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Risk and Vulnerability in Socially Excluded Groups and Communities: Welfare Issues and Policy Responses

Submission for the degree of Ph.D. by Research Publications

University of Edinburgh

Mike Titterton

June 2008

Statement by Ph.D. by Research Publication Candidate

I confirm that the work I have submitted for consideration for the degree of
Ph.D. by Research Publications is my own work. Where jointly authored
publications have been discussed, I have both acknowledged that other authors
were involved and I have made clear what my contribution to these publications
was in each case.

Signature ....

Date............ June 16th 2008 ....

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Synopsis

The research publications of the author have as their focus a coherent concern with risk behaviours and the management of the personal and social problems underpinning these forms of behaviour, including policy responses within the changing context of welfare. This has formed the common core of both his academic and professional research activities, and is reflected in his research outputs.

These inter-related themes have formed key motifs in the author's work: vulnerability, risk and resilience in socially excluded groups and communities; social policy responses, including prevention strategies and forms of health and welfare provision; shifts in the context for welfare, especially in state-voluntary sector relations; and the development of conceptual and methodological approaches to improve our understanding of these problems and our responses to them, applicable in both UK and international settings.

In this critical review, he describes and explains the development of these motifs, illustrating how a consistent and focused body of knowledge has been assembled and articulated in his research publications. It is contended that this has influenced both theory and practice in social policy, particularly in relation to the fields of health promotion, health care and social work. This reflective account embraces theoretical themes, methodological approaches, empirical settings and applications, and impact and influence of the research.

Theoretical themes

In order to improve our understanding of these problems and responses to them, this research has entailed the development of conceptual approaches. This includes an interest with the construction of social problems such as "vulnerability" and "risk" among socially excluded groups and communities and the evolution of responses to these issues. In addition, a focus of critical attention is social explanation and particularly concepts of the "middle range", which include the management of personal welfare, risk, resilience and vulnerability. A key endeavour has been the development of

intermediate concepts that allow for purchase on particular social issues, of the sort contained in the author's Risk, Resilience and Vulnerability Model.

Methodological approaches

Emphasis is given to some of the methodological innovations that have been developed in the course of the author's research. In terms of qualitative techniques, he pioneered the development of the Facilitated Discussion Group Method. This approach allows for the facilitation of perspectives of vulnerable and excluded individuals, enabling them to discuss their issues, including risk behaviours. Participatory research approaches have also been developed, for example, among disadvantaged groups in the context of the UK and Eastern Europe.

Empirical focus

The empirical settings and applications of the research as contained in his publications are held up for consideration. The contention is that the application of middle range concepts, such as the management of personal welfare or risk, can be relevant whatever the context, though some tailoring in their application to specific circumstances may be required. Therefore his work has included a range of related empirical contexts and research populations, though there is a particular concern with disadvantaged groups and communities, in both UK and international contexts.

Impact and Applications

A major achievement of this research and associated publications has been their impact on policy and practice in health and social services, as well as on theoretical and methodological development in the field of social science. This impact has occurred at three key levels – the theoretical, the methodological and the empirical. Numerous examples are provided, particularly of the impact of this research upon social policy organisations in relation to risk. International examples have also been included, touching on the author's work in Europe, especially Eastern Europe.

Foreword

This critical review provides a consideration of the body of research upon which my publications are based. It has been submitted to the University of Edinburgh in support of my application for the degree of Ph.D. by research publications. While only a short selection of my more recent publications has been included for consideration, in the review I touch on publications arising from a career spanning thirty years in research, policy and practice.

I would like to express grateful thanks to Alex Robertson, of the Social Policy Department at Edinburgh University for his advice and support. Gratitude also needs to be extended to those co-researchers who joined me in some of the research described within: Lisa Curtice, formerly of Glasgow University, now based at the Scottish Learning Disability Centre; Stephen Maxwell, based at Scottish Council for Voluntary Organisations; Professor Malcolm Hill, formerly of Glasgow University and now at Strathclyde University; and Colin Clark, formerly of Newcastle University, now also at Strathclyde University. I wish to thank my examiners, Professor Steve Platt of Edinburgh University and Mike Maas-Lowit of Robert Gordon University.

This extension of gratitude must also embrace research participants in the UK and in Eastern Europe, too numerous to mention by name. They include policy makers, welfare professionals and users of public services. It is my hope that the research contained within my research publications will continue to contribute towards more enlightened policies and more empowering forms of intervention and prevention in these countries. Some examples of the impact to date of my research are discussed in this review.

I would also like to thank my wife, Helen Smart, for her companionship in some of the research discussed here and for her forbearance of my undertaking of other research, which sometimes involved lengthy stays outwith the family home. My children, Cathy and Michael, deserve a very warm mention in respect of the latter and I was always delighted to hopefully make up for any absences on my return.

For coffee and illuminating discussions on research and on life after gym sessions at Warrender Baths in Marchmont, I would like to thank Arne Kruse of Edinburgh University. Fellow graduates David Wright, Alan Gerono and Dave Campbell should also be mentioned for their insights and support.

Finally, I would like to dedicate this submission to the memory of those no longer with us: my parents John and Cathy, my brother John, and my aunts Veronica and Mary. Pete Small, whose own postgraduate studies could not be completed, also holds a special place in this respect.

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Introduction

In this critical review of the research publications selected for submission for the degree of Ph.D., I have three aims:

1. to provide a narrative account that links together my research publications into a coherent whole for discussion;
2. to present a critical account of the principal themes and issues in these publications;
3. to supply a reflective examination of the advantages, as well as the limitations, of the conceptual and methodological developments and their empirical application, which are contained within my publications.

My research publications have as their focus a coherent concern with risk behaviours and the management of the personal and social problems underpinning these forms of behaviour, including policy responses. This has formed the common core of both my academic and my professional research activities, and is reflected in my research outputs.

These inter-related themes have formed key motifs in my work: vulnerability, risk and resilience in socially excluded groups and communities; social policy responses, including prevention strategies and forms of health and welfare provision; shifts in the context for welfare, especially in state-voluntary sector relations; and the development of conceptual and methodological approaches to improve our understanding of these problems and our responses to them, applicable in both UK and international settings.

In this critical review, I describe and explain the development of these motifs, illustrating how a coherent and focused body of knowledge has been assembled and articulated in my research publications. As well as setting out the rationale and logic behind this development, certain contextual nuances are painted at appropriate junctures, in order to assist the understanding of the background and setting for this work.

To this end, this review is structured under the following headings.

- Theoretical themes
- Methodological approaches
- Empirical focus
- Impact and applications

Some concluding comments follow this discussion.

In this review, I seek to trace an intellectual journey, one of self-discovery and investigation of intriguing social phenomena. It has been a journey requiring dedication, as well as time, in order to assemble the necessary concepts, methods and evidence, and to reflect on one's mistakes and one's gains. This review represents a valuable opportunity to describe this voyage and to set out the central motifs that add up to a coherent research career.

I begin, in the following first chapter, with a critical exegesis of the key theoretical themes that can be distinguished in my research publications.

For ease of reading, I have adopted the following convention. Where I cite my own research publications, they are given in the text as, for example, (RP 1), with the number corresponding to the list of publications in Appendix 1. The latter can be detached and used alongside the critical commentary I provide. The sample publications, which have been singled out for particular attention, are provided in Appendix 2. These comprise the following publications: RP 1; RP 4; RP 14; RP 41; RP 42; RP 43; RP 38; and RP 44. All other citations, i.e. those from other authors, are given in the standard Harvard format. These have been kept to a reasonable minimum, as the principal referenced discussions are contained in the research publications themselves.

Chapter 1   Theoretical themes

In this chapter the key theoretical themes that link together my research are outlined and discussed. Some reflective comments and self-critical analysis are included in addition. As well as setting out the development of these themes, the contextual framework is described at particular points, in order to assist understanding of the rationale for addressing such thematic motifs.

The main thrust of my research publications can be summarized here as follows. There is a focus upon risk behaviours and the management of the personal and social problems underpinning these forms of behaviour, including policy responses. The themes singled out for attention are these: vulnerability, risk and resilience in socially excluded groups and communities; and social policy responses, including prevention strategies and forms of health and welfare provision.

