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## REVIEW ARTICLE

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# Towards a contemporary social care 'prevention narrative' of principled complexity: An integrative literature review

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**Abstract**

Prevention has become increasingly central in social care policy and commissioning strategies within the United Kingdom (UK). Commonly there is reliance on understandings borrowed from the sphere of public health, leaning on a prevention discourse characterised by the 'upstream and downstream' metaphor. Whilst framing both structural factors and responses to individual circumstances, the public health approach nonetheless suggests linearity in a cause and effect relationship. Social care and illness follow many trajectories and this conceptualisation of prevention may limit its effectiveness and scope in social care. Undertaken as part of a commissioned evaluation of the Social Services and Wellbeing Act (2014) Wales, a systematic integrative review was conducted to establish the key current debates within prevention work, and how prevention is conceptually framed, implemented and evaluated within the social care context. The databases Scopus, ASSIA, CINAHL and Social Care Online were initially searched in September 2019 resulting in 52 documents being incorporated for analysis. A further re-run of searches was run in March 2021, identifying a further 14 documents, thereby creating a total of 66. Predominantly, these were journal articles or research reports ( $n = 53$ ), with the remainder guidance or strategy documents, briefings or process evaluations ( $n = 13$ ). These were categorised by their primary theme and focus, as well as document format and research method before undergoing thematic analysis. This highlighted the continued prominence of three-tiered, linear public health narratives in the framing of prevention for social care, with prevention work often categorised and enacted with inconsistency. Common drivers for prevention activity continue to be cost reduction and reduced dependence on the care system in the future. Through exploring prevention for older people and caregivers, we argue for an approach to prevention aligning with the complexities of the social world surrounding it. Building on developments in complexity theory in social science and healthcare, we offer an alternative view of social care prevention guided by principles rooted in the everyday realities of communities, service users and caregivers.

**KEYWORDS**

ageing, caregiving, complexity theory, prevention, social and health services, social determinants of health

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## 1 | INTRODUCTION

Prevention in social care is not new (McCave & Rishel, 2011; Ruth et al., 2015). Early pioneers were motivated to address the material and social conditions that shaped lives and opportunities for individuals, families and communities, as well as ameliorating individual and social hardships. Jane Addams' (USA) work for community development, education and wider social and legislative reform; Alice Salomon's (Germany) focus on internationalism and a holistic approach to social work knowledge; Octavia Hill's (UK) innovations in housing reform for the poor are examples. Throughout the 20th century, the focus on prevention in social care scholarship in western contexts fluctuated (McCave & Rishel, 2011; Rapoport, 1961; Wittman, 1961). McCave and Rishel (2011; 229) map out peaks of interest in the 1960s and 1980s. Prevention is again in the spotlight, yet the picture is mixed. The Social Work Interest in Prevention Study – Expansion examined 'the extent and attention of prevention scholarship' in nine key social work journals for the period 2000–2010 (Ruth et al., 2015; 126). Although there was a rise in prevention-focused papers over this decade, the North American researchers found this was only 9% of all papers published in the selected journals (Ruth, et al., 2015). Set against the complexity of social issues and inequalities, the authors called for a widespread dialogue on prevention (Ruth, et al., 2015; 132).

Consideration of complexity in social issues is not a new pre-occupation. Rittel and Webber's (1973) framing of 10 properties of 'wicked social problems' attempts to gain a measure of complexity in the realm of social issues. They suggest social problems 'have no definitive formulation', 'multiple causes', can be 'explained in many ways' and 'have no stopping rules'. Unlike 'tame problems' that may be technically complicated but have boundaries and solutions, like building a desalination plant, Rittel and Webber argue that social problems are comprised of multiple dynamic components and defined from ideological perspectives. Capacity to isolate cause and effect is problematic, which is a longstanding philosophical debate. In Aristotle's frame, as Crane and Farkas (2011; 369) write, causes can be viewed as 'giving an account of why something is the way it is'. In Aristotle's own words, a cause is '...that from which (as immanent material) a thing comes into being' (Aristotle, in Crane & Farkas, 2011; 380). In discussing causation, the philosopher David Hume distinguishes between Relations of Ideas and Matters of Fact (Hume, in Crane & Farkas, 2011; 382) and theorises that it is difficult to discern what the mind sees as 'conjoined objects' with an impression of causation and what is a relationship of cause and effect.

The constitution of relations between cause and effect is a key difference between a public health preventative paradigm and prevention in social care. In the 1960s, Wittman, in crafting a conceptual framework for prevention, contrasts the nature of an illness trajectory with the more fluid nature of social issues dealt with by social work:

There are visible difficulties in the adaptation of prevention as it is known in other fields. In public health there is physical intervention, made possible through

**What is known about this topic?**

- Prevention in social care is commonly tied to three-tiered, linear public health preventative narratives.
- Drivers for prevention have been contested, including values-based logic and reduced dependence or council expenditure.
- The conceptualisation and enactment of preventative work in social care varies significantly between localities.

**What this paper adds?**

- There is a continued reliance on linear, cause-effect models for prevention in social care and limited accounts of the complexity associated with everyday life.
- Developments in complexity theory within social and healthcare sciences offer new perspectives on how prevention is conceptualised and enacted.
- Prevention work will arguably benefit by integrating guiding principles embracing the complexity of service users' and carer's lives.

knowledge of causation or the agents of transmission of a specific illness. In social work there is less that is concrete to work with in terms of illness. (1961; 21)

Rapoport (1961; 3) in a comprehensive analysis of prevention in public health and social work begins with the view that *...the concept of prevention, borrowed largely from the public health model, is often used in a distorted and confusing manner in the social work framework.* She argues, public health employs a 'unifying notion of prevention', whereas social work is based on many concepts and practices, operates in 'complex systems' about presenting issues in the here and now, as well as what is yet to happen and often with incomplete knowledge of causation. The latter, she writes, is one of the social work's '...built-in professional stresses' (1961; 8). Rapoport contends that shoehorning social work into a model from public health will not iron out confusion unless there is a more precise definition based on social work's purpose, knowledge bases and models. She writes:

...social work has major responsibility for amelioration and control, and a vital role in all levels of prevention. Prevention should be more strictly defined to sharpen professional practice and give impetus to greater activity in the area of primary prevention, which involves the imaginative application of all social work methods in anticipating problems and need. (1961; 12)

We report findings from an integrative review of the literature on preventative social care with the following research questions and objectives:

- What are key debates in prevention work in the context of contemporary social care?
- How, and in what ways, is prevention work conceptually framed in the social care context?
- How are preventative interventions in social care being implemented and evaluated?

