services, we undertook a qualitative interview study with service users and staff.

Interviewees described difficult life circumstances around the time of referral. The complexities of accessing advice and of understanding the benefits system were recounted. Participants felt the advice was beneficial regardless of whether it resulted in additional income. The majority receiving additional benefits described a positive impact on life choices and control, quality of life, independence and health. Awareness of eligibility and availability of benefits and benefit advice remains low, and many older people and carers still feared the intrusion of benefit provision and advice. Whilst these findings confirm the valuable role of specialist benefits advice workers, more anticipatory rather than reactive approaches are needed to identify vulnerable adults who are not already known to the social care system.

Keywords: Welfare benefit advice, older people, social care intervention, qualitative

Introduction

In recent years, increasing focus has been placed on providing effective and accessible welfare benefits advice within the community for the older population as one means of tackling material deprivation and its associations with poor health status (Paris & Player, 1993; Acheson, 1998; Hoskins & Carter, 2000; McConaghy *et al.,* 2003; House of Commons Committee of Public Accounts, 2004; Abbott *et al.,* 2005). Although accessing benefit advice can lead to increased benefit income (Abbott & Hobby, 2000; Toeg *et al.,* 2003; Campbell *et al.,* 2007), the complexity of the benefits system may pose a considerable challenge for an older person or carer, and benefit uptake amongst older people remains relatively low (Great Britain National Audit Office, 2002).

Benefits advice is increasingly being provided within health and community settings and particularly within primary care (Abbott & Hobby, 2003). In some instances, dual-purpose teams have been set up within social services to take on the role of calculating client contributions for social services, as well as providing financial advice to maximise the individual's income (Audit Commission, 2000; Department of Health, 2001). Such an approach aims to be user-focussed, often has an advocacy role, and adopts holistic strategies. Older users' and carers' views on obtaining benefits in this way and of the less tangible associated effects, such as the potential impact of benefit advice on health, independence and well-being, have not been widely explored.

Using qualitative methods, this study examined the experiences of older people, carers of older people and officers from a specialist, social services-based, home-visiting advice team, regarding the provision and perceived impact of obtaining welfare benefit advice. This study was run in parallel to an associated longitudinal observational study examining the impact of welfare benefits advice on client health and well-being, whose findings are reported elsewhere (Campbell *et al.,* 2007).

Methods

Ethical and research governance approval was obtained in June 2003. Older people (age 60 years or over) and their carers (spouses and relatives, all ages) were identified through social service records of recent referrals to the welfare benefit advice service. Potential participants were purposively sampled to include individuals with a range of physical and mental health needs who either lived alone or with others, and who had been newly or previously referred to the service. Permanent nursing home residents and any participants taking part in the associated longitudinal observational study (Campbell *et al.,* 2007) were excluded. Trained welfare benefit advisors from the financial advice team, who ranged in expertise and experience, were also invited to be interviewed.

Older people and carers were approached by a brief covering letter from the welfare benefits team, with an accompanying letter, information sheet and reply slip from the research team. The information sheet reassured potential participants that the welfare benefits team would not know who took part in the study, and that their participation was voluntary and would not influence any advice, support or benefits received through statutory services both now and in the future. Invitations for interview were sent to 63 older people and 42 carers (including 19 pairs). Five invitees died before or during the mail shot period.

Non-responders were sent a reminder letter after two weeks. Individuals who indicated that they were willing to take part in the study were asked to provide written consent.

The tape-recorded interview took place in the participant's own home. The interviewer (RW) used a topic guide during the interview that was developed from relevant literature, respondents' free text and verbal reports from the associated longitudinal observational study (Campbell *et al.,* 2007), and was further refined during the course of the data collection period. Participants' experiences of the referral process and financial assessment, and its perceived effects (positive or negative) were explored. Interviewees' views on the processes involved in obtaining benefits advice for older people and their carers were discussed. A second interviewer interviewed the benefits advice team members as RW had some personal involvement with the team over the study period.

Analysis

The interviews were recorded, transcribed verbatim and depersonalised and each transcript assigned a unique identifier (letters A-Z) to identify the origin of the quotes selected. An Interpretative Phenomenological Analysis (IPA) framework (Smith *et al.,* 1999) was used to capture the interviewees' perceptions and understanding of the benefits assessment, its outcome and its effect on their everyday lives, their health status and well-being.

Validation of the analysis

Steps were taken to maximise the validity of the findings (Elliott *et al.,* 1999). Recruitment continued until saturation of themes had occurred. Each transcript was read alongside the recording, re-read several times and individually coded. The emergent coding framework was checked against original transcripts for confirmation or contradiction of the coding categorisation

identified. Five transcripts were also independently coded by a second researcher and compared for convergent and divergent themes. Key themes identified by each of the independent coders were compared and discussed and any conflicts were resolved through discussion within the research team. A summary was sent to each participant who was invited to comment on its accuracy from their perspective. Feedback forms were reviewed for conflicts in theme interpretation. Key themes were also checked for credibility against free text and telephone notes from the concurrent quantitative study. The role and influence of the researcher in this process were recorded in a reflexive diary.

Results

Thirteen older people and ten carers expressed an interest in participating. Four additional people who accompanied the invited respondent and wished to contribute to the study also consented to interview. Twenty-seven people were thus interviewed in twenty separate interviews (Table 1). A further six interviews were conducted with benefits advice officers.

The distinction between older people and their carers was found to be somewhat arbitrary as the majority of carers were themselves past retirement age and were often in a vulnerable state of health. 'Older people' were defined as those older people referred to the service who did not have a carer role, while 'carers' were people of any age who provided some regular support or care to an older person. Here we provide contextual information regarding the life circumstances of the study participants, before describing our four key themes of (i) the complexities associated with accessing welfare benefits, (ii) awareness of benefits and advice existence – concerns versus interference, (iii) the importance of forming relationships to facilitate the assessment process and, (iv) perceptions of impact of assessment on health and well-being.

Describing the life circumstances of carers and older interviewees

Many interviewees reported a recent change or deterioration in their own condition or of the person they cared for (e.g. had been hospitalized, could no longer cope alone) which had occurred at the time of their referral for benefits advice. Many interviewees had also recently been introduced to, or had received an increase in social service provision. For example, one 82 year-old lady who had suffered a heart attack, two falls, hip replacement and dislocations in recent months and lived with her husband recalled:

Table 1 Socio-demographics of older people and carers participating in interviews

		Older person (n)	Carer (n)	Total (n)
Gender:	Female:	6	9	15
	Male:	7	5	12
Living situation:	Lived alone:	7	1	8
	Carer lived with older person:	4	7	11
Age group:	40-50:	0	1	1
	51-60:	0	3	3
	61-70:	2	5	7
	71-80:	6	0	6
	80+:	5	2	7
	Not known:	0	3	3
Interview situation:	Interviewed alone:	7	6	13
	Interviewed with others:	6	8	14
Total		13	14	27

I definitely need the help at home. I mean Mr [name of husband]'s 87 and you can't expect an 87 year old man to start housework and cleaning when he's not used to it. ... And, and I couldn't do it. And still I'm not able to do these and that's very frustrating to me. ... I've led a very active life and kept fit and well and to suddenly find myself in this, has not gone down very well. We've had to take the brunt of all of this. (A)

A 65 year old carer (suffering from a chronic condition herself) supported her husband (aged 77), who has Parkinson's disease. A recent head injury had left him confused and less mobile. He attended a day centre once a week and she reported:

You can't leave him for a couple hours ... that's 24 hours a day. I can't go out except for on a Wednesday when he goes to [Name of day centre]. .... I mean I can't even go round to the shops and say 'sit in the car while I go in the shops' because by the time I come out he would be out of the car and wandering up the road and not knowing where he is. (C)

A 76 year old woman had fallen and broken her knee cap, could not get up the stairs at home and had made a temporary bedroom downstairs with a commode, was needing daily support from a care worker and said:

I couldn't manage to take the commode upstairs to empty it. I couldn't have done that. .... Well, you couldn't ask a neighbour to do it. (O)

Participants varied in terms of the type and amount of benefits received as a result of receiving an assessment from the welfare benefits advice team officer. Some individuals obtained additional financial benefits which they could spend as they liked (e.g. carers allowance), whilst others received the additional benefit necessary to pay for the social services input (for example, home care). Some participants

were unclear about which benefits they had received or were waiting for the outcome of their assessment, whilst a few participants received no additional benefit following their assessment.

The analyses identified four overarching themes, each encompassing a number of minor themes relating to: the complexities of accessing welfare benefits; awareness of benefits and advice services; forming relationships between clients and services and the impact of benefits advice on the health, well-being and quality of life of recipients.