In order to improve our understanding of these problems and responses to them, my research has also entailed the development of conceptual approaches. In the discussion that follows, these approaches and the themes outlined are presented and considered in relation to the context and reasons behind the selection as research topics. A diagram is presented on page 6 that shows the inter-relationship of these themes. This represents what I have called the Risk, Resilience and Vulnerability Model and it provides a synthesis of the guiding motifs of my research.

There are three main premises of the Risk, Resilience and Vulnerability Model. These have been derived from my research, which is discussed in more depth later in this chapter. They can be described as follows.

First, children need to face risks as part of their development and as part of finding out about themselves and the world around them. I have argued that 'developmental perspectives that acknowledge the centrality of risk offer particularly valuable ways of moving forward' (RP 1, p. 132). The dual nature of risk – that it embodies positive as well as negative aspects – is recognised throughout my work. The argument applies, *mutatis mutandis*, to adults who could be said to be vulnerable in some way, due to disability or disadvantage.

It is contended that 'for people to grow and develop as creative and autonomous beings, they have to engage with risk' (RP 4, p. 221). For adults to develop and build up confidence, skills and knowledge, opportunities to be challenged by risk require to be made available by society and by welfare professionals. Some of the implications for those who work in health and social services are spelled out in my research. For both vulnerable children and vulnerable adults, however, this has proved a difficult task: the Risk Averse or Safety First model has, as stated in my book (RP 1), largely dominated policy and practice.

Two provisos are needed here. One is that children and young people need education and support in taking risks. Vulnerable adults, who may have previously had little opportunity to take risks, will likewise need support and guidance. The other is that we need to clarify the terms we are using; there are, for example, few helpful definitions of 'risk taking' in the academic and professional literatures. Risk taking is defined as 'a course of purposeful action based on informed decisions concerning the possibility of positive and negative outcomes of types and levels of risk appropriate in certain situations' (RP 1, p. 25). The significance of this definition is this. It proposes that the conceptualization of the taking of risks should include the elements of purpose and the setting of objectives. It should involve informed decision-making, where individuals who are vulnerable exchange understandings, perceptions and information about risks with welfare professionals and mentors. Further, it should embrace the appraisal of options, particularly in relation to potential harms and benefits from a course of action or from a set of circumstances. Finally, it sets boundaries for decision making about risk taking.
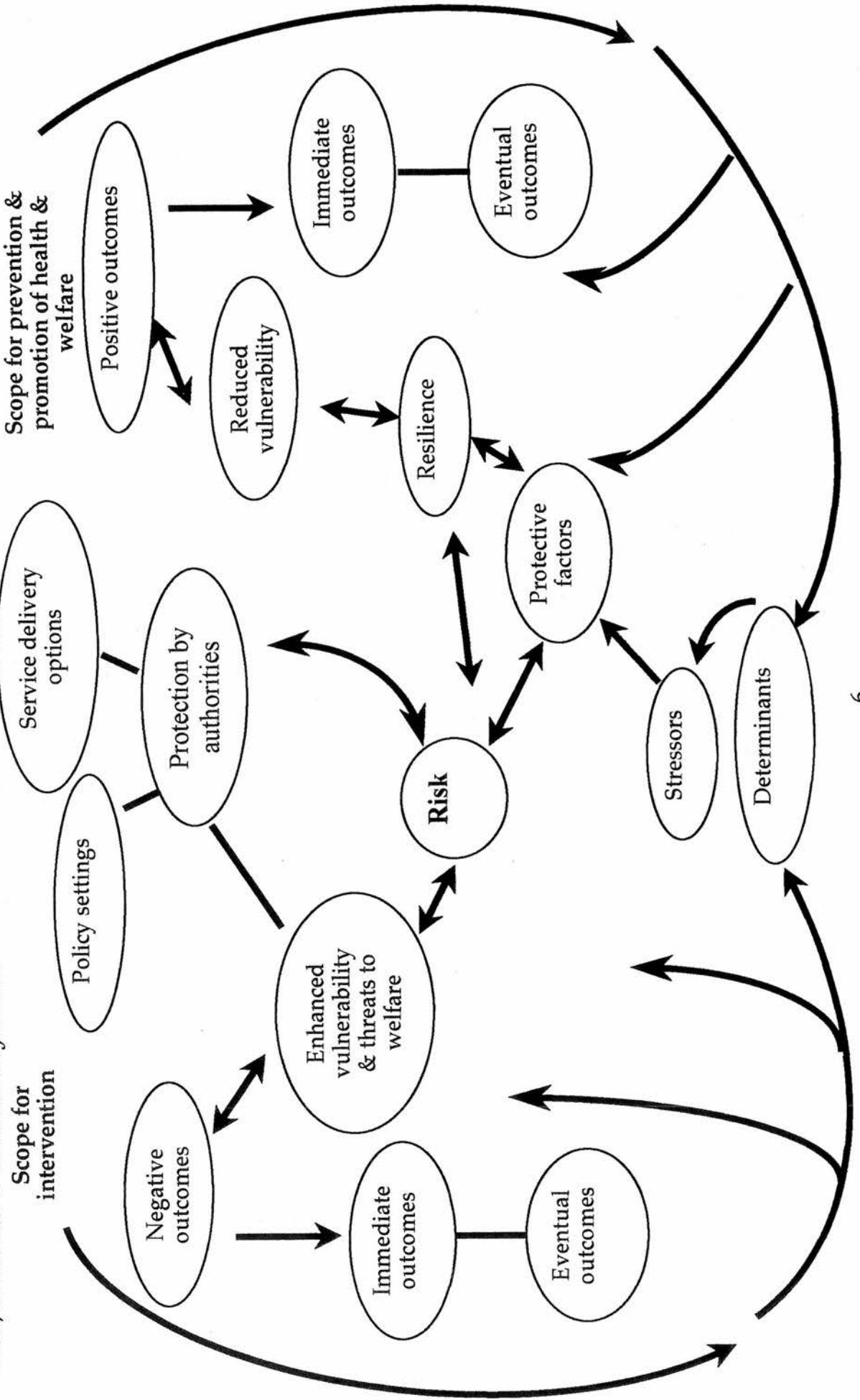
Second, the differential nature of vulnerability, and how creative human agency responds differentially to welfare problems, needs to be taken into account by researchers (RP 26). This applies across vulnerable groups and across the lifespan, including for children and young people. Our focus should be on the differential nature of vulnerability and risk among individuals and the differentiated reaction to threats to welfare. This reaction includes the use of personal and informal resources, and the use of social

support. We should seek to identify threats to welfare, mediating structures and outcomes. There is a role for the consideration of structural determinants, enduring difficulties and life events, and how responses are shaped by access to different material, social and personal resources. It encourages a concern with not just vulnerable people in contact with welfare agencies, but also the vulnerable who are not in contact, and the 'invulnerable', in other words the resilient who do well, despite stress or deprivation (RP 26).

Third, there needs to be greater sensitivity to how risk, protective and resilience factors can operate and influence outcomes over time, along with an appreciation of the opportunities for intervention and preventive work. These factors 'can impact at different points in a child's life and often they change over time. Since the young child's life course may be characterized by both continuities and discontinuities of factors and outcomes, good and bad outcomes are not predetermined' (RP 42, p. 30). They represent then 'key turning-points or decisions that can increase the chance of a good outcome and it is these on which health promoters and welfare professionals need to focus' (RP 42, p. 30).

The diagram overleaf maps out the core topics that have formed the focus of my research throughout my career, and illustrates the connections between them. At the top, are indicated the policy settings and context for service delivery, which include both statutory and non-statutory options. Below are responses by social policy agencies, such as social work, health and educational bodies, with a particular focus on risk. The links between risk, vulnerability and resilience are provided, along with their connections to differential health and welfare outcomes. The latter are influenced and shaped by the strength and direction of

Risk & Vulnerability in Socially Excluded Groups & Communities: Welfare Issues & Policy Responses

Risk, Resilience & Vulnerability Model

Scope for prevention & promotion of health & welfare

Scope for intervention

Positive outcomes

Immediate outcomes

Eventual outcomes

Reduced vulnerability

Resilience

Protective factors

Service delivery options

Protection by authorities

Policy settings

Risk

Stressors

Determinants

Enhanced vulnerability & threats to welfare

Negative outcomes

Immediate outcomes

Eventual outcomes

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these factors, mechanisms and processes; they also combine together and can be influenced by the mediating effects of health and welfare agencies, *inter alia*. The role of stressors and determinants, which comprise, for example, forms of social exclusion and material forms of inequality and deprivation, is indicated at the bottom. Also delineated is the scope for intervention, including short-term and crisis work, and for longer-term prevention and promotional efforts by social policy agencies.