In addressing these questions, we confirm the recurrent nature of issues outlined by both Rapoport and Wittman in the 1960s, highlighting a continued reliance on the discourse of the public health paradigm, but alongside other emergent prevention narratives. Following Rapoport (1961) and Lundberg (2020), the latter writing in the context of public health, we explore the potential for a reconfiguration of how prevention is conceptually bounded and understood in the realm of social care that offers greater consideration of the complexity underpinning it. In framing our discussion, we use a definition of social care as inclusive of social service and welfare supports to meet human needs that are provided by the state, market and households, and are both formal and informal.

## 2 | MATERIALS AND METHODS

Initially undertaken as part of a commissioned evaluation of the Social Services and Wellbeing Act (2014) Wales, an integrative review of the literature was conducted, allowing for a range of methodological approaches to be included, as well as both academic and grey literature (Llewellyn et al., 2020; Whittemore & Knafl, 2005). The guidelines and framework of PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-analysis) were followed to identify the set of included documents and to guide the review process (Moher et al., 2009).

### 2.1 | Study selection criteria

Searches were initially conducted within the Scopus, ASSIA and CINAHL databases during September 2019, with limitations in place to exclude references on the following criteria: published before August 2014; not being written in English; being drawn from non-Western countries; and non-journal articles. For Social Care Online, though the search was also initially conducted in September 2019, the same limitations were not repeated based on the database containing legislation, government documents, practice and guidance, research briefings and more alongside journal articles (Social Care Online, 2020). As such, grey literature such as books and reports were included within the search with no prescribed date range in the first instance so as to capture documents that paved the way to the current situation. Any articles meeting these criteria were selected as part of the initial data extraction by the research team.

Study leads reviewed the list of reference abstracts in conjunction with the research team for topic relevance, identifying any further exclusions based on this or the previously outlined criteria. A significant

proportion of articles were excluded due to covering prevention of hospital admissions or related issues. Additionally, at this stage, it was decided to restrict Social Care Online documents to be published from 2000 onwards based on diminished relevance. Study leads conducted a further snowball search within key articles to identify any additional reading of relevance to prevention within the context of social care. Articles deemed relevant were marked for inclusion, incorporating those identified through the snowball search. Any articles felt to have limited relevance were put to one side and discussed with the wider team before a consensus decision was made.

Finally, a refresh of these searches was conducted in March 2021, identifying a further set of 14 relevant documents once duplicates and exclusions had been applied. These were analysed as a separate supplementary exercise by study leads to assess whether new information had emerged since the initial searches were performed.

### 2.2 | Literature search terms

Combinations of search terms were entered into the online databases Scopus, ASSIA, CINAHL and Social Care Online. The search terms incorporated an array of variations using terms such as 'prevention', 'social care', 'social care and support'; 'role of the third sector in prevention and social care'; 'community development in social care' and 'community development in social services', all querying the title field. Further detail on search terms can be found in Table 1.

### 2.3 | Data extraction and analysis

Documents selected for inclusion were extracted full-text for thematic analysis by the research team. This process sought to identify any patterns in how prevention was discussed, methodologies used, primary research setting and topic. Several strategies were used to improve the rigour of analysis including multiple iterations of search terms in the initial phases, familiarisation and close individual readings of returned documents / articles and regular research team meetings to discuss the categorisation and interpretation of findings (Ritchie & Spencer, 1994). In practice, this led to the analysis itself undergoing several iterations as primary themes and sub-themes were developed, re-visited and re-developed. After each stage, the research team re-applied the latest iteration of the conceptual framework to those documents already analysed to assess whether new approaches may be beneficial (Whittemore & Knafl, 2005). This also saw the emergence of hitherto unexpected concepts and research areas, including those of social enterprises and community businesses that ultimately became central to contemporary understandings of the topic. The emergent conceptual framework integrated the key components of the research questions: how prevention is discussed, framed and conceptualised; the manner in which studies of prevention activity have sought to implement and evaluate themselves; and the similarities and differences associated with such processes.

**TABLE 1** Literature search terms, field limiters and exclusions

	Field limiters	Exclusions	Search terms
Scopus	<ul style="list-style-type: none"> <li>Published after 02/08/14</li> <li>Journal article</li> <li>English language</li> <li>Search title only</li> </ul>	Non-developed and non-Western countries	<ul style="list-style-type: none"> <li>“prevention” AND “social care and support”</li> <li>prevention AND social care and support</li> <li>prevention AND “social care”</li> <li>“social enterprise development in the UK”</li> </ul>
ASSIA	<ul style="list-style-type: none"> <li>Published after 02/08/14</li> <li>Journal article</li> <li>English language</li> <li>Search title only</li> </ul>	Non-developed and non-Western countries	<ul style="list-style-type: none"> <li>“social enterprise development”</li> <li>“role of the third sector in prevention and social care”</li> <li>role of the third sector in prevention and social care</li> <li>“community development in social care” OR “community development in social services”</li> </ul>
CINAHL	<ul style="list-style-type: none"> <li>Published after 02/08/14</li> <li>Journal article</li> <li>English language</li> <li>Search title only</li> </ul>	Non-developed and non-Western countries	<ul style="list-style-type: none"> <li>community development in social care OR community development in social services</li> <li>“community based approaches to supporting wellbeing”</li> <li>community-based approaches to supporting wellbeing</li> </ul>
Social Care Online	<ul style="list-style-type: none"> <li>English language</li> <li>Search title only</li> </ul>	Non-developed and non-Western countries	<ul style="list-style-type: none"> <li>“information and assistance and advice services in local government”</li> <li>information and assistance and advice services in local government</li> <li>“family strengthening programmes”</li> <li>family strengthening programmes</li> <li>“planning for preventative services in social care”</li> <li>planning for preventative services in social care</li> </ul>