Complexities associated with accessing welfare benefits

Many participants found it difficult to describe the route that they had taken or the chain of events that resulted in a visit by the welfare benefits team. Some were unclear about how the benefits advice service had been accessed, in part because many individuals who had received visits from various health and social care workers (often in quick succession) were often unclear as to the type of professional (e.g. social worker, occupational therapist, home care team leader, etc.) and the service being offered. Similarly, the advice team thought that some people saw them as commensurate with social services, despite the team emphasising their own identity and purpose. One lady caring for her husband commented:

She [the social services home care-co-ordinator who visited] said you have to be assessed by a financial person so she sent somebody round about that. ... Well I don't know who it was. It was - I thought it was somebody from social services. But I mean you say the [name of financial advice team] team are connected with social services? ... But that's, that might be who it was, I don't know. We only had one person come round about the financial side of it. (H)

Older people and carers reported feeling "pretty swamped" (Q) by the sheer quantity of paperwork associated with claiming benefits. Some found difficulty in completing forms because hands were "so unsteady" (N) or perceived the forms to be "scary" (C). Benefit officers were very aware of these stresses and often completed the necessary paperwork, something that was universally appreciated by the participants. One officer commented:

> *But for most people regardless of their status, education, class, background, anything like that, people get to a certain point in their lives, …. where they just can't cope and they see a brown envelope come through the door and it really is a huge thing for them. I know a lady who shouts to her husband "is there any brown envelopes?" and she doesn't even want to come down stairs. I mean she's a lovely, lovely lady, articulate, intelligent, very funny, educated, …. And I think people worry about what they put down on official forms in case they're going to get into a lot of trouble.* (Z)

Older people, carers, and officers alike, emphasized the value of a specialist home visiting service, feeling that older clients "prefer someone to come round and visit" *(Z)*. Some interviewees described their surprise when they were advised that they were eligible for a benefit, having previously felt they were "struggling" (U) for years, in a system that had felt "very daunting" (D). One benefits assessment officer noted:

> *But the elderly ones which are the majority of our cases tend to you know, they haven't claimed pension credit, they've not claimed income support. They don't even know what it is or the Attendance Allowance. They get muddled up with another benefit …. or they don't want to claim but you know they're, they're frightened that it might stop something else that they're getting.* (W)

Awareness of benefits and advice existence: concern versus interference

Older people, carers and benefits officers described friends, relatives, neighbours and clients in the local community who had been unaware of the available benefits or the existence of the benefits advice service. Some felt more could be done to "flag up" (D) those who reached retirement age to provide information and welfare checks:

> *I don't know, not a criticism of them [the welfare benefits team] really but how, how is Joe Public supposed to know about them? … The main thing I think erm is being aware of their existence. … There are people who need them [the welfare benefits team] and they exist but the two don't know about each other.*
> (D – Carer)

One carer felt that "prevention is better than cure" (E) and suggested involving the general practice surgeries systematically in identifying older people "above a certain age" (E) who could be in need of welfare and benefit advice. However, one officer commented on the pragmatic and ethical difficulties of identifying those in need of advice:

> *But there are probably individuals within that category who we could be helping and we could increase their income, we could put some assistance in to make their life easier, but then they may not want it, they may not want interference, so it's (a) how do you identify (b) do you want to identify … or do they want to be identified?* (Y)

Some older people and carer interviewees felt that there was still a widely held view in the community that receiving benefit was "almost degrading" (E) and that there were those who would not want interference from advisors or to receive additional benefits. Welfare benefit advisors were also aware that for some clients having to disclose their

financial situation was disconcerting and indeed some chose not to do so. However, most older people interviewed had accepted the input of the service and the necessary disclosures, and were "not worried so long as I am assured that it's confidential" (J). Conversely, several younger carers (who had not needed to disclose their own finances) felt that if they had to provide detailed financial information of their own or their parents' situation they "would have to think seriously about it" (D) prior to agreeing to go ahead:

I think maybe it might be a bit secretive because our generation if you can understand really don't want to talk about it [receiving benefits]. (O - Older person)

The word 'means tested' does mean quite significant things as I said. A lot of people will remember what it was like many, many years ago when it was a case of 'well you look as though you could sell that'. I think it can be a very distressing period if they're needing help they're obviously quite vulnerable anyway. (Z - Officer)

Forming relationships to facilitate the assessment process

The welfare benefits advice team viewed their 'core business' as involving visiting clients in their own homes, and "generating income for the Council but also ensuring that the individual is getting the best out [of] their benefits and income" (V). In this way, the team acknowledged that there were tensions arising from their dual purpose role, seeing it as a "a double-edged sword" (Z). However, all the officers emphasized the importance of putting clients at their ease, gaining client's trust, and their extended caring role (e.g. helping with small tasks such as posting a letter) which not only enhanced the relationship with their clients, but also helped to provide the

widespread "feel good factor" (V) amongst officers towards their job.

... It's a very fine line [when visiting a client] but you cannot go out and meet people and go into their homes and listen to their lives and their circumstances without giving something of yourself. ... And I think that's probably why the team's been successful because you do give something of yourself. It's, it's not an impersonal service. ... There's nothing like it. I have come - I've come away from visits erm and felt oh just so incredibly happy. (Z - Officer)

I gave them the information they wanted and this lady who came was very pleasant and I got on very well with her. She seemed to be very understanding and sympathetic and so on. (J - Older person)

Older people and carers described their impressions of the welfare benefits officers as generally very good ("efficient", "clued up" (wife of M)), and the process was described as "a satisfying procedure" (Q) once people had met with the officer. There was a sense of confidence and security knowing that the team involved were able to negotiate their way through the system on behalf of their clients:

... So you know I've passed their [the welfare benefits team's] existence on to, to others who didn't know, didn't know about them. ... And the wife [of a neighbour], had been looking after him for 9 years and he'd never heard of Attendance Allowance. Erm so I, I said to him ... "phone social services and just ask for finance and benefit team and you know they'll come and just talk about anything and everything". (D - Carer)

Officers were very aware of the range of attitudes surrounding their visits, with some clients being initially "very defensive" whilst others "just want to have you in and have a cup of tea" (Y).

Perceptions of impact of assessment on health and well-being

Choice, control and security

Most interviewees who received a benefit felt that the money gave them extra choice or control over important, practical aspects of their lives. One couple, for example who both received Attendance Allowance, commented "we don't have to be so careful", adding it had "made a big difference to our lives" (M), choosing to have higher quality meals from a private meals company, and being able to purchase services and equipment:

> *They (name of firm supplying meals) do some nice things. ... I mean, we're not extravagant and we make one meal do for two of us because we haven't got big appetites. But, they have more... some more expensive meals which are quite a big improvement. But umm, you know, we feel now, well we can have one of those between us. Whereas before we would probably have thought, "Oh-oh".* (M – Older person)

For some it enhanced financial security and reduced anxiety: it could be used "in an emergency (for repairs)" (S), whilst it allowed others to use taxis or to go on outings or:

> *I don't worry if anything goes wrong like the cooker or the washing machine.* (S - Older person)

Paradoxically, there were also those participants for whom receiving extra benefit caused some anxiety, as they felt that they would "get used to living as you do at a different level" (V), which could cause concern if the benefit amount was reassessed due to changing circumstances or if the benefit ceased:

> *But if you used it [the Attendance Allowance] for every day living [rather than spending it on care] and then something happened to your husband then you suddenly would be, I mean you'd be on a lower income anyway and then you'd be that much lower as well, and that would be stressful. ... We're financially not rich but average, but if anything happens to my husband I will be on a very low wage.* (C - Carer)

Quality of life, independence and health

Perhaps related in part to increased choice and control, a number of people described improvements in their quality of life or health following benefit receipt. Increased options for transport were common (use of taxis, maintaining their own car) which enabled easier access to their general practitioner or hospital, allowed more regular trips to social events and made visiting relatives and friends and shopping easier. Some participants had also set up or maintained private services (e.g. gardening, cleaning services) with the extra benefit:

> *We belong to a luncheon club which we go to on a Tuesday morning and we didn't want to give that up, erm, so we have a wheelchair taxi, you know a taxi that takes a wheelchair, ... It's booked every Tuesday morning. Erm, and that costs £10, erm so that, you know, comes out of the attendance allowance.* (H - Carer)

> *Affording taxis is a big thing for erm a lot of the older people. A lady up in [town name], her son was really concerned because he was in London and she kept saying "the hill's like that [steep] to walk down", really steep and she took something like an hour and half to get back from the local shop. It was only about 200 yards down the hill and erm but she wouldn't pay for a taxi ... I got her the Attendance Allowance which was near on £40 a week and she was whizzing down to (town name) town centre a couple of times a week to meet*

her friends for coffee and said it completely opened her life up because she didn't feel so cut off at the top of this big hill. (W - Officer)

Tangible effects were described regarding physical and mental health for some receiving additional benefits. A new 'scooter' had encouraged one couple to take turns in exercising alongside it, whilst another participant used the additional money to pay for alternative therapies. The positive impact on mental well-being was also reported by interviewees. For carers in particular, there were clear benefits as the extra income allowed them to buy in services, which in turn gave them greater freedom and reduced the strain of caring:

> *We get very nice meals at the (name of local town 1) Club and, er, they are not overly expensive. We just walk down, er, and it relieves me. It is a help. [Name of husband] likes to go to chat, or, just being the ambience of, you know, nice people.* (L - Carer)

> *I got into this sort of phase where we get these depressions and you can't be bothered and you lose interest in things. But you see suddenly things started to change and I think a lot of it was worrying about things. ... What's going to happen, are we going to be able to keep this car going, ... and all these things. They all build up.* (A - Older person)

A few participants found that they were not eligible for specific benefits; however this did not appear to negate their experiences of the assessment. One carer who found she was ineligible for a benefit felt that:

> *It didn't put me off. As I said my expectation was very, very low anyway because I thought it was just too good to be true. We're not entitled to anything else I know.* (D)

This carer had gone on to recommend the service to others. Conversely, three participants who had received benefits did not believe the additional money had any tangible effect. All three individuals described their health and functional status as so poor that by the time the allowance had come through it had little or no impact:

> *No, I've no desire to do anything more darling. I just want to, if I can just walk to the kettle every day and cook my vegetables and be steady I'm grateful. It really is like that when you have been bad. ... I mean you have to focus on the basics. ... I've no aspirations for anything.* (Q - Older person)

Negotiated feedback

Eleven of the twenty interviewees completed feedback forms asking for their views on each of the main themes arising from the analysis as well as providing any additional comments about their experiences. Most participants either made no further comments or said that the themes were an accurate reflection. Those that made comments gave support to the researchers' interpretation of the interviews and some offered further illustrative examples of their experiences relating to one or more of the main themes (Box 1).