The chart provides us with a useful heuristic, demonstrating the relationships and linkages that should occupy the centre of attention for social scientists, policymakers and practitioners. At the heart of the model sits risk, and its inter-connections with resilience and protective factors. This mutually determining relationship, illustrated by the triangular depiction in the centre of the diagram, is of the greatest importance in explanatory terms. I have argued that the latter should surrender their much-loved occupation of listing sets of discrete risk, protective and resilience factors, and instead focus on the mechanisms and processes that bind these together (RP 42; see also Rutter 1993).

The model encourages us to consider this inter-relationship as fundamental and not treat risk, protection and resilience separately and in isolation from each other. It invites us to dwell on the paradox that without risk, resilience cannot exist. Children and young people, for example, cannot develop qualities associated with resilience, without encountering and dealing with risk-laden situations and circumstances. This consideration is, at least in part, my response to the intriguing point raised by E.J. Anthony, who relates the story of three dolls:

'One is made of glass, the second of plastic and the third of steel. They are each hit by a hammer. The first breaks. The second is scarred. But the third gives off a fine metallic sound ... It's that sound that we're all trying to investigate.'
(Cited in RP 26)

I have argued that this investigation of the constitutive nature of that 'fine, metallic sound' has formed one of the great challenges for social science (RP 26). However, many researchers have set off on this quest to find the Holy Grail of resilience, only to come to grief in the dry and dusty lands of pursuing individual attributes associated with the former. The model indicates that more fruitful and pleasant valleys await us in the re-thinking of the meaning and importance of risk, and in exploring its triadic relationship with protective factors and resilience.

Let us consider an example of a topic that is very much in the news headlines currently, and indeed is rarely far from them, namely that of child abuse and neglect, along with the issue of the protection of children. Current thinking and practice tends to separate off issues to do with abuse and protection from those of health promotion and prevention, and to be risk averse into the bargain (RP 1). The Risk, Resilience and Vulnerability Model offers a markedly different, and potentially more empowering, way of thinking and working with a child-centred, developmental perspective, which can help join up these agendas presently treated as diverse: health education and health promotion for children and young people; child protection and safeguarding; and risk assessment and risk management. This applies across settings, whether they be early years, pre-school, school, post-school and so on. Included in this are children and young people in a range of institutions, including the different forms of street shelters, children's homes, residential and penal institutions to be found. Children in family, foster care and adoption settings are also embraced. The approach would, among other things, stop or reduce attempts to simply slot children into pre-existing services and programmes (RP 37).

Theory and practice based upon the model would embrace risk and seek to work with it at different levels. In addressing child abuse and neglect, the inter-relationships between risk, protective factors and resilience would become the focus of intervention and the focal point for longer term preventive work with children and families. The adversity that some children face can be broken down into life events (e.g. birth of a new baby, arrival of a step father) and chronic and

enduring difficulties (e.g. emotional and challenging behaviour; low educational attainment) (RP 26). These affect the adverse risk behaviours of the child or the parent, fuelled by the circular and linked interaction of these aspects, which have been extrapolated from factors examined in one of my papers (RP 42): low self-esteem and confidence, susceptibility to negative peer pressure and role models, low levels of personal skills, lack of nurturing, poor relations and relationship skills, mixed or confused knowledge about growing bodies and their needs, inappropriate mastery and control issues, distorted or non-existent help seeking, limited problem solving, negative coping strategies, lack of bonding, and poor parenting. These in turn help to facilitate yet more adverse risk behaviours.

Intervention efforts and preventive strategies based on the Risk, Resilience and Vulnerability Model can work with this adversity, and work to support positive risk behaviours, which depend on the development of these aspects, also extrapolated from the paper (RP 42): self-esteem and confidence, dealing confidently with peer pressure, effective personal skills, good attachment and bonding, being knowledgeable and informed about bodies and their needs, having appropriate mastery and control, help seeking, problem solving and positive coping strategies. These contribute to the making of informed choices and they feed back into the further development of positive risk behaviours of the parent and the child. To use the language of the model, these efforts and strategies are respectful of the dynamics and inter-relationships to be found between risk, protective factors and resilience.

None of the foregoing constitutes an argument for undermining the grounds of intervention to remove a child (or an abusive parent) from a situation judged by health, social work, educational or law enforcement professionals to be seriously injurious to the welfare of a child, or for a child or a vulnerable adult to be casually left in circumstances that could be potentially harmful. The arguments and guidelines I have set out in my publications (RP 1; RP 4; RP 15; RP 16; RP 51), and elsewhere in this review, should make it plain that I am talking about planned and responsible risk taking. Further, I have in some of my publications sought to emphasise the critical importance of the early years of a child for his or

her social, emotional, physiological and neurological development (RP 41; RP 42; see also Perry 2002). This points up the pressing need for thoughtful and effective intervention and investment in the early years age group (RP 41).

There are several notable implications of the model, which can be set out here, as they touch on topics addressed in my publications and are mentioned later in this review. The first of these relates to the scope of concerns to do with risk behaviours and their determinants. The pressures on children, for example, can come via pressures on adults through social stressors and so broader determinants need to be taken into account, which the model allows us to do. Second, there are implications for improving the practice of educationalists, social workers and health promoters. They need to be prepared to work with positive models of risk and to better understand how risk is socially constructed and how it is perceived by children and adults. The third implication has to do with how young people can be better supported in positive risk taking and in developing learning skills for dealing with the pressures around potentially harmful risk taking. This argument can be extended to embrace issues to do with eating disorders and negative body image, problems that affect young men as well as young women (RP 49; RP 110). I have contended elsewhere that 'health literacy' programmes have a role to play here, particularly in respect of socially excluded groups, including young people involved in the criminal justice system (RP 59).

Fourth, as we saw above, the model can be expanded in relation to the cycle of adverse risk behaviours with respect to child protection and safeguarding issues, for example, for the consideration of the impact of poor parenting. Parenting support programmes thus have a role to play in relation to working to reduce harmful risk behaviours and boosting more positive behaviours among children and adolescents. Fifth, health promoters, social workers and educationalists are enjoined to take into account, in their theory and practice, the relationships between risk, protection and resilience, which can vary in strength in the transitions that children, young people and vulnerable adults make at different stages of their life.

This discussion has set out the key staging posts in the mapping of theoretical themes of my research publications. How these came to be signposted in the intellectual journey reflected in these publications is now described.

Social policy as socially constructed and politically contested

In my work social policy is conceived of as socially constructed and politically contested. Examples include social policy that relates to 'risk', as contended in my book on risk and risk taking (RP 1) and that relating to 'child mental health', as suggested in my research publications RP 41 and 42. Thus the study of social policy embraces a broad, holistic conception embracing health, social welfare and educational settings, along with the construction of social problems and the development of responses to these problems. This approach was initially fashioned from my postgraduate and post-university experience in the Scottish Office and pursued more coherently as an OU tutor and in my first university lectureship in social policy at Glasgow University, where it gave a thread to both my teaching and research interests. It was later picked up in my consultancy work and my return to university work at Ulster University and Queen Margaret University, and continues to be an overarching theme.

The initial context for this early development was one of a period of major change and restructuring of the welfare state, begun in the late 1970s and continued well into the 1990s. This was described as a shift from a Keynesian welfare state model to a monetarist or Thatcherite model of welfare (RP 128; RP 129; RP 130). These were to lead to lively battles over welfare provision and local spending (RP 108; RP 109; RP 113; RP 124; RP 125). The critiques of the New Right had a profound impact on views of welfare, along with critical pressure for change from social movements involving such diverse forces as women's groups, disability coalitions, and black and ethnic minority organisations (RP 112; RP 115). At the same time, there was unease in the academic camps. This was reflected in the move from 'social administration' to 'social policy', sometimes combined with social work, and sometimes subsumed within sociology. More

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seriously, the social scientific enterprise itself was under question, particularly by a new political administration and an Education Secretary who queried whether 'social science' was indeed a science. Distinctly chilly winds now blew across whole subject and departmental areas, whether it was politics, sociology or social policy. While others were hunkering down in their subject bunkers, I was more interested in looking across subject areas and in the potential of inter-disciplinary studies. What was at stake across the social sciences, it seemed to me, was a search for more rounded and satisfactory forms of social explanation.