### 3 | FINDINGS

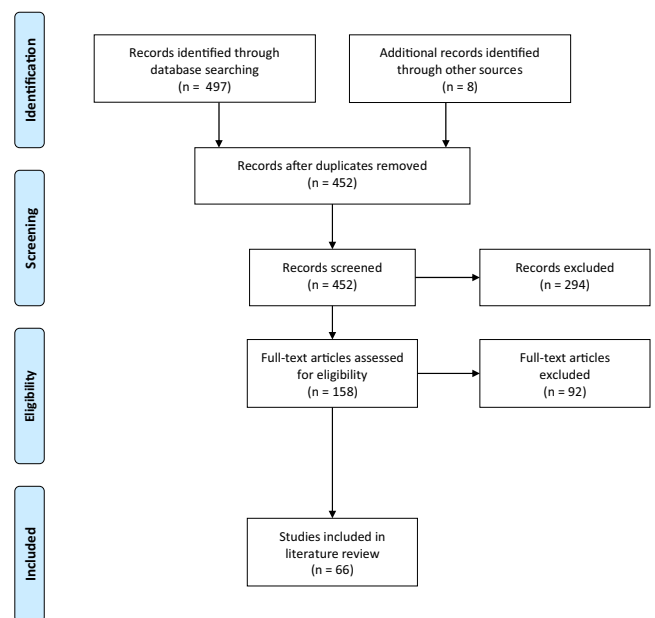
We commence our findings with a brief description of the returned sample of literature including document type and primary focus. Following this, we will outline the core themes emergent from the analysis: the drivers for prevention activity; the varying concepts and definitions of prevention; and how the literature shows this to be actualised in the social care context.

#### 3.1 | Sample description

From a total of 505 references identified through database and snowball searches, 66 documents and articles were included for review. Figure 1 PRISMA flowchart outlines the selection process:

After eliminating duplicates and reviewing against the inclusion criteria, as well as ascertaining topic relevance by scanning titles, 158 articles were extracted for full-text review by study leads. These were assessed by study leads for relevance based on title and abstract with any exclusions noted for discussion with the wider team. This provided a total of 66 articles deemed to fit the criteria and with relevance to the topic. Table 2 provides the characteristics of the documents analysed.

The final document set predominantly comprised project-specific research reports ( $n = 29$ ) and journal articles ( $n = 24$ ), with the remainder being categorised as guidance or strategy documents ( $n = 10$ ), briefings ( $n = 2$ ) or process evaluations ( $n = 1$ ). Initial analysis also categorised the documents by theme and primary focus, highlighting a range of different, often overlapping, topics being discussed under the umbrella of preventative social care. These primarily included community development ( $n = 23$ ), community



**FIGURE 1** PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-analysis) flowchart of inclusions and exclusions

businesses, social enterprises and the wider voluntary/community sector ( $n = 15$ ), and documents focussing specifically on adult, children, family or older people services ( $n = 20$ ).

#### 3.2 | Drivers for prevention activity

The Cambridge online dictionary defines ‘prevention’ as an act ‘to stop something from happening or someone from doing something’. Historically, the drivers for preventative policies and practices in social care have been diverse and contested, influenced by ideologies

and values about what it is that is to be stopped from happening, different theories and knowledge about causation, and how to frame and act on solutions (Clark, 2019; Curry, 2006; Gough, 2013). The contemporary landscape is no different, most recently highlighted by an evaluation of the Social Services and Well-being Act in Wales (Llewellyn et al., 2020). Ambiguity and prevention in social care have remained related (Curry, 2006; Llewellyn et al., 2020; Marczak, Wistow, et al., 2019).

A contemporary preventative agenda is an emphasis on prevention to reduce state expenditure by stopping current and future demands for high-cost services. This agenda is based on arguments about unsustainable social care expenditure (Bown et al., 2017; Curry, 2006; Kerslake, 2011; Wavehill Social and Economic Research, 2019). For instance, Kerslake argues the 'primary goal of any prevention strategy has to be the reduction of future demand' (2011; 14). An example is preventative strategies to reduce falls in the older population which can stop falls-related hospital admissions and associated expenditure (Curry, 2006). A discourse of prevention to save future expenditure can seep into an agenda about budget cuts and the transfer of provision of care and support to the household and community sector. Marczak, Wistow, et al. (2019), in their study of prevention in social care in England, find that economic, cost-saving discourses are prominent in practice.

There are counter viewpoints that prevention in social care needs investment. A review of the implementation of the Care Act 2014 in England identified financial pressures as the clearest driver for prevention activity, but also acknowledged that such pressures were common barriers to sustainability and success (Tew et al., 2019). Additionally, a report by Cooperatives UK (2017) identified cooperative approaches to prevention and well-being as an 'untapped cost saving resource, with too little recognition of the fact that integrating volunteers with professional services can involve costs and burdens, as well as boosts to overall effectiveness' (2017; 4). Miller and Whitehead write on prevention models:

In adult social care an investigation regarding the deployment of such models in local authorities discovered that they are being developed, but raised concerns of the "dangers of top-down solutions, of such approaches being misconstrued as 'cuts' and of trying to rush a process that many felt needed to be small-scale, bottom-up and led by communities themselves." (2015; 1)

Other writers argue for prevention based on human rights perspectives, of both reducing social injustices and responding to immediate human needs (Smith, 2018; Young et al., 2014). Preventative action in terms consistent with this perspective ranges from structural change, 'bottom up' community development and community micro-enterprises, state social welfare (Bedford & Phagoora, 2020; Foot & Hopkins, 2010; Smith, 2018; Wales Cooperative Centre, 2011), community infrastructure (Holding et al., 2020; Walters, 2015), community participation (Statham et al., 2010; Watt et al., 2000;

Young et al., 2014) and integrated services and programmes across functional areas. An example of a preventative programme using an explicit human rights discourse is a comprehensive child protection model proposed by Young et al. (2014) to combine protective work with the provision of supports and services using community development principles. One of the implications from a reading of debates in the literature reviewed is the need to name and reconcile competing motivations and agendas for prevention in the context of political processes and contestation about the allocation of scarce resources.