Discussion

The study aimed to explore the experiences of older people and their carers in receiving welfare benefit advice through a specialist, social services-based team and its effects on health and well-being. Their accounts highlighted the perceived and real difficulties associated with accessing benefits and benefits advice, often at a stage of acute ill-health or difficulty in coping. Nevertheless, those who received an assessment viewed it as a positive and supportive process. The assessment often resulted in provision of increased welfare benefits which helped to pay for new

services and heightened feelings of improved security, control, independence, and the associated beneficial effects on quality of life and health. However, participants expressed concern for those unaware of the service or the benefits available. This was in contrast with the view expressed by a few participants that such a provision could be viewed as intrusive, or that the benefits arising were being provided too late to have much impact. These perspectives raise important issues about how a service provider might best target those at risk or in need.

Although the study was conducted through only one welfare benefits advice team, the validity and reliability of the study is supported and strengthened through feedback within and between concurrent studies. First, negotiated feedback from interviewees and interviews from the service provider viewpoint supported our interpretation of the findings. Second, an associated longitudinal observational study of older people and carers that was conducted concurrently also highlighted the vulnerability and general poor health status of those receiving benefits advice (Campbell *et al.*, 2007). Third, free text comments and telephone notes from the latter study also support these findings. Fourth, the primary and secondary coders (with different professional backgrounds)

were able to come to a consensus on how themes were categorised and interpreted.

This project explored the impact on older people of benefits advice provision and differed from similar studies because of the team's dual role, providing benefits advice as well as calculating contributions required to support the implementation of social services. In addition, this service was largely a home visiting service. Other services have focussed on the provision of benefit advice through providing a benefits advice officer located in a general practice surgery or in the offices of the Department of Work and Pensions. In both cases, calculating actual contributions to social care services is not normally conducted alongside the provision of advice around eligibility for benefits. In these situations, the older person has to deal with an additional social services agency to calculate any contribution to care provision, an issue which has been highlighted as time consuming and confusing (Mayor, 2003). One large longitudinal observational study (involving structured interviews) of clients of all ages receiving benefits advice within GP practices found improvements in health, however, clients were referred elsewhere for housing benefits and did not assess payments for social services alongside any increases that they received (Abbott *et al.* 2005).

Box 1 Negotiated feedback: Examples of comments

Barriers to the uptake of financial benefits and social services
E (Carer of mother): *Many older people are very proud and worry terribly about finances. My mother still regularly asks how she is paying for her residential home.*

Impact of accessing new financial benefits
P (Carer of husband): *Would not have had a clue of where to start and would probably not have bothered because of the emotional state you are in at the time.*

Suggestions for change:
M (Older person): *Would it be possible for someone to regularly check up to make sure that things are still satisfactory?*

Our study underlines the importance of specialist welfare benefits advice for older people and their carers where receipt of benefits may be linked to service provision. Respondents valued the home-visiting service and often reported improvements in well-being and health even though the high levels of ill-health were evident amongst those accessing benefits. Our findings emphasize the need to encourage the early awareness of benefit availability and to provide tangible help to facilitate access to benefits at the same time as payment for social services (House of Commons Committee of Public Accounts, 2004). Further research exploring the best means of targeting benefits advice to vulnerable older people is needed.

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Notes on Contributors

Rachel Winder is an Associate Research Fellow in Primary Care. Her interests include social welfare and housing for older people, and the management of chronic diseases and end-of-life care, using both quantitative and qualitative methodologies. She is currently involved in a randomised controlled trial examining the effectiveness of treatment of depression through the provision of exercise in primary care settings compared with usual care.

Dr Suzanne Richards is a Senior Lecturer in Primary Care specialising in research into the delivery of health and social care of older people. Current projects, using both quantitative and qualitative methods, include exploring the use of out-of-hours health care for patients with palliative care needs, the role of mentoring for socially isolated older people, and effectiveness of exercise programmes at reducing the risk of falling for people with Parkinson's Disease.

Dr Katrina Wyatt is a Senior Research Fellow in Child Health. Her research interests lie in developing and evaluating complex interventions, evidence synthesis and consumer involvement in research. She is currently involved in a trial looking at the effects of cranial osteopathy on cerebral palsy, developing and evaluating an intervention to prevent and reduce obesity in primary school children and a national cohort study looking at the effectiveness and cost effectiveness of enzyme replacement therapy for lysosomal storage disorders. All of these projects have had patient and public involvement in the design and delivery of the research.

Professor John Campbell is the head of the Primary Care and General Practice Research Group of the Peninsula Medical School. With broad clinical and research interests across the spectrum of community medicine, he specialises in the development of measures to assess patients' and clinicians' views on the quality of health care, and trials of complex interventions.

Address for Correspondence

Dr Suzanne Richards
Primary Care Research Group
Peninsula Medical School
Smeall Building
St Luke's Campus
Exeter, EX1 2LU

Telephone: 01392 262742
Fax: 01392 432223
E-mail: suzanne.richards@pms.ac.uk

Young carers: still 'hidden' after all these years?

Janet Warren, Anglia Ruskin University, Cambridge

Abstract

Although legislation and policy guidance within the United Kingdom provide a framework for intervention and good practice with young carers, children and young people caring for ill or disabled family members continue to remain 'hidden' or 'invisible' in our communities. This paper reports key findings from doctoral research which identify a group of children and young people within the population who have not been formally recognised in their caring roles nor formally assessed as young carers. It highlights, for the first time, the differences in the nature, frequency and time spent on caring tasks by this sub-group of carers, compared with known young carers and 'non-caring' children and young people. Indicating a high level of unmet need among parents and other family members who are ill or disabled, these findings have important implications for professional policy, planning and practice across adult and children's services. The paper concludes that greater professional awareness of the work that all children perform in a household, earlier intervention and effective collaborative practices could do much to ensure that children, young people and their families receive the services that they need.

Keywords: Children, disability, research with children, young carers

Introduction

Over the past thirty years, a combination of factors has made it more likely that children will take on caring roles. These factors include the de-institutionalisation of care, advances in medical care, reductions in family size, an increase in privatised family life-styles and the adoption of policies in the United Kingdom, which place emphasis on informal care within the community (Olsen, 1996). The development of legislation and policy guidance relevant to the needs of these children and their families has provided a framework for intervention and good practice which, in theory, should enable welfare professionals to define when and how to intervene to provide services and support to families. Much of the qualitative and quantitative research in this field, however, continues to highlight the failings of agencies to provide adequate support to these children and young people, commonly referred to as 'young carers'. In particular, the virtual invisibility of these children and young people, the ongoing lack of recognition among agencies of the work that they do and the impacts of caring when children and their families lack appropriate care support, are well documented (see, for example, Aldridge & Becker, 2003; Cree, 2003; Thomas *et al.*, 2003).

Building on such literature, this paper seeks to highlight the experiences of a group of children and young people in the general population whose caring roles and responsibilities remain hidden. Drawing on findings from doctoral research undertaken in 2001, the paper presents a profile of this sub-group of carers: who they are, what they do and how their experience differs from other children and young people who do not adopt care-giving roles and those who are known as 'young carers'. This is the first study to provide a three way perspective of children and young people's care-giving, as shown in Figure 1. The study suggests that children and young people who show signs of being in a caring role are potentially more vulnerable than *known* young carers, in that they do not appear to have been formally

recognised in their caring roles, nor formally assessed as young carers. Unidentified and unsupported, children's voices continue to be unheard, and their care-giving remains as hidden today as it did in 2001 (see Barnardo's, 2006). It is hoped that the findings presented in this paper will be of practical use to a range of professionals working in children's and adults' services, informing developments in policy, practice and research, for the benefit of young carers and their families.

Background

Why do young carers remain 'hidden'?

Previous research and practice guidance have suggested a number of reasons why young carers' contributions to family life in the United Kingdom remain 'invisible' and their needs unmet. There can be a lack of recognition of the child's role as a caring one by both the child and parent (Aldridge & Becker, 1993). There may also be reluctance, by family members, to admit to the presence of a child carer within the family, for fear of professional interventions that might lead to family separations (Bilsborrow, 1992; Aldridge & Becker, 1994). The perceived stigma associated with

alcohol misuse, HIV/AIDS, mental illness or caring more generally, particularly among young black and South Asian carers, may also affect families' openness about child care-giving (see, for example, Imrie & Coombes, 1995; Shah & Hatton, 1999; Aldridge & Becker, 2003). Significantly, the lack of recognition among professional workers about young caring as a welfare issue, combined with the ongoing lack of awareness among professionals of the potential for children and young people to assume caring roles, can result in failure by many professionals to recognise the potential 'triggers' for young caring (Aldridge & Becker, 2003). Furthermore, the myths and racial stereotypes associated with black and South Asian communities, which may lead some professionals to assume that, because of extended family networks, families 'take care of their own' (Shah & Hatton, 1999), combined with the discrimination and institutional racism experienced by black and minority ethnic families in accessing education, social and health services (Shah & Hatton, 1999; Jones *et al.*, 2002) are also impacting on professional recognition and identification of young carers.

Figure 1 Classification of children and young people's care-giving

- **'Non young carers' ('non-caring')** - children and young people who do not look after, or give special help to someone at home who is ill, has a disability or other special needs. They undertake low levels of domestic and caring tasks considered appropriate for their age and level of maturity.

- *Known* young carers - children and young people who have been formally identified and recognised in their care-giving roles. They undertake a range of domestic and caring responsibilities which vary in amount, regularity, intensity and duration according to the context of care, and most importantly, the nature and effectiveness of services and support available from outside of their family (see Becker *et al.*, 1998).

- **Children 'showing signs of caring'** – children and young people who look after, or give special help to someone at home who is ill, has a disability or other special needs, and who undertake a range of caring responsibilities that are sometimes as substantial or more significant than known young carers, but who appear not to have been identified or recognised in their caring role.

How many young carers are there in the United Kingdom?