The early promise of human behaviouralism and social interactionism (Rose 1962) remained stillborn, particularly as social researchers were increasingly tempted by the agenda of structuralism. However, I began to suspect that structuralist approaches had often thrown the explanatory baby out with the bath water (RP 102). At this time I closely followed the debates in sociology, which was still wrestling with what Alan Dawe memorably called the two sociologies – one of structure, one of action (see Dawe 1978). Till his attention was mercifully caught by the topic of risk, which we come across below, and perhaps less mercifully by that of 'modernity', Anthony Giddens set about tying up sociology in tortuous knots with the inelegantly named notion of 'structuration' (see e.g. 1984; 1991). Finally, for all the allusions made to the thinking of Thomas Kuhn (1962) and Imre Lakatos (e.g. Lakatos and Musgrave 1970), little attention was being paid to what struck me as the principal intellectual challenge of the day, namely the nature and adequacy of social explanation in contemporary forms of social science.

The fashioning of social explanations

I have, therefore, long had an interest in the nature and function of social explanations and the adequacy of explanatory strategies. This has included early attempts to go beyond what I considered to be explanatory failures in the literature regarding the State, as well as forms of welfare provision at national and local levels. This was a postgraduate interest of mine, reflected in my postgraduate papers (RP 126; RP 125), later worked up into manuscripts (RP 112;

RP 113). Initially attracted by general theories of the state (RP 129; RP 130), I was puzzled by what I saw as a double failure in Marxist and non-Marxist explanations alike. The first was a failure to satisfactorily allow for the role of social actors and forms of contention; an example of this was the neglect of social forces in accounts of the development of the modern welfare state out of the Second World War (RP 127). The second concerned explanations of the role and function of the 'local state' (RP 35; RP 128). I grew progressively interested in urban public services and the nature and meaning of local protests in defence of forms of welfare provision. I developed the intermediate notion of local polities as 'repositories of historical demands' (RP 113), inspired by the Spanish writer Manuel Castells (1978) and his ideas on the 'politics of consumption' and on social movements, and the historical perspectives of the likes of the American author Charles Tilly (1978) on the 'politics of contention'. This allowed me to feed my interests in labour history, especially the role of local labour movements in influencing the development of local welfare states, and social geography.

As an aggressive Conservative government set about showing little respect for the autonomy of local electorates or city administrations, I had the feeling I was not going to be disappointed in my Edinburgh base, where I had close links to the action, in part due to my voluntary efforts in the area of community-based welfare rights work and my days as a tutor with the WEA and adult education department of the regional council. My instincts were proved right in a most dramatic fashion, as local labour movements, local authorities and local health agencies in Scotland spent the next decade and a half resisting encroachments by Conservative-led central governments, sometimes in spectacular ways (RP 126; RP 125; RP 124; RP 108; RP 109; RP 105; RP 104; RP 117; RP 113; RP 36). However there were unhealthy backwaters like 'urban sociology', intellectual swamps where lurked crocodiles feasting on the ideas of unwary postgraduates. It was with relief that I escaped to seek the sunnier uplands offered by health and social care studies and the broader range of perspectives to be developed there.

Studies of the politics of consumption and corporatism in relation to social policy and state intervention (see e.g. Cawson 1982) provided a neat link with my

earlier studies. It was ironic that while some in 'urban sociology' at Sussex University had dispensed with the role of radical social forces and simply substituted ownership of housing as the bulwark of a new conservative reality, a claim easily refuted by the results of the 1997 election (and indeed by the current mortgage crisis), the work on consumption by Cawson in the field of political studies at the same university suggested much more promising avenues to explore. However, it did strike me as odd that the biggest 'consumers' of publicly provided services in the UK and in much of Europe – those vulnerable and socially excluded groups comprising people with learning disabilities, people with mental health problems, people with physical disabilities, older people, younger people in care – notably did not feature in these sorts of analyses as meaningful social actors (RP 115; RP 117).

Social constructionist approaches (see e.g. Loney et al. 1987; Walker 1984) held out the prospect of allowing for the role of contention by social forces 'from below', while taking on board policy pressures 'from above' at local, national and international levels (RP 117). Researchers had also begun to address themselves to the distributional impact and redistributional effects of the health and social services (George and Wilding 1984; LeGrand 1982), belatedly picking up on the deliberations of Richard Titmuss (1968). Nonetheless, these approaches and arguments were often conducted at a level of generality, which made them hard to apply, for example, in terms of better understanding policy and service developments on the one hand, and forms of health and social behaviour on the other, all within the changing context of welfare (RP 117).

As I read and reflected on such debates, it became clearer than ever that a core interest of mine was the formulation of satisfactory explanatory strategies in the study of welfare (RP 120, 121). This interest particularly embraces concepts of the 'middle range' (Merton 1968), which include the management of personal welfare, risk, resilience and vulnerability. This reflects a key concern of mine and I have endeavoured to develop intermediate concepts that allow for connecting particular social issues of an empirical nature with theoretical themes. This interest started in my postgraduate studies (RP 113) and continued in my

research fellowship days at Stirling University (RP 120, 121). I helped to develop some of the themes and interests of the Social Work Research Centre in its early days, which had been set up in the context of concerns about the effectiveness of social work services. As far as I was concerned, the question 'is social work effective?' could not be answered without first considering what I termed the 'epidemiology of social and personal problems' (RP 120) and their translation as presenting risks for social workers, health care and housing support staff to deal with.

A core theme has been developing a theoretical purchase on what C. Wright Mills (1959) fruitfully called the distinction between personal troubles and public issues. I have long been intrigued by this distinction and the interconnections between issues in the private sphere and those within the public sphere. This interest can be seen, for example, in my contribution to a book of that name, published in the late 1980s (RP 12). This piece developed this theme in relation to personal social services and the difficulty of satisfactorily gauging the effectiveness of these services for the poor and disadvantaged groups in a welfare society. In many ways welfare professionals, such as social workers, straddle this uncomfortable distinction and have to deal with competing views on how to resolve the contradictions that are thrown up. It is my view that issues associated with 'risk' and 'risk taking' provide the flashpoint for contention arising from contemporary forms of this distinction, an angle that I explore in later writings such as in my book on risk in health and social welfare (RP 1; see, for example Chapter 1).

There has also been an interest with the causal mechanisms affecting the 'epidemiology of social and personal problems' (RP 120). Mills caught my imagination as an undergraduate with the clarity of his writing. He is oft quoted but few have stayed to ponder more deeply on the distinction he drew. It occurred to me that if we are to develop preventive strategies for social policy and social work, we need a more informed understanding of the origins and development of particular personal and social problems, and of the role social policy and social work efforts have to play in tackling such problems. I argued

for a much more disaggregated approach to social problems, particularly for a focus on the intermediate processes that provide the links between the individual and society. Directions for research were also suggested and these are discussed in the methodological section.

One difficulty I faced at this point in my research career was that the argument I was conducting was at quite a high level of abstraction and my thinking on these complex matters was still at a preliminary stage. This began to be more sharply focused on particular issues as I sought to get deeper into this. This surfaced in the following forms.

Social policy responses

One was an interest in welfare issues and the provision of health and social services in their diverse forms, and what shaped these forms. Thus I was interested in the various factors that came into play, both policy factors and broader social forces at local and national levels. It struck me that both were necessary for a more complete understanding, and many writers simply focused on one or the other. There were, as noted, conceptual difficulties to do with the 'welfare state' in its local and national manifestations (RP 112; RP 113). This was also reflected in my interest in the evaluation of forms of welfare provision, such as social work services, a theme of my research at the Scottish Office and university posts early in my career (e.g. RP 47; RP 118; RP 119; RP 121).

Another was to do with the 'nation state' and its meaning within the context of the United Kingdom, a political entity consisting of four different nations: England, Wales, Scotland and Northern Ireland. Different trajectories of development for welfare provision were being pursued. Thus I explored the meaning of 'community care' in different contexts, with a special consideration of the Scottish context (RP 11; RP 27; RP 97; RP 114). These themes were taken up later (Titterton RP 5; RP 61).