### 3.3 | Prevention concepts and definitions

Mirroring this contestation over the drivers for prevention activity, sampled articles offered various viewpoints on how prevention itself is conceived, defined and delivered. Many of these were reliant on pre-existing public health narratives, commonly drawn from a three-tiered approach to prevention, that conceive it as a linear, layered and interlinked pathway (Wavehill Social and Economic Research, 2019). Within this, as both Gough (2013) and the National Collaborating Centre for the Determinants of Health (2014) establish, the predominant understanding remains heavily indebted to Coote's view that prevention occurs in one of the three distinct but interrelated areas:

- 'upstream (prevent harm before it occurs),
- 'midstream (mitigate the effects of harm that has already happened)' and
- 'downstream (cope with the consequences of harm, stop them getting worse)'. (2013; 3)

Though notably reliant on a definition of prevention associated with public health, similarly conceived three-tiered approaches were also prevalent within the social care literature reviewed. While not directly aligning with the upstream-midstream-downstream metaphor, several articles outlined primary-secondary-tertiary categories which mirrored similar thinking. In the context of support for older people, for example, Curry (2006) cites the work of Wistow et al. (2003) who depicts three levels of prevention as:

- 'to prevent or delay ill health or disability consequent upon ageing'
- 'to promote/improve quality of life of older people, their independence and inclusion in social and community life'
- 'to create healthy and supportive environments'. (2006; 6)

Much like the stream metaphor in public health, this three-tiered set of objectives may also require a range of interventions, activities and services specific to each level. For instance, the work needed to create healthy and supportive environments for older people may overlap with, but also require fundamentally different approaches to those delaying ill health upon ageing. Similar perspectives are also offered in the context of 'childhood maltreatment' (Stagner & Lansing, 2009), adult learning disabilities (Emerson et al., 2011) and obesity prevention for younger people (Warin et al., 2015). Each set of authors again highlight

TABLE 2 Analysed document characteristics

Author (year)	Country	Document format	Research method
Abendstern et al. (2014)	United Kingdom	Journal article	Narrative: mixed methods
Abrams et al. (2019)	United Kingdom	Guidance document	N/A
Allen and Glasby (2010)	United Kingdom	Journal article	General review
Allen and Miller (2013)	United Kingdom	Research report	Scoping review
Austin et al. (2015)	United Kingdom	Research report	(i). Literature review (ii). Mixed methods
Barton et al. (2020)	United States	Journal article	Narrative: quantitative
Bedford and Harper (2018)	United Kingdom	Research report	Case study: qualitative
Bedford and Phagoora (2020)	United Kingdom	Research report	Narrative: mixed methods
Body (2019)	England	Journal article	Narrative: qualitative
Bown et al. (2017)	United Kingdom	Evaluation	Process evaluation: mixed methods
Bull et al. (2021)	England	Journal article	Narrative: quantitative
Care Inspectorate Wales (2020)	Wales	Research report	Narrative: mixed methods
Clark (2019)	United Kingdom	Journal article	General review
Community Catalysts (2017)	England	Research report	Case study: mixed methods
Cooperatives UK (2017)	United Kingdom	Research report	Case study: qualitative
Curry (2006)	United Kingdom	Research report	Literature review
Department for Communities and Local Government (2009)	United Kingdom	Guidance document	N/A
Department of Health (2010)	United Kingdom	Strategy document	N/A
Emerson et al. (2011)	United Kingdom	Research report	Scoping review
Fernandez et al. (2020)	England	Research report	Narrative: mixed methods
Foot and Hopkins (2010)	United Kingdom	Strategy document	N/A
Gough (2013)	United Kingdom	Journal article	General review
Gray (2014)	United Kingdom	Journal article	Narrative: mixed methods
Henderson et al. (2018)	Scotland	Research report	Narrative: action research
Holding et al. (2020)	United Kingdom	Journal article	Narrative: qualitative
Hull et al. (2016)	United Kingdom	Research report	Narrative: mixed methods
Institute for Voluntary Action Research (2018)	United Kingdom	Briefing evaluation	Narrative
Kenny (2018)	Non-specific	Journal article	Opinion piece
Kern and Holman (2017)	United Kingdom	Briefing evaluation	Narrative
Kerslake (2011)	United Kingdom	Research report	General review
Knapp et al. (2012)	England	Journal article	General review/cost-benefit analysis
Kumpfer et al. (2020)	United States	Journal article	Narrative/case study
Local Government Association (2017)	United Kingdom	Research report	Case study
Marczak, Wistow, et al. (2019)	United Kingdom	Journal article	Narrative: qualitative
Marczak, Wittenburg, et al. (2019)	United Kingdom	Journal article	General review
McClellan et al. (2019)	Global	Research report	Systematic review
Munoz et al. (2014)	United Kingdom	Journal article	Narrative: qualitative
Public Health England (2015)	England	Guidance document	N/A
Richards et al. (2018a)	United Kingdom	Research report	Narrative: mixed methods
Richards et al. (2018b)	United Kingdom	Research report	Narrative: mixed methods
Richards et al. (2018c)	United Kingdom	Research report	Narrative: mixed methods
Rolock et al. (2019)	United States	Journal article	Narrative: quantitative
Shapiro et al. (2013)	United States	Journal article	Randomised trial
Skills for Health Skills for Care (2017)	United Kingdom	Guidance document	General review

Journal/publisher	Primary theme	Focus/context
British Journal of Social Work	Prevention in social care	Adult social care
Building Connections Fund	Co-production	Community development
Journal of Integrated Care	Integrated care	Older people services
National Institute for Health Research	Prevention in social care	Older people services
Health & Care Professionals Council	Preventative models	Health & social care
Children and Youth Services Review	Preventative models	Children services
New Economics Foundation	Sustainable social care	Community businesses
New Economics Foundation	Preventative models	Social enterprises
Voluntary Sector Review	Prevention in social care	Policy & commissioning
National Development Team for Inclusion	Preventative models	Adult social care/community development
British Journal of Health Psychology	Preventative models	Health & social care
Care Inspectorate Wales	Prevention in social care	Older people services
Social History of Medicine	History of prevention	Health & social care
Somerset Council	Sustainable social care	Social enterprises
Co-operatives UK	Sustainable social care	Community organisations
King's Fund	Prevention in social care	Health & social care
Communities and Local Government	Integrated care	Community organisations
Department of Health	Sustainable social care	Voluntary, Community and Social Enterprise
National Institute for Health Research	Prevention in social care	Adult social care/learning disabilities
National Institute for Health Research	Prevention in social care	Adult social care
Local Government Association	Preventative models	Community development
British Journal of Political Science	Prevention frameworks	Policy & commissioning
Housing, Care and Support	Preventative models	Community development/older people services
What Works Scotland	Preventative models	Community development
Health and Social Care in the Community	Prevention in social care	Community development
The Power To Change Trust	Preventative models	Community businesses
Social Enterprise UK	Integrated care	Voluntary, Community and Social Enterprise
Community Development Journal	Prevention frameworks	Community development
Nesta	Integrated care	Community development
Oxford Brookes University	Integrated care	Older people services
Community Development Journal	Prevention in social care	Community development
Evaluation & The Health Professions	Prevention in social care	Children services
Local Government Association	Integrated care	Voluntary, Community and Social Enterprise
Journal of Long-Term Care	Prevention in social care	Policy & commissioning
Eurohealth Observer	Prevention in social care	Older people services
The Power To Change Trust	Preventative models	Community businesses
Community Development Journal	Preventative models	Social enterprises
Public Health England	Integrated care	Community development
The Power To Change Trust	Preventative models	Community businesses
The Power To Change Trust	Preventative models	Community development
The Power To Change Trust	Preventative models	Community businesses
Journal of Evidence-based Social Work	Preventative models	Children services
Journal of the Society for Social Work and Research	Prevention in social care	Community development
Skills for Health, Skills for Care	Prevention in social care	Community development