Historically, the hidden nature of child caring has precluded definitive conclusions about the extent of young caring in the United Kingdom. The 2001 Census (ONS, 2003), which presents the most accurate figures available to date on the numbers of children providing unpaid care within their family, shows that nationally 174,997 children and young people aged under 18 are carers (ONS, 2003), of whom 149,942 live in England and Wales (Becker, 2004). These statistics also show that more than 13,000 of these children are providing more than 50 hours a week of unpaid care (Becker, 2003) - longer than the adult maximum working week. Whilst these data are helpful in revealing what is known about the extent of unpaid caring for family members within the United Kingdom, concern has been expressed by academics and practitioners that many more vulnerable children and young people, not accounted for within these statistics, continue to provide care to family members without the services and support that they need (Barnardo's, 2006; Carpentieri, 2006). A recent survey of 83 young people aged 6-19, all of whom were supported by Barnardo's young carers' projects, revealed that on average each young carer had spent four years looking after a relative or parent before they received any support (Barnardo's, 2006), highlighting the extent to which children remain unidentified and unsupported in our communities.

Defining children as 'carers'

Over the past two decades, the social construction of children and young people as 'young carers' has helped to focus thinking on what might be considered 'normal' or 'appropriate' involvement of children and young people in domestic and caring work. This has led some academics to question whether children with caring roles do, in fact, do anything more or different, with respect to household work or caring responsibilities, than other children and young people living in families where there are only non-disabled or 'well' members (Parker & Olsen, 1995; Olsen, 1996; Olsen & Parker, 1997). This lack of knowledge about the help that is provided by all children and young people in running a household, and the lack of consensus that has continued to exist with regard to differentiating 'normal' and 'inappropriate' levels of child involvement in domestic and caring work, provided the impetus for the research upon which this paper is based.

Research methodology

The research aimed to examine how the lives of children and young people who are known to adopt caring roles differ from other children and young people in the general population who, on the face of it, are not looking after someone who is sick or disabled. The intention was to provide quantitative data on the types and levels of domestic and caring tasks undertaken by 'non-caring' children and young people within the home, and then to compare and contrast these experiences with those of children and young people who were known to adopt caring roles.

A short, structured questionnaire, based on the social survey carried out by the Office for National Statistics (Walker, 1996), was designed for use in face-to-face interviews. A series of closed questions with multiple choice or scaled responses was used to seek specific information about: children and young people's perspectives on the nature of domestic and caring tasks performed; the levels of responsibility undertaken for such tasks; the extent to which they were able to participate in leisure and recreational activities, and their feelings about helping at home.

One fundamental definitional question which had to be addressed at the outset of the interview, centred on the need to

distinguish between 'non-caring' children and young people, and other children and young people in the general population who might show evidence of being in a caring role. Aware that children and young people do not necessarily think of themselves as 'young carers', a question was formulated that invited all children and young people to identify whether they looked after someone, or gave special help to someone at home who was ill, had a disability or other special needs. This question was important in helping to differentiate between those children and young people who lived in families where there were:

- non-disabled or well members;
- disabled or ill members who *did not* require their child(ren)'s assistance with care needs; and
- disabled or ill members who *did* require assistance with care needs from their child(ren).

These distinctions about the context of family care were important, for it was this willingness to listen to children and young people's own viewpoints about definition and perception of their caring roles which, ultimately, generated the most striking and unexpected finding from the research study.

Data collection took place between July and November 2001 and was conducted within a principled framework that took full account of diversity and equality issues. Assistance was sought, for example, from indigenous community consultants and advisory groups regarding cultural needs, including religious festivals that might affect when, and how, the research was conducted. Consent to undertake the research was obtained, where appropriate, from a wide range of adult gatekeepers including head teachers, youth club managers, shopping centre managers and parents, before contact was made with children and young people. All respondents were informed that participation was entirely voluntary and that they could withdraw at any time during the interview.

Respondents were not asked for any personal details that could identify them in any way, and due regard was given to the participant's privacy, dignity, rights, safety and well-being during the interview process.

Research sample

Overall, a sample of 390 children and young people, aged between 9 and 18 years, was interviewed to find out their perceptions of what they do to help at home. Using a form of cluster sampling, 378 of these children and young people were randomly selected from the general population found in targeted areas of a unitary authority, including the grounds or vicinity of educational establishments, youth clubs, the town's main shopping centre and local residential areas. An urban area of multiple deprivation, this authority has districts which have been ranked within the top 10% and 20% of all Super Output Areas (SOA) nationally (ODPM, 2004) and is one of the most ethnically diverse local authorities outside of London (ONS, 2003). A further 12 children and young people were selected on the basis that they were known, by education welfare and social services, to be young carers living in the same unitary authority. The lack of any specialist young carer project in the target area in 2001 and the lack of recognition of children's caring roles generally among local health, social and education agencies, created difficulties with regard to identifying and recruiting a larger sample of known young carers.

Of the 378 children and young people from the general population sample who participated in the survey, 59% were female and 41% were male. Their ages ranged from 9-18 years, the majority (43%) being of secondary school age (11-15 years), with an average age of 13 years. Three-quarters of respondents described their ethnic origins as white European. The majority of children and young people who participated in the survey lived with at least two adults (84%) and in households where at least one of

these adults was in full or part-time employment (92%). Interviews were also conducted with 12 known young carers, 8 of whom were female and 4 were male. Their ages mirrored that of the general population sample, ranging from 9-18 years, the majority (8) falling within the secondary school band, with an average age of 14 years. Whilst most of these children and young people were white European, 5 young carers were from backgrounds of dual heritage, mostly white/Asian. However, in contrast with the general population sample, three-quarters of the young carers lived in lone parent families, exclusively with their mothers and two-thirds lived in households where no adult was employed.

Data analysis

Statistical analyses of the data collected were undertaken using a quantitative data analysis computer software package (SPSS for Windows, 1999). From the randomly selected sample, it became possible to categorise respondents into two groups: 'non-caring' children and young people, and children and young people who had defined themselves as looking after or giving special help to someone at home who was ill, had a disability or other special needs. This allowed analysis of the caring tasks and responsibilities undertaken by 'non-caring' children and young people, *known* young carers and those children and young people showing signs of being in a caring role, together with the effects of these experiences on children and young people's lives.

Key findings

Whilst the research provided new knowledge about who young carers are, what they do and how their experience differs from other children and young people in the general population (see Warren, 2007), perhaps the most striking and unexpected finding was the existence of a group of children and young people in the population who showed some evidence of being in a caring role through the provision of a range of domestic, personal and intimate caring tasks to family members. This group of children and young people, because their roles and responsibilities remained 'hidden', appeared not to have been identified in their caring roles, and were subsequently unsupported in the community.

How many 'hidden' young carers?

Of the 378 children and young people who were randomly selected for interview from the general population sample, 34 (9% of the total sample) identified themselves as looking after or giving special help to someone at home who was ill, had a disability or other special needs. This unexpected finding has more recently been replicated by the Princess Royal Trust for Carers (PRTC, 2004). In an unpublished study of the experiences and views of a representative sample of over 1300 children and young people aged 7-19, the Princess Royal Trust for Carers found that around 12% of these young people showed signs of performing caring tasks within the home (PRTC, 2004). Together, these two pieces of research provide strong evidence to support the view that the 2001 Census data is likely to undercount the true number of young carers in the United Kingdom.

A profile of the 'hidden' young carers

Fifty-nine percent of the children and young people in this survey who showed signs of being in a caring role were female and 41% were male. Their ages ranged from 9-18 years, the average age being 13 years. Just over half (59%) described their ethnic origins and background as black/black British, Asian/Asian British or dual heritage, the largest minority group being Asian/Asian British (44%). This may reflect cultural expectations expressed by extended family members in South Asian

communities regarding young people's duties to adopt caring roles (Shah & Hatton, 1999). The majority (91%) of these children and young people lived in households where there were at least two adults and where at least one adult was employed either full-time or part-time (76%).

What roles and responsibilities do these children undertake?

Two main findings emerged from the research relating to the nature and extent of domestic and caring tasks undertaken by those children and young people who showed signs of adopting care-giving roles. First, this group of children and young people undertook a similar range of tasks in and around the home to those children and young people who were known to be young carers, which included domestic, general care, personal and intimate care, and emotional caring responsibilities. Moreover, the nature of these caring experiences and the level of responsibility assumed by these 'caring' children for such tasks, differed from the experiences of other children and young people in the general population who were not carers. For example, as shown in Table 1, young carers and young people showing signs of caring were more likely than 'non-caring' children to tidy, dust and vacuum-clean communal areas of the home, wash their own clothes, wash and iron clothes for other people in the home, weed and maintain the garden and mow the lawn. They were also likely to perform such domestic tasks more frequently than 'non-caring' children and spent longer hours on these tasks each week. Overall, less than a third of those interviewed who showed signs of being in a caring role, spent under two hours a week on domestic tasks, compared with over half of 'non-caring' children and young people. Children and young people who did not adopt caring roles, rarely, or only sometimes, performed such tasks, spending shorter periods of time each week on chores such as tidying and dusting their own bedroom and making light meals such as preparing a sandwich.

Table 1 Examples of some domestic tasks undertaken by non young carers, young people showing signs of caring and known young carers

	% of non young carers n=334	% of young people showing signs of being in a caring role n=34	% of known young carers n=12
Tidy/dust own bedroom	94	94	92
Make light meals	91	94	92
Vacuum clean communal areas	71	79	92
Tidy/dust communal areas	70	82	83
Iron own clothes	53	65	83
Weed/look after the garden	45	59	50
Mow lawn	36	47	58
Iron clothes for other people in household	34	59	50
Wash own clothes	28	47	50
Wash clothes for other people in household	20	32	42
n=390 Percentages are rounded to the nearest whole number. N.B. 378 children and young people were randomly selected from the population, of whom 334 were 'non young carers', 34 defined themselves as being in a caring role and 10 didn't know whether they looked after or gave special help to someone at home with an illness, disability or other special needs. A further sample of 12 young people were identified as 'known young carers' by professionals.			