The context here was one of the growing debate on devolved power within the UK, particularly in Scotland, Wales and Northern Ireland. This was given a special twist in the latter, where I worked in 1998 and 1999, with the efforts to find a peaceful settlement. The arrival of the Major administration signalled a key shift and willingness to broker a peace, a theme picked up more vigorously by the new Labour Government after May 1997. This period saw the arrival of the Scottish Parliament and new executive, as well as the Welsh Assembly. Thus a new context for social policy was established (RP 61). The scope for different policy outcomes in the four countries was enhanced, with their different welfare mixes and forms of welfare pluralism. The role of the independent sector was again underlined, but with different emphases, for example, in Scotland and Northern Ireland. The role and potential of the voluntary sector was to be an important theme in my research and consultancy work (RP 6; RP 20; RP 22; RP 55; RP 71; RP 74), a theme that continued into the new century (RP 43; RP 69). This thread, and that of welfare pluralism, is picked up again below.

The third was to do with the nature of vulnerability and risk in welfare settings. It seemed to me that these concepts allowed for a purchase on the "epidemiology" of social and personal problems. It could also facilitate a more disaggregated approach to social problems, with a focus on the intermediate processes that supply the links between the individual and society, in which I had been interested earlier. In addition, "risk behaviours" began to attract my attention more, because these bring sharply into focus the interplay between structure and action, context and vulnerable states. This was picked up later and I return to this theme further below. One problem researchers faced was the restricted understandings of vulnerability and help seeking, and it is to these themes that I now turn.

The context for these issues is rather more complex and aspects of it are described below. However two principal factors can be pinpointed here. The first is the transformation of agendas from the Thatcher and Major administrations through to the Blair governments, with their continuities and discontinuities (see e.g. Hutton 1996; 2002). The former include a growing consensus on the need to

reform the legal and formal processes governing the welfare of vulnerable children and adults, while the latter include a drive to incorporate human rights concepts into UK law. The second relates to changes in perceptions of governments, public agencies, welfare professionals and academics of rights, responsibilities and risks, and how these interact. It is one of those intriguing paradoxes that just as views of 'risk' were becoming restrictive, views of vulnerable people were shifting towards supporting their rights (see also RP 1, especially Chapter 2, for a discussion of elements of this shift). This arose in part due to partial definitions and understandings of risk and vulnerability and it is to this that we can now turn.

Vulnerability, risk and resilience

New understandings of vulnerability and welfare

These lines of thought were then developed in work conducted on behalf of the Economic and Social Research Council while I was at Glasgow University. I was responsible for working up a new paradigm for welfare research. The background for this work is interesting to note, and it also provides part of the broader backdrop for some of my other research publications.

The request came at a time when a major initiative for welfare research had been rebuffed. In brief, it was in part due to a climate that was hostile to traditional notions of welfare, public expenditure, and in part due to a dissatisfaction with provider agendas and resource-led concerns, and to the perception in certain quarters that the independent and informal sectors of welfare were being overlooked. One reflection of this concern was the critique of state welfare approaches, developed by the likes of Hadley and Hatch (1981) and Johnson (1987). Despite critical reviews by e.g. Beresford and Croft (1984), this critique had a powerful resonance, and tied in with a search for a wider range of welfare options evident in the inquiry into community care by Sir Roy Griffiths and the inquiry into residential care by Lady Wagner (for an extended discussion see RP 11). Other influences came from the critiques of the New Right and market

choice (see RP 95; Green and Lucas 1992) and an increasing assertion of the role and potential of informal and voluntary welfare, a movement that was to grow more vociferously throughout the 1990s (RP 6; RP 20; RP 22; RP 85; RP 88; see also St. Leger and Gillespie 1991; Davis Smith et al 1995; Royal Commission on Long Term Care 1999). This will be referred to again later.

It was indeed a daunting task to work up a research paradigm that would somehow accommodate these emerging agendas and, perhaps most critically, would not fail to win substantial funding. It was possible that another failure to launch a research programme would lead to the closure of the welfare research programme in its entirety.

I sought to meet concerns and criticisms of prevailing models of welfare and to develop further some of the pressing theoretical themes that I had been developing earlier, which struck me as valuable and highly pertinent themes for myself and other researchers to explore.

The new paradigm for welfare research

My argument was that one of the reasons that welfare researchers were struggling to engage successfully with emerging agendas was in part due to a fundamental explanatory failure. There were, in my view, parallels between competing ends of the political spectrum, which had both failed in their attempts to conceptualise welfare problems and difficulties on the one hand, and how individuals actually responded to their troubles on the other. There was a tendency to fall back on very limited perceptions of human agency, and restricted notions of vulnerability. The differential nature of vulnerability and of risk, and how creative human agency responded differentially to welfare problems, was being neglected. This applied across vulnerable groups and across the lifespan. The upshot of this was that very limited and partial conceptions of welfare models and welfare provision were being advocated across the political spectrum.

The argument in full is discussed in my paper for the ESRC (RP 103) and main points summarized in the article in the Journal of Social Policy (RP 26). However some of these points may be briefly noted here, as they directly impinge on the subsequent theoretical issues taken up in my later publications. These are the critique of the pathological view of health and welfare, the notion of the 'welfarised person', the treatment of vulnerable groups as unitary constructs, the failure to accommodate sociological models of the life course, and restricted conceptions of vulnerability and help-seeking behaviours.

A principal argument was advanced that needs to be noted at this point. This is the critique of the hidebound and limiting conceptual approaches, which affected the vocabulary that was used by welfare researchers. The constant search for a social pathology meant that the crucial mediating structures interposed between individual and wider social forces were being ignored. This was an argument first rehearsed in RP 120 and extended further in RP 12. On the one hand this meant that the notion of the creative, self-reflexive individual, creating his or her own structure that then constrain choices, was being rejected; on the other, it meant the earlier rejection of individual pathologies also left a key explanatory gap. The individual/social antimony and the structure/action divide had combined in dominant models of welfare research to produce an explanatory stasis. Adding to this the favoured focus on 'statist' models of welfare provision meant that welfare researchers and social policy writers were in danger of being left in a conceptual cul-de-sac, out of touch not only with developments in other social scientific fields but also with political developments.

By shifting foci to look at how individuals cope with adversities throughout the life course and by taking advantage of advances made in other disciplines such as social psychology and social psychiatry, a new approach could be put forward. This would be sensitive to the heterogeneous nature of vulnerability and risk. The new focus should be on, as indicated in the discussion at the outset of this chapter, the differential nature of vulnerability and risk among individuals, as well as differentiated reactions to threats to welfare. These reactions and responses would include the use of personal and informal

resources, and the deployment of social forms of support. The new paradigm would identify threats to welfare, mediating structures, and outcomes. There would be a role to consider determinants of a structural nature, enduring difficulties and life events, and how responses come to be informed by access to different forms of material, social and personal resources. It encouraged a concern with more than those vulnerable people who come into contact with welfare agencies. Those who are vulnerable but who are not in contact, and those who do well despite stress or disadvantage, or so-called 'invulnerables', also deserve our attention as social scientists.

Five guiding questions were posed for researchers to follow, relating to stressful circumstances, coping strategies, their relation to the welfare state, what professionals had to learn from these, and what were the most effective ways of responding, including the use of statutory, voluntary, market and informal resources.

These arguments and the proposals I drew up for the ESRC were well received. Not only was a new welfare research programme passed, but another agency in the form of the Joseph Rowntree Foundation also came on board to jointly fund the programme. This joint ownership was very important for the broader acceptance into the wider, non-academic community. It was judged a success, with valuable research projects completed and well evaluated. I was involved in the follow-up evaluation for the ESRC with Helen Smart (RP 76).

As well as setting a new research programme, these assumptions and questions have helped to set out my own trajectory since. The concepts of vulnerability and risk could now be examined in different settings and applications. It occurred to me that a key mediator was that of risk, and particularly the taking of risks, as a way of coping and a way of linking the individual to broader processes. Risk behaviours, including those that troubled researchers, policymakers and service providers alike, were one form of the manifestation of this. The failure to see this meant many things; one such was that health promoters and social care providers were often left alone to struggle with risk;

and sought to avoid it, rather than embrace risk and work with it. This line of thought struck me as a particularly fruitful line of inquiry to pursue.