(Continues)

TABLE 2 (Continued)

Author (year)	Country	Document format	Research method
Smith (2018)	Scotland	Research report	Literature review
Smith and Barnes (2013)	England	Journal article	Process evaluation
Social Care Institute for Excellence (2010)	United Kingdom	Research report	General review
Social Care Institute for Excellence (2019)	Northern Ireland	Research report	Case study
Stagner and Lansing (2009)	United States	Journal article	General review
Statham et al. (2010)	United Kingdom	Research report	Literature review
Terry and Townley (2019)	United States	Journal article	Literature review
Tew et al. (2019)	England	Research report	Narrative: mixed methods
Thiel et al. (2013)	Wales	Research report	Case study
Think Local Act Personal (2016)	United Kingdom	Guidance document	N/A
Think Local Act Personal (2017)	United Kingdom	Guidance document	N/A
Trup et al. (2019)	United Kingdom	Research report	Narrative: mixed methods
Voluntary Organisations Disability Group (2019)	United Kingdom	Research report	Case study
Wales Cooperative Centre (2011)	Wales	Research report	Case study: qualitative
Walters (2015)	United Kingdom	Journal article	Narrative/case study
Warin et al. (2015)	Australia	Journal article	Ethnography
Watt et al. (2000)	Scotland	Journal article	Action research – case study
Wavehill Social and Economic Research (2019)	United Kingdom	Research report	Literature review
Welsh Government (2008)	Wales	Strategy document	N/A
Wilding and Barton (2009)	United Kingdom	Research report	Process evaluation
Wistow et al. (2003)	United Kingdom	Guidance document	N/A
Young et al. (2014)	United Kingdom	Journal article	Narrative

the underlying importance of causation in prevention, stressing the importance of understanding how one event has led to another and what may be an effective intervention to influence the future. This perspective is particularly enhanced by Warin et al. whose work highlighted a 'spatio-temporal disjuncture' between the aims of an obesity prevention initiative and its intended audience (2015; 309). They argue that this is based on the issue of obesity being too temporally distant from the experiences of its target audience, suggesting instead that preventative work should be informed by 'shorter future horizons' based on self-identified needs and desires (2015; 309). Though writing specifically on obesity prevention, similar issues are implied across a range of the prevention literature and across varied contexts.

However, while this suggests a commonality in that prevention is generally understood across a set of spheres or levels all implying forms of causation, numerous authors highlight the great disparity in how this is enacted. Marczak, Wistow, et al. (2019) study of six local authorities in England explored how prevention was conceived by them and the way this influenced commissioning. The authors suggest that ambiguity in how prevention is defined impacts on decision-making and in-house practices. Indeed, they articulate the severity of this problem as follows: '[T]he under conceptualisation of prevention and its contested nature posits serious challenges to the development of necessary evaluations and requires further study' (Marczak, Wistow, et al., 2019; 213). Similarly, a Skills for Care

commissioned research report demonstrated a 'lack of consensus' on what preventative social care entails and to what extent this work is already underway (Wavehill Social and Economic Research, 2019; 5). Kumpfer et al.'s (2020) timely paper on replication failure in evidence-based prevention highlights the importance of local implementation conditions when replicating prevention models, that is, the 'programme dosage', 'enthusiasm and quality' of the people delivering the intervention, training in the intervention, etc. Importing a prevention model that worked elsewhere is no assurance of success.

### 3.4 | Prevention, social care and context

As suggested by Marczak, Wistow, et al. (2019) and confirmed by other papers in this review, how prevention activity is actualised in the social care context is varied, encompassing person-centred, family-focused and community-led approaches, as well as diverse local conditions, policies, decision-making and funding constraints (Miller & Whitehead, 2015; Richards et al., 2018a, 2018b, 2018c). Numerous authors highlight how prevention approaches will necessarily vary based on the identified needs, the organisational contexts of implementation and the nature of interagency collaboration. There are, for instance, a range of social care interventions aiming to respond to needs: information or advice services,



Journal/publisher	Primary theme	Focus/context
IRISS	Prevention in social care	Community development
Health and Social Care in the Community	Prevention in social care	Older people services
Social Care Institute for Excellence	Sustainable social care	Community development
Social Care Institute for Excellence	Integrated care	Voluntary, Community and Social Enterprise
The Future of Children	Prevention in social care	Children services
Centre for Excellence and Outcomes in Children and Young People's Services	Preventative models	Children services
American Journal of Community Psychology	Preventative models	Community development
Social Care Institute for Excellence	Prevention in social care	Adult social care
King's Fund	Integrated care	Older people services
Think Local Act Personal	Preventative models	Community development
Think Local Act Personal	Preventative models	Community development
The Power To Change Trust	Preventative models	Community development
Voluntary Organisations Disability Group	Preventative models	Voluntary, Community and Social Enterprise
Wales Co-operative Centre	Sustainable social care	Social enterprises
Mental Health and Social Inclusion	Co-production	Community development
Social Science & Medicine	Prevention frameworks	Children services
Community Development Journal	Preventative models	Community development
Skills for Care	Prevention in social care	Policy & commissioning
Welsh Government	Preventative models	Voluntary, Community and Social Enterprise
Race Equality Foundation	Preventative models	Family & children services
University of Leeds	Prevention frameworks	Older people services
Child Care in Practice	Prevention frameworks	Children services

re-ablement programmes, falls prevention, physical activity promotion, asset-based approaches, home visiting programmes for pregnant women and families of young children, family strengthening programmes and 'self-directed support' (Allen & Miller, 2013; Barton et al., 2020; Curry, 2006; Kumpfer et al., 2020; Social Care Institute for Excellence, 2019; Wavehill Social and Economic Research, 2019). Each of these may be informed by different notions, viewpoints and principles on how to maintain independence, empower individuals, develop skills and reduce isolation (Holding et al., 2020; Marczak, Wittenburg, et al., 2019).