The data also showed that young carers and young people showing signs of caring were more likely than 'non-caring' children and young people to undertake regularly general care tasks such as paperwork, taking someone they lived with to visit their General Practitioner (GP) or hospital, and interpreting or signing for someone that they lived with. They also spent longer hours (over 3 hours) on these tasks each week than 'non-caring' children and young people.

Similarly, these groups of 'caring' children were more likely than 'non-caring' children and young people to give emotional support, such as 'keeping someone company', 'keeping an eye' on them to make sure that they were alright, or accompanying someone to social activities outside of the home (including visits to friends or taking them out for a walk). They also spent longer hours on emotional care tasks each week than other children and young people in the general population. Approximately 15% of children and young people who were not carers spent in excess of two hours per week on emotional care tasks, compared with over half of those young people showing evidence of being in a caring role, some of whom spent up to 15 hours per week.

Second, the research also highlighted that children and young people who showed signs of being in a caring role, sometimes performed more tasks and took full responsibility for these tasks more frequently than either known young carers or 'non-caring' children and young people. As shown in Tables 2 and 3, this group of young people performed more tasks of an intimate and personal nature such as giving assistance with washing, bathing, showering or using the toilet, and by giving medication, injections or changing dressings, than either young carers or 'non-caring' children and young people, and were more likely to take full responsibility for these tasks. This sub-group of young carers were also more likely than known young carers or 'non-caring' children, to provide child care (looking after brothers or sisters) or emotional support by, for example, 'keeping an eye' on the person with care needs. In fact, almost two-thirds (65%) of these young people accompanied the person with care needs to visit friends or relatives, or took them for a walk, compared with one third (33%) of known young carers in the study.

Table 2 Personal care tasks undertaken by non young carers, young people showing signs of caring and known young carers

	% of non young carers	% of young people showing signs of being in a caring role	% of known young carers
Help to walk, get upstairs, get in and out of bed	9	56	25
Give medication	16	53	42
Help to dress/undress	9	51	25
Help to wash	6	44	25
Help to bath or shower	7	35	17
Help to cut nails	5	29	17
Help to eat and drink	4	27	17
Help to use toilet	4	24	25
Help to shave	1	12	0

Table 3 Frequency of personal care tasks undertaken by non young carers, young people showing signs of caring and known young carers

	% of non young carers		% of young people showing signs of being in a caring role		% of known young carers	
	Always	Mostly	Always	Mostly	Always	Mostly
Help to dress/undress	0	2	12	9	0	8
Give medication, injections, change dressings	1	0	12	6	0	8
Help to walk, get upstairs, get in and our of bed	0	<1	6	12	8	8
Help to bath or shower	<1	1	6	12	0	17
Help to eat and drink	0	<1	6	6	0	0
Help to use toilet	<1	0	6	6	0	0
Help to wash	<1	0	3	18	0	25
Help to cut nails	0	1	3	6	0	0
Help to shave	0	0	3	0	0	0

Although an explanation for this needs to be tested by further research, these findings suggest that the families of children and young people showing signs of being in a caring role may not be receiving the support needed to allow them to reduce their reliance on their children, with regard to the provision of emotional support and personal and intimate care tasks. Where adequate support and services were provided to assist parents with their illness or condition, the need for children to take responsibility, for example, for accompanying a family member outside of the home, appeared to be removed (Warren, 2007).

What support do these children and young people receive?

Overall, the research findings indicated that young people showing signs of being in a caring role were supported by fewer health and social care services than households with young carers. Only one in ten of these households appeared to access the support and services of social work and social care professionals. Many of these young people, for example, gave assistance with washing, bathing or showering, without the services and support of a social worker, home care agency or community/district nurse. In contrast, in this study no known young carers, living in households with regular social work contact, undertook comparable intimate care tasks. Similarly, young people showing signs of caring undertook full responsibility for a range of domestic tasks without the additional support of a home care agency or cleaner. These findings suggest that this group of children and young people is particularly vulnerable, as their families appear less likely to have contact with a social worker who might otherwise assist them to access appropriate community care services, thereby reducing or preventing altogether the need for these children and young people to adopt caring roles.

Whilst research indicates that nationally around 18% of young carers have been assessed under legislation and the proportion of young carers providing personal and intimate care has decreased from 21% (in 1997) to 18% (in 2003) (Dearden & Becker, 2004), the findings from this study suggest that many other young carers may be undertaking less intimate and personal care tasks than those young people who show evidence of being in a caring role. If this sub-group of children and young people are not identified and

defined by professionals as young carers, and their parent(s) do not receive services to assist them with caring, then they could be potentially in a worse position than known young carers with regard to some kinds of care tasks. Existing research has demonstrated that such caring roles can have negative outcomes for children and young people's psycho-social development and transitions into adulthood (Dearden & Becker, 2000).

Messages for policy, practice and research

Up to 9% of children and young people in the general population may be showing signs of being in a caring role. This suggests that in a UK population of approximately 11.66 million dependant children (ONS, 2004), up to 1.05 million may provide care that remains hidden. The study shows that many of this sub-group of young carers appear to be from black and Asian backgrounds (59%), which suggests that in the UK, where approximately 1.45 million dependant children are from black and minority ethnic backgrounds (ONS, 2004), as many as 619,000 of these children and young people may be undertaking caring roles and responsibilities that remain hidden and unrecognised. Given that the proportion of children from black and minority ethnic backgrounds in the sample population is approximately 25% compared with 12% of the population as a whole, this figure is more likely to fall within the range of 309,000 to 619,000. Clearly, this is an area that requires further investigation and no claims are made that these findings can be generalised more widely. However, this sub-group of young carers is potentially more vulnerable than *known* young carers in that, because they have not been recognised, nor formally assessed in their caring roles, they continue to provide a range of domestic, social, emotional, intimate and personal care tasks to family members who are, themselves, less likely to access the services and support of health and social

care professionals. This suggests that the extensive network of young carer projects that exists currently within the United Kingdom could potentially be working at the less 'severe' end of 'young caring', which, in turn, poses challenges for health and social care agencies in both the statutory and voluntary sectors.

A very clear role exists for social workers, their organisations and their partner agencies in promoting a more proactive response to the recognition and identification of children and young people who show signs of adopting caring roles. Greater awareness is needed by professionals of the work that all children and young people perform in a household, including the levels of child involvement in domestic and caring tasks, so that those children and young people showing signs of caring can be recognised and identified in their caring roles. Any child who has been recognised and identified as a 'young carer' can then be assessed either as a 'child in need' or in some cases as a carer requiring professionals to use the legislative and policy framework to meet the needs of the child and their family. Early social work intervention is, therefore, crucial in ensuring that these children and their families receive appropriate services at the earliest opportunity.

The current moves to integrate education, social and health care services in the United Kingdom could prove particularly beneficial to families where children's caring roles remain hidden and unrecognised. As 'children in special circumstances' who often remain 'invisible to the system' (DoH, 2004) and whose needs are not always fully recognised by staff working in the statutory sector, these children and young people require a high level of co-operation between staff in different agencies. The development of an integrated, consistent and co-ordinated approach is, therefore, important in identifying, assessing and meeting the needs of families where children's caring roles

remain unsupported. Multi-disciplinary training of staff in health, education and social services needs to be developed and sustained to equip professionals to recognise and respond to these families' circumstances. Better co-operation and improved co-ordination of services is needed to ensure that families receive services at the first onset of problems so that children and young people showing signs of caring are not obliged to take on inappropriate levels of responsibility. Other ongoing developments will also be important in ensuring that children and their families receive the services and support that they need. These include: the development of multi-agency practice guidance to help in recognising situations where children may be caring; the development of protocols for information sharing; the embedding of the national Common Assessment Framework (DfES, 2005) to identify children's needs early, and the development of a more systematic approach to improving access to multi-disciplinary, community-based services. To this end, services and support which are co-ordinated around individual and family needs, and which take account of children and young people's views, are important in enabling professionals to respond to these children and young people, both in relation to their role as carers and to their needs as children.

Finally, we need to know far more about this 'hidden' group of 'caring' children and young people and how their needs and experiences may differ from known young carers and other young people in the population. In particular, we need to know more about the specific needs and experiences of black and minority ethnic communities whose families do not access professional support and services - why these children and young people become young carers and how support and welfare services can respond more effectively to their families' needs. Further research with this 'hidden' group of young carers and

their families has an important part to play in informing the future direction of policy and practice.

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Notes on Contributor

Janet Warren is a Senior Lecturer in Social Work and Manager of the Service User and Carer Involvement Project at Anglia Ruskin University, Cambridge. She teaches social work at both qualifying and post-qualifying levels, and has a long-standing interest in the needs, experiences and rights of young carers and their families.

Address for Correspondence

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

Telephone: 0845 196 2535
E-mail: j.l.warren@anglia.ac.uk

Merely experts? Reflections on the history of social work, science and research

Ian Shaw, Department of Social Policy and Social Work, University of York

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Abstract

Early social work was often associated with a strong position on the congruity of practice and science. I illustrate this through the stance of the UK Charity Organization Society, and early developments in Chicago University. One consequence of this was the development of major effectiveness studies in the UK and USA. The crisis of confidence that resulted from studies in the 1960s and 1970s helped to prompt a range of research developments, most of which continue to the present. Yet there are several linked new developments in current UK social work. I conclude with some reflections on the forms that arguments take about the relationship between social work and science.

Keywords: Science, history, social work, research

The title of this brief paper has an intended modesty and collective self-deprecation. These are 'reflections' on social work, science, research and evaluation[1] rather than a carefully worked analysis. By asking 'merely?', I give away one stance on their relationship that I regard as important and challenging for those of us who do one or both of science and social work.