Risk and Risk Taking

'Risk' therefore began to take shape as a concept worth exploring in greater depth, particularly as this featured in my work with social work departments, health agencies and voluntary sector organisations in the early to mid 1990s. This included work in remote and rural locations in the north and west of Scotland; this is explained further in the section on empirical focus. This coincided with the growth of interest in "risk" as a topic of social scientific inquiry, with the appearance of Ulrich Beck's The Risk Society (Beck 1992), which prompted Giddens and others to examine it further (e.g. Giddens 1998). This background and problems are discussed in my book, *Risk and Risk Taking in Health and Social Welfare.*

Risk thus became a key focus for my work and theoretical development. It forms a useful intermediate concept and is a valuable way into understanding changes in welfare and health behaviours, as well as signifying broader changes in societal and organizational cultures in health and social welfare. It is evidently a major concept for the Welfare State and the provision of forms of help and assistance.

In my work a more socially constructed conception of risk, and risk taking, has been called for, one which moves beyond the discourse of the 'Risk Society' set out by Ulrich Beck in his publications (e.g. Beck 1992). The German sociologist and his adherents have set out a compelling vision of contemporary societies dominated by new concerns about risk; indeed risk replaces social class as one of the key motors of social and political change. This argument can best be seen in the context of the massive environmental problems raised by the Chernobyl incident and it has proved valuable for looking at apparently discrete issues such as BSE, HIV / AIDS etc (Franklin et al. 1998; Adam et al. 2000). However there are three central difficulties with this argument. First, countries such as the USA and

the UK can be arguably seen as becoming 'Risk Averse Societies', where risks are sought to be avoided at all costs. Second, the implications for the health and social services have been far from clear in Beck's analysis, which was largely limited to environmental risks. Third, Beck and his followers operate with limited and partial conceptions of risk, failing to address its more positive features.

However it was clear to me that there have been major definitional issues affecting our perception and understanding of risk, with serious consequences for those working in health and social services, and those receiving those services. There have been widely prevalent understandings of risk and risk taking, which are very negative and constrained. These have directly affected both policy and practice in the welfare state. By developing an appropriate conceptual response, it has been possible to recast risk work in a more positive light, and develop more empowering approaches with vulnerable groups.

This has involved critiquing existing approaches in the academic and professional literatures, at different levels of the debate, from Beck's high theory to the more prosaic concerns of social work researchers and practitioners, to focus more sharply on positive risk taking.

The argument was that while limited definitions and understandings of 'risk' abound in policies and in the academic and professional literatures, we need a much more positive definition. This will help not only to overcome defensive practice but also to improve the quality of care provided, and enhance the quality of life experienced by vulnerable people. It will also, with respect to my contention earlier, have the effect of valuing the 'invulnerables' and the 'resilient' more than has been the case so far. An additional problem was that for all the masses of literature on risk, few writers had sought to define 'risk taking' as such. So part of my argument was that we needed a decent definition that helps capture this more positive construction. Thus I came up with the definition quoted earlier, namely that risk taking is a course of purposeful action based on informed decisions concerning the possibility of positive and negative outcomes

of types and levels of risk appropriate in certain situations (RP 1). The significance of this definition – that it is purposive, informed, appraising and boundary setting – has been discussed earlier.

The positive conception of risk and risk taking, and the critique of negative definitions have provided a way forward for researchers and writers in health and social welfare, as well as pointing to a more progressive practice. However there was another problem with the professional and research literatures, namely a lack of certainty about what factors were important in determining how welfare professionals such as social workers made risk decisions, and this was reflected in the preparation of risk assessment tools that were often of a 'tick box' nature and that failed to encourage the welfare professional to dig behind the presenting problem.

I therefore proposed the concept of 'welfare dilemma' and suggested this definition:

> 'A welfare dilemma involves choices that welfare professionals, vulnerable people, their informal carers and their communities face between options that entail possible benefits and possible harms. These choices may be equally acceptable but their outcomes essentially remain unknown.' (RP 1, p. 50)

My argument was that what lay behind many risk situations, and the problems which welfare professionals are presented with, are welfare dilemmas, which should form the theoretical (and indeed practice) focus for understanding and intervention by welfare agencies. I further contended that practitioners needed to be developing their skills, knowledge and understanding of welfare dilemmas, as a way of boosting their confidence in dealing with risk scenarios.

In addition, the principles and elements for enlightened risk assessment and risk management have been discussed and set out in my book (RP 1). These, and the preceding arguments, are drawn together in my Person Centred Risk

Assessment and Management System (PRAMS) model. In their recent review, the authors of a Social Policy Research Unit paper commissioned by the Department of Health (Mitchell and Glendinning 2007) discuss two of my research publications (RP 1 and RP 4). They point out, *inter alia*, that my PRAMS model is a 'standardised and comprehensive model of practitioner risk assessment that is also flexible and relevant in different organizational settings and types of agency' (op. cit. p. 58).

These points are picked up again in the section on empirical applications of my work.

Combining vulnerability and risk

I was interested, moreover, in exploring what would happen when one combines concepts of vulnerability on the one hand, and those of risk and risk taking on the other. The problem is that there are limited conceptions of risk in relation to e.g. children and young people, including children of early years. This was related to research work conducted for Health Scotland and the issue of mental health promotion in the early years. I was responsible for leading the research and for writing up the papers, with inputs from colleagues Helen Smart and Malcolm Hill, who assisted with the reviews (RP 62; RP 41; RP 42). The context was provided by a widespread concern that the mental health of children and young people was being overlooked in policy and practice, and this was particularly the case for the early years group. Health promoters and other professionals were unsure about the rationale and effectiveness of prevention and early intervention efforts.

The argument was that there was a lack of conceptual clarity in respect of the early years group of children, particularly in terms of their specific characteristics, needs and their attributes. There was also much uncertainty concerning the evidential basis for welfare interventions and concerning genuine gaps in academic knowledge. This in turn meant that there was a lack of development of suitable frameworks and policies for the early years group.

It was further argued that the concept of mental health of children is contested, in line with my contention about the social construction of social policy earlier. In addition, a broader and more positive conception of mental health and well-being has to be promoted, along with a recognition that mental health for this age group is both multi-faceted and multiply determined. I was keen to place the child's creative abilities to cope with adversities and stressful life events at the centre of the picture, in line with my earlier arguments above. My earlier concerns about the links between risk and resilience were brought to the surface, but to this was added the notion of 'protective factors'. These factors affect the vulnerability of the individual child; in turn they can have either an enhancing or reducing effect, and this then can lead to either positive or negative outcomes in terms of the child's mental health.

Again in line with my earlier arguments about the new paradigm of welfare, this approach allows for the study of the key determinants, mediating factors and outcomes. A difference here is that a distinction was made between immediate outcomes (e.g. in relation to the current well-being of the child) and eventual outcomes, or the long-term well-being of the infant.

The final contention I made was that the case for making preventive and early intervention efforts had been well established and it was now time for researchers to move on to focus on interactions and processes associated with risk, protective and resilience factors. This was, on the face of it, a brave argument to make, since it called for a bolder affirmation of promotion and prevention approaches, and called for researchers to forego their time-honoured obsession with lengthy lists of risk and protective factors, and to look instead at mechanisms and links that underpin such factors, as was mentioned earlier.

Further development of middle range concepts

The challenge of developing concepts of the middle range needs to be picked up in a more determined fashion by social scientists. This is what I have sought to

do in my theoretical work. They are intended to fit between the grander concepts of social policy and social work, and the more grounded concerns of policymakers, practitioners and users of welfare services. The concept of managing threats to welfare, as well as the concepts of risk, risk taking and vulnerability, are designed to meet this challenge.

This argument was made in my article on social policy in Russia (RP 14). The contention there was that if we are to make sense of the challenges and changes in a country as complex as the Russian Federation, with its new forms and patterns of social exclusion, then we need properly worked-up middle range theories and concepts. It was suggested that the management of personal welfare, for example, would be a very fruitful approach to examine further within the context of Russia, and indeed Eastern Europe, due to their rapidly changing social, political and economic structures.

These themes feed directly into other research through my research career, as well as in my consultancy and developmental work. This includes work in the field of mental health and young people, and in Russia and in the UK too.

Finally, these themes have been pulled together in my Risk, Resilience and Vulnerability Model, set out on page 6, that provides a valuable heuristic for addressing the diverse factors that link together to form processes, which either enhance resilience, or enhance vulnerability. This is applicable to a wide range of 'risk groups' and forms a handy example of how the theoretical motifs of my research career to date have formed a coherent whole.

In the next chapter, I move on to discuss the principal methodological features and developments contained within my research publications.