Similarly, alongside initiatives that start with individual needs, there is a focus on community development and community-based prevention approaches (Bedford & Phagoora, 2020; Miller & Whitehead, 2015). Approaches here are derived from a range of theoretical perspectives on social determinants, how best to identify, meet needs and deliver interventions, as well as how to engage well with communities (Kumpfer et al., 2020). Increasingly, contemporary efforts have focussed on relationship-based approaches such as Asset Based Community Development with underpinning notions of social capital, voice and control, and co-production commonly woven in (Foot & Hopkins, 2010; Kern & Holman, 2017; Public Health England, 2015; Social Care Institute for Excellence, 2019). Richards et al. (2018c) offer an example of this in relation to the development of community businesses:

Community businesses are usually established by local communities in order to meet a local need, whether that is to revive local assets, protect the services that local people rely on, or address local needs. (2018c; 3)

Highlighting instances where community businesses had positively influenced local communities, the authors identify a range of initiatives including 'social enterprises, community interest companies, community benefit societies, social co-operatives and charitable trusts' (2018c; 13). Within many of the examples offered, a reportedly common factor for success is identifying and maintaining a focus on specific community needs (Institute for Voluntary Action Research, 2018; Munoz et al., 2014; Public Health England, 2015; Think Local Act Personal, 2016, 2017). A prerequisite to this is strong community engagement, identified in the context of community hubs (Richards et al., 2018b; Trup et al., 2019), social enterprises and numerous distinct community-based projects. Indeed, a recent study of community hubs and businesses identified the importance of management skills such as financial governance and adaptability, but also that such skill sets can 'nearly always be found from within or close to the local community, including from local businesses and professional services' (Trup et al., 2019; 9).

Social Care Institute for Excellence (2019; 1) in over-viewing five 'promising' models of preventative community-based care in Northern Ireland notes the challenge to move from workable small-scale models of practice to their mainstream delivery. They contend this shift requires commissioning processes that enable the potential benefits, evaluation tools that capture the process and outcome of such work, and interagency practices that bring together assets and innovative intelligence (Social Care Institute for Excellence, 2019; 1).

## 4 | DISCUSSION

### 4.1 | Study limitations

Given this review was conducted as part of a larger project evaluating the wider implementation of the Social Services and Well-being Act (Wales) 2014, it was time-limited and incorporated only the primary databases with publication date restrictions largely aligned with the Act's publication. That said, the use of snowball searches by the study leads, as well as less restrictive searches within the Social Care Online database, enabled the inclusion of key documents that paved the way to the crop of recent literature.

### 4.2 | General reflections

The review indicated broad comparability in many drivers and definitions of prevention. Discourse of cost-saving initiatives predominated, alongside a leaning towards a public health paradigm of preventative spheres or levels. Yet the overarching debate on how prevention is, and should be, defined in social care remains contested. This is exemplified by Allen and Glasby's (2010; 33) comment that in 'spite of a stated commitment to prevention, there is a lack of clarity about what it means or how to do it in practice'. Similarly, a recent report highlighted how practitioners from different settings are 'often not sure they are talking about the same thing, let alone working to the same goals' (Think Local Act Personal, 2016; 7). On this basis, existing prevention narratives require further interrogation to establish how they are failing to command clear understanding from their targeted audience.

We argue that this lack of clarity in how prevention work is understood and enacted in social care may, partially at least, stem from the reductionism embedded within the narratives surrounding it. For the public health paradigm, rooted in concepts of sickness, the metaphor of a river flowing downstream is characterised by structural interventions designed to prevent an individual and community's deterioration in health. However, recent thinking on the social determinants of health suggests that the way individuals respond to such interventions can be multi-faceted, varied and unpredictable (Lundberg, 2020). To address this issue, work there has focussed on unpicking the current narrative so as to establish, at a theoretical level, where the narrative misaligns with evidenced reality.

Adherence to medication intended to prevent future illnesses occurring is a case in point. Research in this field has highlighted the importance of understanding structural factors as to whether people take their medicine as prescribed (e.g., prescription problems, unclear guidance), as well as individual decision-making and motivational issues (Jackson et al., 2014; Pound et al., 2005). Notably, adherence issues are reportedly more pronounced when conditions are asymptomatic and degenerative, where lived experience of the illness may lead people to believe the medication is unnecessary (Miller, 1997).

Understanding the dynamics of how prevention activity embeds into day-to-day realities for social care will require the translation of theoretical approaches encompassing both structural determinants and interventions, as well as individual agency. Stagner and Lansing (2009) integrated further consideration of the latter in conceptualising prevention in terms of temporality or past and future horizons. This is enhanced by findings from Warin et al. (2015) who noted that prevention agendas concerned with a long-term future time horizon, such as within public health obesity initiatives, may be too distinct from the everyday realities of those they are targeting (2015; 309). For a prevention narrative to successfully conflate the inputs of both organisational activity and individual response, it first requires a theoretical underpinning better encapsulating both aspects, as well as how they interact together.

Developments in complexity theory within the social sciences may offer helpful insights in this regard. Much like in the realm of prevention, sociological thinking has also wrestled with issues of structure and agency, grand narratives and contradictory particularities. This ongoing debate, as Walby (2007) notes, has been characterised either by a theoretical emphasis on social systems (e.g., Parsons, Durkheim) or on individuals at the expense of the structures surrounding them (e.g., Lyotard, Braidotti). For Urry (2005) the complexity turn offered a new means of encapsulating the dynamism of social systems:

Complexity investigates emergent, dynamic and self-organizing systems that interact in ways that heavily influence the probabilities of later events. Systems are irreducible to elementary laws or simple processes. (2005; 3)

When considering prevention activity, the notion of influencing future events is self-evidently crucial. Indeed, the existing prevention narrative, by encouraging activity upstream to avoid it being required downstream, implicitly aligns with this. However, the linearity of this model reduces some of the evidenced complexity associated with how prevention initiatives play out, as well as how different areas of social care may conceive, commission, plan, design and deliver such programmes. This reductionism, therefore, has potential to extend into the presumed purpose of prevention activity as well. Within social care, prevention can extend to issues of child abuse and neglect, maternal and child health outcomes, homelessness, unnecessary admissions to hospital, promotion of well-being,

strengthening resilient communities and reducing the need for formal social care services. Each of these can be interpreted with the principles of addressing social inequalities, moral principles and values, or, as reported by various research, cost-saving for the social sector (Curry, 2006; Gough, 2013). Certainly, as Marczak, Wistow, et al. (2019) report, the blurring of these discourses together has the potential to result in ambiguity in both conception and decision-making (2019; 210).