Science and social work – each conceived in various ways at different times – stand in a relationship of constant and perhaps inevitable tension. I open the paper with a few observations about attitudes to science during the history of social work. I then spend some time working through several historical moments of social work, organized thematically rather than in careful linear sequence, sometimes focusing on the UK, sometimes on the USA and sometimes speaking more generally. Finally, I return to the opening theme and to say something more formal about the relationship between social work and science/research/evaluation, as it was viewed historically. The paper had its origins in an invitation to reflect on this theme. I have deliberately left some of the more personal touches, the unduly broad sweep, naming some names of institutions and people whose work I respect, and

possibly idiosyncratic judgements and opinions of the spoken word. This risks, as a gentle editorial reminder drew to my attention, falling through thin ice, and I welcome any expressions of disagreement.

Science and social work

I was shaped in aspects of my early thinking by Noel Timms' *Language of Social Casework*. He refers to attitudes to science in social work in its early history. It is fairly easy to detect instances of optimism and hope for the gains social work would obtain from science. Charles Loch (founder of the London-based Charity Organization Society in the 1860s) argued that charity "is not spasmodic, casual and emotional, but, like science, an all-observing, all-comprising intelligence. It is not antagonistic to science: it is science - the science of life – in operation – knowledge doing its perfect work" (Timms, 1968, p.59). Early social work writing tended to exhibit confidence in science as displaying laws of human behaviour, and to refer to behaviour being 'determined', and to faith in the model of the natural sciences. This last remark is probably anachronistic in that, to contemporary social workers, there may not have seemed to be any choice about which

model of science from which to work. The issue was being debated within European social philosophy of the time and, what we now regard as, the humanist and interpretive tradition had its roots in that period in the work of Willhelm Dilthey and the emerging work of Max Weber (c.f. Hughes, 1980), but I have not been able to trace any evidence that the social work community of the time was engaging with that work.

I suspect that this optimism continues as a persisting thread throughout the subsequent history of social work, surfacing from time to time in the relatively absolutist form to which Loch adhered. Take, for instance, Joel Fischer's only slightly hedged prophecy of the end of ideology, with his prediction as recently as 1993 that "by the year 2000, empirically based practice – the new social work – may be the norm or well on the way to becoming so" (Fischer, 1993, p.55).

The late 19th Century confidence in science was linked with trends in Christian thought and action. This was in part a secularizing process. Beatrice Webb, in her autobiography, recalled the "current belief in the scientific method ... and the consciousness of a new motive: the transfer of the emotion of self sacrificing service from God to man" (Webb, 1929, p.130)[2]. But it was equally the manifestation of a series of almost seismic shifts within the Christian church of the time. The Charity Organization Society (in both the UK and the USA) and the university settlement movements (prominently associated with the universities at Oxford and Chicago) were associated in their formative stages with Christian Socialism, which, when mingled with Victorian Romanticism and progressive social evolutionism, produced an urgent search for the image of God 'in the most fallen and debased of the human race' (Burrow, 1966; c.f. Fine, 1979). Early sociology and social work were strongly associated with several of these strands, such that for example, Chicago University

was a Baptist foundation, and the early Chicago sociologists included among prominent leaders those who came from an expressly religious background. "Some of the impetus for the development of sociology in the United States came from the 'social gospel' movement within American Protestantism" (Diner, 1997, p.44).

Social work has faced recurrent stark categorizations such as advocacy/care/control or change/maintenance. These took early shape in the emergence of social work. Charles Loch, for example, was the person perhaps most responsible for the idea of casework. Yet the charity organization societies in the UK and the USA developed in some tension with the reform-minded settlement movement first at Toynbee Hall, Oxford, and later in New York and more widely in the States. Stephen Diner, referring to the USA, expresses it nicely:

> *Professional social work in the United States developed from an imperfect union between the late nineteenth-century "scientific charity" movement ... on the one hand and the slightly younger social settlement movement, with its strong orientation towards social reform and social survey on the other.* (Diner, 1977, p.3)

Alongside this there was a tension from the first between scholarly aspirations and employer demands for training, specialisms and practical curricula – this remains social work's "troublesome legacy" (Lubove, 1965, p.143) to the present.

There can also be found doubts about science, though less often in writing. "This is partly because such a position is often viewed as essentially a moral one, which can be stated only with difficulty and argued not at all" (Timms, 1968, p.60). Scepticism regarding the methods of science also may be persistent through the history of social work, whether it be the therapeutically

inclined Elizabeth Irvine bemoaning that "science deals splendidly with all that can be weighed, measured and counted, but this involves excluding from the universe of discourse the intangible, the imponderable, all that cannot be reduced to statistics" (Irvine, 1969, p.4), more contemporary doubts expressed through feminist criticisms of masculinist methodology, or arguments for inquiry led by engaging critically in the political agenda. At different positions between these poles can be found the moderate scepticism expressed in the closing paragraphs of this paper, the more modest claims of Kirk and Reid (2002) or the early quotation from 1923, that:

> *Whether there be a science in all this or not, the problems are to be studied and solved in scientific ways – by openmindedness, by use of the teachings of experience, by efforts to see causes and results.* (Lubove, 1965, p.142)

Moments in social work history

The aside regarding Chicago links to one of the most significant periods and episodes in the early history of social work and sociology - the events leading to the separate establishment of the School of Social Service Administration at Chicago and the founding of the Journal *Social Service Review*. Chicago was far from being a microcosm of either discipline. For many years social work research and training in the school has taken a distinct, almost unique line in the USA. But it is interesting because it exemplifies in stark and sometimes innovative ways how a tension between scholarly objectivity and the desire for advocacy has been present throughout the history of social work.

Across the States, efforts to develop a scientifically grounded method of modifying individual behaviour were the central concern of the 1920s. Following the separation of the Department of Sociology and the School of Social Service

Administration in 1920, Edith Abott and Sophonisba Breckinridge formed the *Social Service Review* in 1927 with the aspiration of undertaking important work that would combine intellectual challenge with social usefulness. These remarkable able and influential women were exceptional in their commitment to research (c.f. essays on them in Deegan, 1991[3]). In fact, the flavour of their intellectual commitment set them somewhat apart from the other influential women at Chicago, some of whom opposed the merger of the social work training with the university, fearing that a practical orientation would not be maintained in the university. However, Abott and Breckinridge had clear views about the kind of research that was needed:

1. It should solve practical problems and not simply advance the frontiers of human knowledge;
2. It had to be good research. They complained that "some of our social science friends are afraid that we cannot be scientific because we really care about what we are doing ..." (Diner, 1977, p.11);
3. They believed that practitioners must have the skills to contribute to research. Research could not be carried out solely by social scientists. "Social workers must be so trained scientifically that they belong in the social science group" (Abbott, in Diner, 1977, p.11).

Viewing these three points as a whole, they have enduring interest. They face both ways, in that they challenge both social work and social science – a stance I find attractive (c.f. Shaw & Gould, 2001, Chapter 1; Shaw, 2005). It is not clear of course how far these exhortations were borne out in social work practice[4]. Other schools were viewed as holding a different position from Chicago, and not including research within social work training. Abbott and Breckinridge held the interesting view that "such training is needed for the sake of

social research itself, which so often demands a competent understanding of the field of social treatment ... and should be carried out by social workers, who are also trained in social research" (Diner, 1977, p.12).

Strangely, the early years of the Journal carried very few research papers, and the few that appeared seemed to be from students (Diner, 1977, p.31). However, there *were* stimuli to research. In the UK this came partly from the advent of psychodynamic social work and within the child guidance clinics. In the USA there was a reform-minded social survey movement, and also a move to develop outcome studies from the late '20s onwards. The survey movement had some similarities to post-war Fabian social policy research in Britain, aiming to provide unbiased data that would stimulate action.

The early confidence in science flowered in the experimental outcome studies that started in the 1930s and went through to the early 1970s. Perhaps Ernest Burgess, the prominent Chicago sociologist, presaged this in 1923 when he claimed "there can be no doubt that social work is moving with increasing momentum toward research" and to the "experimental study of human behaviour" (Burgess, 1923, p.376, p.368). But several major studies in the late 60s yielded depressing apparent evidence that social work was not effective: e.g. in the USA the Chemung County study (Wallace, 1967); *Girls at Vocational High* (Meyer *et al.*, 1965) and in the UK *Helping the Aged* (Goldberg, 1970), the IMPACT studies in Probation (e.g. Folkard, 1974), and Clarke and Cornish' study of a therapeutic community for young offenders in Bristol (Clarke & Cornish, 1972).

This led to a period of sharp introspection, and what Kirk and Reid describe as the 'effectiveness crisis', reflected for example in Fischer's review of effectiveness (Fischer, 1976), reviews of *Girls at Vocational High* and several other retrospective pieces e.g. in UK Probation. We can detect two kinds of response in these. First, that the problem is poor practice (this was Fischer's line); second, that poor research was the problem. Kirk and Reid (2002) suggest that both were at fault. Whatever our conclusion, it led to a diversification of research, stimulated partly by this debate but also by other developments such as programmes of positive discrimination in the USA and UK, the influence of qualitative approaches to social science, and so on. In no particular order, I would pick out among these diversifying research developments:

- A *Research and Development* approach. The Reid and Shyne study of brief and extended casework was one of the few studies that seemed to yield clear positive messages (Reid & Shyne, 1969). Reid followed this with a lifelong development of task-centred intervention. It also led to research on the intervention process (still upheld by Mullen at Columbia). Some of this was fairly continuous in stance with previous outcome studies, while some has gradually been more influenced by inductive and qualitative stances.