Chapter 2   Methodological approaches

As I stated in the introduction, my work has involved the development of methodological approaches, in order the better to enable my research into vulnerability, risk and resilience in socially excluded groups and communities, along with social policy responses and forms of welfare provision. This has included both quantitative and qualitative techniques (including, for example, combined quantitative and qualitative indicators of risk and need).   In this chapter, emphasis is given to some of the methodological innovations I have developed in the course of my research, as contained in the research publications under review.

Methodological approaches

Throughout my research career, I have been involved in using both qualitative and quantitative methods, and at times attempting to combine them. I have been acutely aware of the debates and strongly held beliefs of both camps, and duly studied the philosophical and epistemological thinking behind both methodological strategies. Researchers were usually invited to pin their colours to their associated poles, whether they be that of Positivism, or that of the allegedly opposing *Verstehen*, an invitation that appeared to me to be less than helpful. I have typically regarded qualitative and quantitative approaches not as opposing, but as complementary. This is particularly the case in the applied research I have been involved with. Thus my research publications have drawn upon both approaches, sometimes combining them (e.g. RP 99; RP 97; RP 70; RP 71).

In terms of the relationship between theory and research, I grew progressively disenchanted with the explanatory failures of what, as we saw in the last chapter, Mills (1959) called Grand Theory, irrespective of whether they arose from contemporary forms of Marxist, Weberian, Functionalist, Symbolic Interactionist, Phenomenologist and other meta-perspectives. These often generated inflated and frankly untestable hypotheses, which rendered much of any emerging methodological debate about how to proceed to empirical study rather redundant. It was discouraging to note that this divorce between theory and research had re-emerged in the works of present

day writers such as Giddens, a tendency criticised in a thoughtful contribution by John Goldthorpe, who has sought to explore the links between theory and research, and what he calls 'numbers' and 'narratives' (see e.g. the introduction to Goldthorpe (2000)). 'Theory ought to create the capacity to invent explanations,' Stinchcombe (1968, p. 3) tells us. Instead, the satisfactory development of explanations, accompanied by the fashioning of appropriate research strategies and methodologies, has often been pre-empted by theory pitched at too abstract a level.

My own interest lay in more disaggregated and lower level approaches, away from Grand Theory, broadly in line what would be later be termed as 'postmodernism' with its rejection of general theories (Corbetta 2003). However I did not subscribe to the postmodernists' rejection of rationality, or of planned intervention in society, or even to their ditching of the role of general theory *per se*. Much of the writing I admired, such as that of Isaac Deutscher (1958) or Edward Thompson (1968), had been inspired by Marxist perspectives, but not all works written from the point of view of the latter had the subtlety and finesse of those by these authors. On the other hand, much of the empirical research I enjoyed reading flowed from the pens of those whose work I had been asked to consider deficient, due to its 'atheoretical nature', such as that of the adherents of the Chicago School. The latter were not lacking theoretical bases, in my view, but rather wore their theory lightly. The joy of investigating the empirical world, and developing suitable research methods, tended to shine through these writings. One such author was Bill Whyte (1943), whose work is mentioned below.

My career began with an interest in qualitative approaches, such as interviewing and forms of participant observation, along with an intermittent interest in grounded theory (as expounded by Glazer and Strauss (1967), before the pair apparently fell out over the direction of grounded theory in the early 1990s), and a more lasting concern with various forms of ethnography. I found I was inspired by re-visiting 'classics' such as Street Corner Society (Whyte 1943), with its lively take on the social composition of an underprivileged community. Another was *Folk Devils and Moral Panics* (Cohen 1972), which used mixed methods and provided an intriguing account of the social amplification of an issue (hence its citation in my book

on risk, RP 1). David Hargreaves's (1967) study of social relations in a secondary school also uses a similar mix of methods, which provides a differing approach compared to Paul Willis's (1977) innovative study of disadvantaged youth. (The latter's complicity in their own subjugation continued to ring many bells as I studied young people at risk in Russia; cf. RP 14). This return to the 'classics' has helped infuse me with fresh enthusiasm and I have attempted to communicate this to students and researchers alike. (In a series of research methods lectures I gave recently I discussed such texts and encouraged the audience to acquaint themselves with them).

More recent texts that have given me inspiration have an American flavour and include Robert Putnam's influential Bowling Alone (Putnam 2000), Anne Campbell's study of girl gangs in New York (Campbell 1992), Schultz et al.'s research into health partnerships in East Side Village (Schultz et al. 2002), and an intriguing study of Native American communities and their health issues (Christopher et al. 2005). One of the themes that link such studies together, moreover, is that of community involvement and participation in research, and this theme was to remain with me, to be revived in a particular methodological approach discussed below.

When I worked in the health and social work services, I used quantitative approaches as well and I learned techniques that would prove useful later. I developed indicators of risk and need, poverty indicators and indicators of effectiveness for both health and social service settings (RP 40; RP 102; RP 103). This interest was picked up from time to time later on in my career, in applied consultancy research. There was a fascinating lesson for me about how the methodological approaches I studied at university have their limits and constraints in policy and practice settings. I had to learn to adapt fast and make do with methods which, while not exactly 'quick and dirty', could produce prompt results for policy purposes. There was often simply not the time or space to undertake grander studies, which might have yielded more robust results but which would have missed the boat in terms of a particular policy concern. There is a fine balance between retaining an emphasis on quality in one's approach and sacrificing this for the sake of a quick win, and this is a perennial issue for policy researchers.

Then, in an interesting contrast, I worked in the Social Work Research Centre at Stirling University, and was given relatively free scope to develop methodologies suitable for the social care and social work services. Here I was expected to produce high-quality research. Qualitative developments included the field of evaluative research. I developed approaches and guidelines for evaluative research in social work (RP 116; RP 118; RP 121). My work on the evaluation of social work services for the poor (RP 12), and my guidance for those working in mental health services influenced both researchers and practitioners (RP 118).

Throughout the 1990s I continued to develop both approaches. Quantitative indicators were combined with qualitative indicators in my innovative research for Lothian Health, a study of East Lothian and Midlothian (RP 70; RP 71). This study was commissioned and got under way in 1998, and mixed a quantitative approach with qualitative measures of need and risk, including key stakeholders' perceptions of needs in their area. The data consisted primarily of needs indicators and was analysed on a comparative postcode basis, which permitted the mapping of the data. It was also analysed alongside the qualitative perceptual data, which was then used to structure the evaluation of the quantitative information. The reports were published in 1999 and were well received by the health board and by local groups and agencies functioning in the respective study areas.

I developed the notion of 'secondary needs analysis', which proved useful for government and local statutory bodies charged with uncovering the needs of local populations and local areas (RP 82; RP 70; RP 71; RP 123; RP 97). I also investigated statistical tests to demonstrate the degree of error involved in these estimations of need within local populations and localities. In these studies the data was typically analysed and grouped up into pre-selected categories for particular needs indicators, supported by appropriate statistical methods. I usually tried to resist letting the statistical testing run the analytical show; rather my approach was that the choice of statistical technique should be determined by the aims of the study (e.g. RP 122; RP 123; RP 70; RP 71; RP 94).

I also gathered primary data and conducted unusual secondary analyses of a range of datasets, gleaned from knowledge gained in health and social services research for government agencies (RP 117). This was tied in with my interest in 'consumption', changes in the context of welfare, and the distributional and redistributional impacts of social policy, mentioned in the previous chapter. I was pleased with the unusual data I had gathered and analyses I had conducted; this included, for example, the analysis of health and social welfare data according to pre-selected categories such as social class, socio-economic group, income group and so on. These raised questions about the arguments that researchers such as Julian Le Grand (1982) and others had made about how it was principally the middle classes that benefited from the welfare state and made best use of it. My analyses showed that the working class and lower socio-economic groups made more use of welfare state services than was alleged to be the case, and indeed that expenditures on the welfare state had substantially risen in real terms, contrary to what was often claimed (RP 117). Le Grand, whose clarity of argument and writing I much admired despite my disagreements, was to cautiously revise some of his thesis some years later, as did some of his colleagues (see e.g. the collection by Hills 1991). Nonetheless, the ambivalent attitudes by social researchers towards the British welfare state, which was always claimed to be in crisis, has left it in a rather friendless condition at times.