As conflicting as it may seem, integrating elements of complexity into how prevention is conceptualised, planned and commissioned may ultimately benefit it with greater clarity. Efforts in this direction are becoming more noticeable in the realm of health care, including the development of the Angel Taxonomy in Wales (Rutter et al., 2019). As Lundberg (2020) notes, 'people's lives are intertwined with social structures' and as such preventative work should look to address social inequalities emerging as both 'a result of structural conditions and the individual responses to those' (2020; 475). Walby (2007) argues that complexity theory, when conceived as a 'set of theoretical and conceptual tools' as opposed to a singular, holistic 'theory', offers a framework by which the age-old issues of structure and agency can be navigated (2007; 456). In order to develop how this may operate in practice, we will demonstrate the complexity associated with two common social service functions mentioned in our findings: (a) support for older people and (b) support for unpaid carers.

### 4.3 | Support for older people

In the context of an ageing population, preventative support for older people has become increasingly central to social and health care services (Wistow & Lewis, 1997). When specifically considering the social care needs of older people, this initially resulted in a prevention model encompassing (a) prevention or delay of the need for care in higher cost, more intensive settings and (b) promotion of quality of life of older people and their engagement with the community (Wistow & Lewis, 1997). Alongside this, there has been an ongoing values-based policy emphasis on issues of 'choice' and 'independence' into older age within Western contexts, apparently incorporating both elements of the model. As Wistow et al. (2003) observe, the perceived overlap between the quality of life in ageing with the potential for cost-saving has resulted in evidenced-based commissioning strategies encouraging older people to remain living in their own homes. Yet the authors also note, that many of these strategies offer high value but not necessarily at low cost (2003; 2). Thus, the common discursive policy driver of cost reduction, in and of itself, cannot be perceived as a singular, linear narrative – prevention work for older people may result in cost savings, but also requires investment.

Beyond this, though, the pivotal notion of 'independence' itself requires unpicking. Central to much of the prevention policy discourse for older people over the last 30 years, its presence has resulted in a diverse array of programmes including falls

prevention, active ageing, re-ablement and adapted housing in order to enable older people to remain living in their own homes (Care Inspectorate Wales, 2020). While there is evidential cause for such initiatives to be in place, as Wistow et al. (2003) state, there has been an overarching tendency for them to focus on individuals approaching crisis. Attempting to broaden understandings of successful ageing, they suggest that prevention activity should embrace questions about how growing older is experienced by individuals alongside, where existent, social networks of family, friends and neighbours (2003; 4). To conceptually demarcate this new perspective, they suggest a shift away from the conventionally adopted discourse of 'independence' to one of 'interdependence' where older people are seen as both individuals, but simultaneously as individuals within their own specific social context (ibid; 5).

Ultimately, the practical implications of these for policy suggested by the authors resulted in another three-tiered model of prevention activity: individual, community and government (ibid). However, by conceptualising the interdependence between these layers of prevention work, some necessary elements of complexity were introduced. Though the emphasis remained largely on the upstream to downstream narrative, the mechanisms by which one stream affected the other were shown to be increasingly interrelated and muddled. This point was furthered by their suggestion that in order to address inequalities embedded into successful ageing, there was the need to address pre-existing inequalities between 'individuals and groups over their life course as well as between different age groups' (ibid; 5).

To some degree, this mirrors the recent assertions of Lundberg (2020) on addressing health inequalities resulting from both structural forces and individual agency. There are clear stages within the ageing process where structural social services activity is likely to be beneficial, but these can never be unilaterally deemed applicable to all individuals within a social group. As with the conception of future time horizons, only those who perceive themselves as requiring support may engage with it. Furthermore, with this perception being drawn from gathered life experiences and priorities that may not be shared by all within a group, the capacity for individual decision-making alongside an awareness of the likelihood of an emergent problem is required at once. For some older people, the desire to live at home may outweigh issues of safety or vulnerability, while for others the complex networks of family, community and friends may lead to alternative decisions being made. Incorporating these interdependencies and their associated complexity, as Lundberg notes, requires a theoretical shift from linear flows of upstream and downstream activity, towards a principled view of prevention where activities are more aware and responsive to individual viewpoints both shared and unshared by others. Within this, to compensate for complexity each approach or intervention will require a prerequisite understanding of the problems sought to be addressed from the perspective of those experiencing it. In this sense, the entwinement between prevention activity and co-production becomes all the more obvious.

#### 4.4 | Prevention and unpaid carers

The sheer volume of people who are unpaid carers and the diversity of factors implicated in caregiving has rendered it '...one of the most important social and economic policy issues worldwide' (International Alliance of Carer Organizations, 2018; 1). Across the world, unpaid care is a main source of support, and majorly done by women (UN Women, 2018). The same arguments posed above, of the inadequacies of a singular, linear narrative about cause and effect, and therefore, what is done in the name of prevention apply here. As Keating and colleagues write, family care is '...variously motivated by love, reciprocity or obligation' (2019; 150) and will look and feel different at certain times in a life course. Care provided by unpaid women and men caregivers, whether parents, children, extended families, and friends, is an essential component of a prevention scaffolding for the person being care for. Personal and social support, access to adequate incomes and the right social environments to enable carers to do these roles is part of the entwined prevention framework for unpaid carers.