- *Qualitative Research.* This was – and still is - relatively stronger in the UK and Nordic countries than in the USA, although the North American scene may be changing through the work of Reissman, Gilgun, Padgett, Ruckdeschel, Witkin, O'Connor and a new generation of younger scholars such as Ungar, Staller and Poindexter. This was consolidated in the major volume by Sherman and Reid (1994), and its successor (Miller & Reid, in press), and current foci have been found in the Norman Denzin annual qualitative research congress and the launch of the *Qualitative Social Work* journal (http://qsw.sagepub.com).

- Taking the *voice of the service user* seriously in research. Mayer and Timms (1970) was the first and most influential of these studies. There was a spell of such studies till the late '70s but the growth of more empowerment-led approaches to research weakened the consumer-study approach, which was criticised for a too neutral stance on data.

- The effectiveness crisis was explained partly in the perceived difficulties of applying group data to practice. *Case-based approaches to effectiveness research*, e.g. single system designs, emerged as a partial response to this criticism. Martin Bloom in the States (Bloom, 1993, 1999) and Kazi (1998) in the UK have been associated with this approach.

- *Action research* emerged less as a response to concerns about the apparent lack of effectiveness of intervention programmes and more as a spin-off from major political commitments to positive discrimination and addressing racism in the USA in the 1960s. This led to action research as part of community organization, and in the UK the Home Office sponsored Community Development Projects took a wholly different line to mainstream social work research, influenced in part by a remarkable cluster of politically radical project staff.

- *Government programme research* was a further influential development from this period. Take, for example, the Home Office research programme in probation studies from the 1960s and 1970s. This was perhaps the most impressive of all social work related government funded research programmes in the UK. Its sheer volume and methodological seriousness mark it out. Davies,

Folkard, Clarke, and Sinclair were all contributing to this work. While it was in part a contributor to the string of effectiveness studies, the diversity of method and quality of research influenced a generation of probation officers and may have contributed to the relatively large proportion of former probation officers now in UK universities.

Where are we now? The trends identified above have continued to the present, alongside a focusing of interest in the potential of evidence-based practice, and systematic review methodologies. These developments have been the subject of wide discussion, and I do not intend to rehearse this familiar territory (Shaw, 2006). I think the present decade has been one of the most interesting for academic social work in the UK for rather different reasons.

A seminar series on 'Theorizing Social Work Research' was funded through the ESRC at the turn of the century. I am fairly certain that this will be seen as the event that opened up a series of important initiatives in the following five years. This has been associated with a shift in the national leadership of social work research in the UK towards people with a less substantive focus and a strong interest in generic methodological rigour, a growing active international network, and a value-led approach to research. The leading role of substantive research at universities like Bristol and York[5] is still there, but the rise of social work research at universities like Huddersfield, Southampton and Cardiff – all known not only for substantive fields but for discipline interest and strong social science links, especially to sociology – has helped foster a greater sense of a national community of scholarly work[6].

This trend has been enhanced by the growing influence of networks like the Joint Universities Council Social Work Education Committee (JUC SWEC) and to some

degree the Association of Professors of Social Work, which have operated as a national voice, whether or not they are entirely representative of the community. They have played a key part in a growing and to some degree successful pressure for social work to be treated as a discipline. The Economic and Social Research Council (ESRC) has proved amenable to lobbying from this grouping, and to the case made through a national research strategy (JUC SWEC, 2006). This includes the development of a case for resourcing capacity and competence strengthening in social work. There may be some serendipity in these developments. For example, the contemporaneous emergence of the Social Care Institute for Excellence (SCIE) and its knowledge development programme has begun to provide a bridge between academic work and knowledge utilization.

A further focus for the development of a research agenda emerged with the first national social work research conference in the UK in 2007. The influence of the Research Assessment Exercise (RAE) has also proved relevant, leading to a greater transparency of research effort and publishing outputs. The growth of number and perhaps standards of UK social work journals has doubtless been pushed forward by the RAE.

Perspective from close in is tricky. However, it is likely that future commentators will also identify the present period as one where the counter claims of globalization and resurgent faith-based positions will be significant. For social work research, this appears to have prompted a wider awareness of cross-cultural connections, the challenge of indigenization, and the difficulties that attach to solely western conceptions of the social work research process. I regard the growth of ICTs as important here although the eventual net impact of ICT on social work research is hard to discern.

The user research movement has been the other significant hallmark of social work research in the 1990s and first years of the new century. While some of this research takes place outside the universities, the gradual institutionalization of user research interests in organizations like SCIE and the JSWEC (Joint Social Work Education Conference) annual event has established user interests as approaching a standing challenge and agenda for much social work research.

There may be something of a pattern in these developments. There is a confidence in the academic community, and a sense of discipline identity. Though there are huge differences from eighty years ago, I detect some points of contact with the Chicago 'project'.

Social work and science relationships

To return in closing to the opening theme, is social work a science? Of course, all depends on what one means by 'science'. Timms (1968) identified three senses in which early writers thought social work was a science.

First, social work was seen as a science in that it applied laws of human behaviour. In Loch's terms, it almost 'obeyed' them. This is now rare, though some strong psychodynamic models are close to this. We have lost the confidence in science in society that marked the 19th Century with Darwin, the Huxleys, Galton's faith in eugenics, and so on.

Second, some early social workers thought that social work was logically like science. This is a very different and more interesting idea. For example, early writers and right through to the '60s suggested it was like science because it was deductive. The COS in the USA argued like this. The classic example is Mary Richmond's *Social Diagnosis* (Richmond, 1917). It is not clear whether social work practice has ever been

hypothesis-testing like that. Indeed, neither is it self-apparent that science is generally like that. Philosophers such as Michael Polanyi preceded many now working in the sociology of science field, in arguing that there are unspecifiable knowledge elements that cannot be stated as propositions but are indispensable. This is a kind of categorisation that is quite different, e.g. intuitive.

Insofar as this is the case, science does not have a single logic. I admire Ray Pawson and colleagues' work on types of knowledge in social care (Pawson *et al.*, 2003). It is bold and imaginative. But I am not convinced that we can unify quality criteria for knowledge in the way they hope[7].

Some suggest that social work and science both proceed in a similar problem-solving way. Kirk and Reid give some interesting examples from early social work. Nick Gould and I have discussed this in some detail (Shaw & Gould, 2001). It is interesting but not straightforward. Bloom (1999) gives an example of where he sees the many parallels between social work and single system evaluation, while authors such as Padgett forcefully demur (e.g. Padgett, 1998). I have tried to set out how I see analogies between qualitative methods and practice (Shaw, 1996) through a process of 'translating' for practice.

This does not exhaust the forms in which arguments for social work as science can be put forward. The third sense in which this claim can be made is through the argument that social work is science as technology. All the talk of social work 'skills', and use of the 'tool' metaphor suggest this idea. The R and D model of research mentioned previously is also technology based. There is now a new form of this issue with the growth of assistive technology. A pending special issue of the *British Journal of Social Work* on social work and technology illustrates the range of these developments.

But in all we should not expect too much from science, research or evaluation. Often the social work community has been too optimistic. I like the words of Socrates:

> *… and if you stay barren [of conceptions of knowledge] you'll be less burdensome to those who associate with you, and gentler; because you'll have the sense not to think you know things which in fact you don't know.* (Plato, *Theaetetus* p.168)

Or, to bring it more up to date, taking the golem – the creature of Jewish mythology – as a metaphor for science, Harry Collins and Trevor Pinch, in their captivating book, seek:

> *… to explain the golem that is science. We aim to show that it is not an evil creature but it is a little daft. Golem Science is not to be blamed for its mistake; they are our mistakes. A golem cannot be blamed if it is doing its best. But we must not expect too much. A golem, powerful though it is, is the creature of our art and our craft.* (Collins & Pinch, 1998, p.2)

Furthermore, "scientists are neither Gods nor charlatans; they are merely experts" (p.143).

Footnotes
[1] 'Evaluation' came as a late 20th Century term within social work, influenced no doubt by the emergence of the evaluation discipline/profession in the USA since the 1960s. I use the language of the times from which my material is drawn.

[2] Moving decades later, it is possible to find welcomes for science from writers as diverse as the early Peter Leonard, Derek Jehu and Florence Hollis.

[3] Deegan has made a major contribution to understanding the gendered nature of early sociology. While her primary interest is in sociology rather than social work, there are fruitful inferences to be drawn regarding women's views of science and practice.

[4] The problem is not restricted to the 1920s. I have recently been sent the engagingly naive memoirs of a social worker who trained at Columbia in the 1950s. Despite training in a leading school, he recalls that "In my experience, practitioners were not interested in research" (Hunter, 2006, p.99).

[5] York's reputation for substantive excellence is independent of the present author.

[6] Naming universities risks counter-claims. But for illustrative purposes I stand by them.

[7] Reflections of this kind raise, needless to say, more questions than they answer. Matthew Norton and I have offered empirical evidence regarding quality criteria in social work research (Shaw & Norton, 2007).

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Notes on Contributor
Ian Shaw is Professor of Social Work at the University of York (England) and co-editor of the Journal *Qualitative Social Work.*

Address for Correspondence
Professor Ian Shaw
Department of Social Policy & Social Work
University of York
Heslington
YORK
YO10 5DD

Book Reviews

In Care and After: a Positive Perspective
Chase, E., Simon, A. & Jackson, S. (eds.)
London: Routledge, 2006, pp. 202,
ISBN: 9-78-0-415-35253-6, £22.99 (pbk.)

This book reports on a series of studies, carried out by researchers from the Thomas Coram Institute at the Institute of Education, University of London, into aspects of the experience of children and young people 'in care'. After a period during which we were asked to call them 'looked after children', this now appears once again to be the accepted term.