The demands of unpaid caring and the needs of carers is acknowledged in public policy across the world (International Alliance of Carer Organizations, 2018; Social Care Institute for Excellence, 2018; UN Women, 2018). In the United Kingdom, there are public policy measures to support carers, albeit with conditions and resource limitations. In England, within the English *Care Act 2014* there is an emphasis on support for adults who need care and support for carers, who meet certain eligibility requirements (Fernandez et al., 2020). This is also the case in Wales with provisions in the *Social Services and Wellbeing Wales Act (2014)* for carers assessments for support to meet needs, in Scotland under the *Community Care & Health (Scotland) Act 2002*, and in Northern Ireland under the *Carers and Direct Payments Act (2002)*. Programmes to support carers come in many forms and are provided by the domestic sphere, state, civil society and the market. SCIE in a 2018 report provide examples; respite services, information and advice, 'emotional support', help when there are 'crunch points' or crises, community development, social security payments and public advocacy to recognise caring roles (Social Care Institute for Excellence, 2018). Prevention across these programmes will be defined in multiple ways, and as noted above, those directly impacted are centrally placed to define what will support prevention.

Yet, set against these supports for carers are public policy shifts that expect care to be delivered in the domestic sphere. In some welfare states, there has been an unambiguous governmental policy agenda to refocus the delivery of care from the state to the private sector and private realm (i.e., self, household, family and friends), in the context of reducing welfare state expenditure (Keating et al., 2019; Williams, 1999). This privatisation agenda has implications for the visibility of and conditions of support available to unpaid carers and the positioning of prevention. It also highlights contradictions in policy agendas which add to the complexity of framing the needs and issues to be addressed and where prevention comes into play. For example, the impact of a privatisation agenda

for care and support at home has been a theme in public submissions to the Australian Royal Commission into Aged Care Quality and Safety. Age Care Crisis Inc (2020), a consumer group, wrote in an open letter to the Commission:

This crisis has also brought the critical 'paradigm issue' that has bedevilled the sector since 1997 to the fore. We are referring to the unresolved issue of whether aged care should be provided within the context of the self-interest driven free market philosophy adopted by government, or within the context of a community focused philosophy based on our responsibility to care for each other. (8 January 2020)

UN Women, in setting out an agenda for action to support unpaid carers, stress the need for the recognition of unpaid care, re-distribution of care within the domestic sphere and reduction of care loads, or what they call a '3 R strategy' (UN Women, 2018; 10). Action within this 3 R Strategy include greater 'public investment in social care', co-ordinated public policy responses across a range of functional areas to support unpaid carers and 'addressing gender inequalities' (UN Women, 2018; 50). In this agenda, prevention is both delivery of programmes to individual carers, and using a gender inequality lens, requires a wider societal and economic response and repositioning of how we care for one another, including social recognition of such care.

## 5 | CONCLUSION

Following Lundberg (2020), we have outlined how current prevention narratives in social care are reliant on assumptions of linearity or cause and effect. However, as the examples highlighted here show, the actualities of social care are demonstrably messier than such assumptions afford. Notions of temporality, complex and interdependent social networks, contradictory policy agendas, structural influences and individual agency all require some standing in how social care prevention is conceived, planned and delivered. In order to progress towards a position where the complexities of social life are embedded into the prevention work of social care, we argue there needs to be a shift away from existing discourses of cost-saving imperative. While a prominent feature in historical incarnations of the prevention problem and undoubtedly a focal point of current renewed interest, much of the simplistic narrative arguably stems from this policy emphasis. Underlying it is a retention of the linear, cause and effect understanding of prevention, that is, actions taken early cause a reduced likelihood of what will follow. Whilst the public health parable of the need to 'go upstream' to prevent people from falling into the river is useful for igniting a structural imagination, there are limitations to this metaphor. Though this is undoubtedly true in many instances within public health, the way prevention is conceptualised within social care has been shown to differ significantly. Furthermore,

the numerous prevention initiatives that fail to deliver on expectations demonstrate that this approach may not always easily translate between these realms.

We have alluded to a 'principled complexity' approach through which the nuances of community, service users' and carers' everyday realities, as well as the overarching social structures around them, are factored into how prevention work is imagined, understood and enacted. Within this, both complexity theory and Rittel and Webber's (1973) defined properties of 'wicked social problems' are helpful. The latter's set of propositions around what comprises a 'wicked problem' include notions of uniqueness and multiplicity that, when applied to the realm of prevention, evoke the complexity of individual agency and how it interlinks with the dynamic structures and systems surrounding it. Beyond this, Rittel and Webber also suggest that 'wicked problems' can often be considered as 'symptoms of other problems' (1973; 165). In terms of social care prevention, this fosters thinking that there may be multiple, dynamic and historically rooted causes for problems and understanding the effectiveness of a solution would need to incorporate a historical imagination and some interlinkage with these multiple causes. While such ideas are useful, some authors have critiqued how Rittel and Webber's ideas have been applied, as well as their potential to imbue what may just be complex issues with an aura of insolvability and defeatism (e.g., Peters, 2017). We share such concerns and believe returning to Walby's (2007) idea of complexity acting not as a universal, holistic theory but more of a lens or conceptual toolkit will aid their navigation. Taking this as our starting point we would suggest the principles embedded within a 'principled complexity' view of prevention would be as follows:

- Social issues requiring prevention activity are often complex, messy and interrelated; as such they may need multiple, interlinked and dynamic solutions.
- 'Communities' may share many characteristics but differ in many other ways. Attempting to understand the diverse characteristics of a 'community' and the social groups and individuals comprising it, is a prerequisite to effective prevention activity.
- Individuals engaged in prevention activity should be considered within their own specific social contexts which, in turn, each offer their own influence.
- Prevention activity may result in future cost-savings, but also requires ongoing investment and engagement to ensure the consistency of activities on the targeted problems, as well as the emergence of others.
- Understandings of causation emerge in the undertaking of preventative activity and to be alert to this emerging knowledge requires a critically reflective approach.
- Certain life events may increase the likelihood of prevention activity being required but do not universally determine the lived realities of communities and individuals.
- What 'works' for one community or individual may not 'work' for others; ongoing engagement with those targeted for prevention may identify the factors provoking this disconnect.

- 'What' we choose to do as prevention activity is equally as important as 'how' we choose to do it.

Though by no means a definitive list, we hope that by conceptualising prevention outside of existing linear narratives and shifting from the policy discourse of cost-saving we may begin the development of a more nuanced approach in line with Rapoport's call, over 60 years ago, for a sharpened and imaginative preventative practice. Within this, the aim should be to demarcate social care prevention from metaphors and parables associated with the public health model and embrace the fluidity, non-linearity and dynamics of social life.

## CONFLICT OF INTEREST

All authors have no conflict of interest to declare.

## DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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