After an introductory chapter by the editors, the book provides an historical overview of care provision for children in the UK, an exploration into what we know and don't know about outcomes for children who have been in care. Then follow chapters on the costs and benefits of educating children in care, the experience of care leavers who go on to higher education and the experience of early parenthood among care leavers. The book goes on to look at private fostering, comparisons between the British and Continental European use of residential care for children, advocacy for children, the involvement of children in research and some concluding comments by the editors. The obvious omission (which the editors acknowledge) is a chapter on *public* fostering which in the UK is the main form in which public care provision for children is delivered - in contrast to the situation in Denmark and Germany (Chapter Eight). Nevertheless this is a wide-ranging and thought-provoking book which will be useful for anyone with an interest in what happens to children in public care.

I was less happy, however, with a few sweeping statements such as:

> *[The Children (Leaving Care) Act, 2001] represented a radical shift in social policy, contrasting starkly with previous policies which envisaged that young people at the age of 16 could simply go forth and survive on their own.* (Chapter One [by Chase *et al.*], p.4)

Sadly, being expected to go forth and survive on their own at 16 has, indeed, been part of the experience of many children leaving care but, to suggest that this was a matter of *policy* until 2001, is incorrect. Guidance issued in 1991 to accompany the 1989 Children Act, for instance, stated that:

> *It is of vital importance that young people are properly prepared [for leaving care] and are given access to support afterwards.* (Department of Health, 1991, p.97)

The authors might object that this guidance was not effective in practice, but how can they be sure that the same will not be true of the new legislation? We should be wary of falling into a kind of politician's rhetoric in which past initiatives are dismissed as failures, but new initiatives are hailed uncritically as if they will necessarily do exactly what they claim. Elsewhere, the opposite error is made of assuming that legislative changes in the past necessarily resulted in changes on the ground. For example, in Chapter Two, Jackson refers approvingly to the change of emphasis in the 1989 Children Act in the direction of reducing coercion: "Court action was in future to be a last resort" (p.19). In reality, the number of care orders made annually in England and Wales increased threefold over the period 1992-2004.

The rigour of the argument is also sometimes weakened by a limited selection of the issues and factors in play. For example, in the interesting international study of residential care by Petrie and Simon (Chapter 8), I would have liked more

discussion of the different ways that residential units are used in the UK, where they tend to be seen as a 'bridge' towards fostering, independence or return home, rather than as homes in their own right. This might help to explain the more 'short-term' approach of UK residential workers as compared to their continental colleagues, an approach which these authors seem to assume is necessarily due to the relative lack of training of UK staff in the continental pedagogical model. Maybe they adopt a short-term approach because their involvement is indeed short-term? I wondered also why the authors did not discuss the existence in the UK of special schools which children attend as boarders, and where a more pedagogical approach might well be evident. I felt that without these complexities being teased out the comparison was a little less useful than it might have been.

The book as a whole is certainly effective at highlighting some of the ways in which our care system (or rather our society as a whole) fails children in care. For example, the chapter on higher education (by Ajayi & Quigley) described heartbreaking instances of high-achieving care leavers having funding and accommodation withdrawn at really crucial moments in their education. The book also achieves its aim of pointing out deficiencies in the system without being negative about children in care themselves, whose own words are frequently cited in these pages. It also avoids the other easy error of scapegoating the people who work in the system. It is a useful contribution to the literature.

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Chris Beckett
Senior Lecturer in Social Work
Anglia Ruskin University, Cambridge

Collaborative Social Work Practice
Quinney, A.
Exeter: Learning Matters Ltd, 2006, pp.153, ISBN: 9781844450145, £15 (pbk.)

This text is designed to help student social workers to gain knowledge about working in partnership with other professions. It is very much an introductory text aimed at students in their first year of study and recognises that students undertaking other health and social care courses will be able to gain insights into the new requirements demanded of social workers through reading it. This book focuses on collaboration with other professionals rather than collaboration with service users and carers, but the needs and perspectives of service users and carers remain an important focus throughout.

In keeping with the other titles in the *Transforming Social Work Practice* series this book is very accessible and user friendly. The book is simply but authoritatively written. Prefacing each chapter with a statement of the relevant National Occupational Standards and Academic Standards helps students to become familiar with the content of these. It uses case studies, research summaries and activity points to aid reflection and to encourage an active approach to learning on the part of the reader. It is practice orientated and offers the reader guidance on further reading at the end of each chapter.

Chapters One and Two set the foundations for the remainder of the book with Chapters Three to Seven looking at the roles, responsibilities and value bases of other significant professionals. Chapter One explores key terms and definitions of collaboration and then sets out the policy and service delivery context of collaboration by identifying significant policy and legislative milestones. It looks back to the Beveridge Report of 1942 and more recently to the Laming Report (2003), New Labour's Modernisation Agenda and reform of the NHS through the NHS Plan. This is really

helpful for the novice social worker who needs to understand the 'signposts' that have guided partnership developments and the new organisations created to regulate services, staff and training.

Chapter Two aims to prepare the student for collaboration, firstly, by outlining the legal framework for developing integrated services and formalised co-operation with local partners that have resulted from the Green Papers *Every Child Matters* (DfES, 2003) and *Independence, Well-being and Choice* (DH, 2005). The author subsequently draws on the work of Barrett and Keeping (2005) which identifies a whole range of factors which can help or hinder collaborative social work practice. These include: knowledge of professional roles, willing participation, confidence, open and honest communication, trust and mutual respect, power, conflict, support and commitment at a senior level, professional culture, uncertainty, envy and defences against anxiety. These factors have a very significant effect on whether a partnership is successful. I would have liked the author to have devoted a little more time to a discussion or a reflective exercise to encourage students to consider how these factors might be managed to best effect. Whilst this book primarily focuses on knowledge it is vital for students to begin to appreciate the skills of collaboration that they will need to develop.

In Chapters Three to Seven, the author looks at other professions and their context in turn (Youth Work and Connexions, Health, Education, Housing and Neighbourhood, and the Justice context). This is to outline their organisational frameworks, highlight historical and landmark developments for that profession, and discuss what those professionals do in practice. The author identifies where other professional codes of ethics and values diverge from those of social work and explains the potential impact this may have. In each chapter pitfalls and inequalities are raised and dealt

with succinctly enabling the reader to quickly understand what the issues of concern are and how these may impede successful collaboration. She provides a wide range of resources, books, journals and websites that a student can follow up when they need to know more.

There is nothing wholly new in this book nor is it deeply philosophical in the way that it addresses issues. What it does offer is the knowledge, in a short and easy to read volume, to enable students quickly to gain a basic understanding of the policy and legislative frameworks that are likely to impinge on collaboration with allied professionals. Part of its strength is that it feels authoritative and up to date. The author will need to revise it regularly so that it remains so. This will enable it to act as a really useful resource and reference guide for students in health and social care.

Reference:
Barrett, G. & Keeping, C. (2005) 'The Processes Required for Effective Interprofessional Working' in Barrett, G., Sellman, D. & Thomas, J. (eds.) *Interprofessional Working in Health and Social Care,* Basingstoke: Palgrave, pp.18-32

Kathryn Farrow
Lecturer in Applied Social Studies
IASS, University of Birmingham

Social Work Practice: Assessment, Planning, Intervention and Review (2nd edition)
Parker, J. & Bradley, G.
Exeter: Learning Matters, 2007, pp.147, ISBN: 1-903300-85-1, £14.00 (pbk.)

This is a useful book for student social workers and those entering the profession. Its contents relate directly to government guidelines for training in terms of key roles and competencies, whilst also promoting reflective practice within a context of policy change and social justice. This is significant because, as the authors observe, the ascendancy of the evidence-based approach

can invite a tendency towards 'tick box' case management, which, given the complexities of social work with vulnerable and socially marginalised individuals, can be reductive.

The book is structured around five aspects of assessment, which for me, as a newly qualified social worker felt pretty familiar: context, assessment tools, planning, intervention and review. Chapter One considers various definitions of assessment, suggesting that the concept is itself problematic, and outlines different approaches, such as task-centred, on-going or time-specific assessments. Case studies are introduced to illustrate the application of different assessment approaches and their strengths and weaknesses. Chapter Two again introduces familiar material with the use of genograms, ecomaps and other assessment tools. The third chapter covers care planning, with an emphasis on community care, which I found frustrating perhaps because I work in child protection and am still struggling to get to grips with the specific challenges of multi-agency care plans and case management rather than direct work and the conflict between care and control with children and families. I felt these issues could have been given more attention within the book, even as an introductory text.

I found Chapter Four the most interesting in its introduction to the theoretical underpinning for social work interventions, and agree with the authors that too much vagueness about theoretical knowledge can lead to an abandonment of theory in favour of pragmatics and a tendency to allow personal preferences to guide the work. The chapter on review and evaluation of practice was straightforward, but again with a sensitive discussion of why review matters.

Overall I thought this was a good introduction to social work assessment. It is inevitably limited by being an introduction and cannot cover all of the issues, but I liked the way the authors consistently drew the reader's attention to the complexity of the debates, rather than falling back on simplistic directives about how to achieve certain outcomes. That being said, as I have already mentioned I would have liked some further discussion of multi-agency working, and perhaps more on the service user perspective, especially in terms of human rights. For example, there was no mention of Family Group Meetings, which are becoming a significant intervention where I work, and are proving beneficial for empowering service users and providing a counterbalance to the agency's bureaucratic agenda. The use of case studies was helpful in that they traced the unfolding of service users' stories, rather than simply presenting a brief cameo to illustrate a point. However, having just completed my post-qualifying year, on looking back over my own training I would have liked a greater sense of the demands of a full case-load; exploring the detail of one case at a time is informative, but the challenge is to do that for umpteen cases simultaneously, and I have not yet read an introductory text which prepares student social workers for that. Nevertheless, this book is a helpful addition to the student's library, and also provides good sign-posting for additional reading.

Maggie John
Social Worker
Children and Families Long Term Team
Cambridgeshire County Council