In terms of qualitative approaches, I continued to develop evaluative research methodologies, with a focus on vulnerable people and appropriate forms of welfare provision to meet their requirements. This work included studies of respite care for people with mental health problems (RP 63; RP 72; RP 50); this involved innovative work in conducting focus groups and surveys among people with mental health problems and welfare professionals. In these studies data was gleaned from semi-structured individual interviews, structured questionnaires with open and closed questions, and focus group interviews. This was analysed within a 'pluralistic' approach (RP 101; RP 118) where the perceptions of those using mental health services were treated as valid constructs, and compared to those of the referring agencies.

Latterly I have revived my interest in qualitative methods, which are particularly relevant to researching vulnerability, risk and resilience among socially excluded groups, and social policy responses. This is reflected in the selection of research publications chosen for this review. It has been most interesting to be involved in this sort of research, where it has been possible to devise, pilot and refine techniques, such as those discussed below.

My strategic approach to qualitative data analysis has been informed by these themes and the theoretical issues described in the previous chapter. Thus the analysis of data has been driven not by the methods and techniques simply available at the time, but by the aims of my research and the core motifs flagged up throughout these chapters. This is described below in the discussion of two methods I have been involved in developing, the Facilitated Discussion Group Method and the Participatory Research Method.

Facilitated Discussion Group Method

One of my foci of interest in qualitative techniques arose from a concern with developing approaches that were more effective at engaging with research respondents and working with them in group settings to explore health and welfare issues. This included both providers of health and welfare services and those who used these services, including those socially excluded groups who were confronted with risk situations.

To this end I pioneered the development of the Facilitated Discussion Group Method, which is an elaboration of the focused interview (Merton et al. 1990). This particular method arose in the course of research conducted on behalf of HEBS into partnership approaches in health promotion in the voluntary sector (RP 43; RP 69). This was developed and tested throughout 1998 in rural and urban settings, with a range of professionals and managers from different disciplines and agencies, from the statutory and independent sectors.

This approach allows, *inter alia*, for the facilitation of perspectives of vulnerable and excluded individuals to discuss their issues, including risk behaviours. This method is designed to draw on participants' practical and

strategic experiences and to develop some collective wisdom by encouraging an exchange of views. The technique is an elaboration of the focused-discussion interview, but with a greater emphasis on information sharing, both between participants and by the group facilitator. It also permits agenda setting, identification of priorities and exploration of solutions.

The Facilitated Discussion Group Method is intended to provide:

- a conducive environment for participants
- a clear framework for discussion
- agenda setting by participants
- identification of key issues
- suggested solutions
- priority setting by participants
- examination of policies/exemplars, etc
- record of discussions

A key aim of the research was to bring together people from different areas in order to discuss what was happening in their areas and to interact. Participants included representatives from each of the main stakeholders such as health boards and health trusts, local authorities, and voluntary sector agencies. The researcher-facilitator had to work closely with participants, facilitating the discussion and helping them to forge a common agenda and priorities for taking forward issues for the development of strategy. A key feature of this method was that it provided participants with the opportunity for learning about each other's perspectives. They were brought together for the FDGs in Bruce House in Arbroath and in the Haughdale Hotel in Inverness, as well as other locations in Scotland.

The strategic approach to data analysis can be described as follows, and is described in the full research report (RP 69), on which the journal publication (RP 43) was based. The emphasis was on extracting key issues emerging from the perceptions of participants at different stages of the research and using these to help structure the analysis of findings. These could then be grouped up into core themes and compared across different backgrounds and characteristics where service users were involved or different sectors, where

professionals were involved. This also helped act as a check on any possible bias that was emerging from any particular sector, such as the health sector.

The interviews were taped and analysed on this basis. Findings from the interviews were used to guide the next stage of the research, namely the conduct of the Facilitated Discussion Groups. The results of the latter were recorded on flipcharts and analysed after each event. Thus key themes were continually extracted to guide the strategic conclusions and recommendations, which were in turn fed back to respondents across health, local authority and voluntary sectors.

Reflections on the Facilitated Discussion Group Method

The advantages of using the Facilitated Discussion Group Method are that it is deal for facilitating the exchange of practice knowledge and information among participants, working to a shared and agreed agenda. This method is valuable in qualitative research settings, especially for bringing a group of participants together and working with them. It is particularly useful for partnership settings, but also for vulnerable people, especially as it uses a more structured format than traditional focus groups.

The method can work well with welfare professionals and with users of services and young people, to address risk behaviours and shared solutions of how to address these behaviours. However in international settings such as Russia this was not so easy, due to language and some cultural differences. While the author's Russian language skills improved over time, at the time this work was first carried out it was necessary for translation facilities to be available for the sessions and informal discussions. Different cultural expectations and behaviours apply too, in countries like Armenia, Bulgaria and Russia; for example, there is more of a culture of polite listening and less willingness to be outspoken. However this can be overcome by icebreakers and games and by building up trust between the researcher/facilitator and the participants. The choice of research venue is an important consideration, as participants can find particular locations intimidating or uncomfortable, or not conducive to involvement and sharing.

A possible disadvantage is that it is a group process and therefore there is not the time to spend too long on individual cases in great depth, though it does encourage participants to speak up and talk about their own knowledge and experiences. Such examples are very useful for others to consider. There is also an issue about sharing information publicly and potential confidentiality issues. However these can be tackled by being open and frank and by agreeing ground rules about the session and about information sharing.

Another limitation is the potential for bias to affect the perceptions of participants, or their interpretations of their own situation. This type of bias may be more difficult to spot and to address where participants are professionals immersed in their own 'assumptive world.' Researchers should therefore be alert to this and make allowances accordingly. The strength of the method is that it makes space for an exchange of perceptions between participants coming from different backgrounds, including various professional backgrounds. The researcher/facilitator can use this to encourage participants to reflect on where they are coming from and on the different value bases there may be around the table. The method can therefore encourage participants to be aware of their own biases and how these influence their responses to particular issues. In the case of the statutory and non-statutory stakeholders involved in the health partnerships research, it was instructive to note how beneficial participants found it to compare and contrast different viewpoints on an issue of concern (such as joint funding agreements or competing policy agendas). Again, the point made above about the need to facilitate honest and open exchanges is an important one.

Participatory research

My interest in developing participatory approaches has arisen in relation to the core research themes of vulnerability, risk and resilience and social policy responses outlined earlier. If we are serious about understanding disempowered and excluded groups and communities, we need to develop methodological approaches that are both robust and innovative, and capable of generating quality research when working with people in collective settings. Traditional methods have their strengths but they have

disadvantages too, particularly in relation to involving the subjects of the research in meaningful ways. They are typically individualist and treat the subject as a 'research object', something to be studied almost as in a laboratory setting. They are also researcher-led and often have to do with the researcher's own agenda; in this sense in can be all too easy to neglect the agenda of powerless groups and communities, or to make unwarranted assumptions. Power relationships and the status quo can also be left unchallenged by traditional approaches.

In order to meet this challenge, participatory research approaches have been developed in the course of my work. This has been the case in research conducted in diverse settings with some excluded and marginalized groups and communities. This has included young people at risk in Moscow, and community groups in a deprived neighbourhood in the south-east of Edinburgh, namely Craigmillar.

My argument has been that participatory research has a number of advantages, which researchers would do well to heed. In the article, RP 38, these strengths of the method were mentioned. First, local knowledge, expertise and resources contribute significantly to the success of research. Second, collaborative partnerships can be mutually beneficial in relation to education and the acquisition of skills. Third, results of participatory research are applicable beyond the community being researched. Provided the challenges are not underestimated, participatory research remains an approach that merits the attention of researchers and workers in the field of community development.

Participatory research can be characterized as an approach where there is meaningful involvement by communities, which are usually lacking in power and which can be enhanced by the research experience. In the research paper, community-based participatory research was defined as:

'the process and outcomes of the active participation of community members and which involves the mutual exchange of skills and knowledge between researchers and the community' (RP 38, p. 54).

This definition allows for a range of different methods and techniques to be deployed. It also means different settings can be used for participatory research, including community, institutional and street settings (e.g. health promotion). I believe this clarification to be useful for researchers and a helpful contribution to the literature.

The research study conducted in Craigmillar was participatory from the outset. This was in keeping with the ethos of the community project, in line with the principles of community development, to involve service users in all aspects of Project activities. The intention was to engage users and to discover their own experiences of health and to use lay people as researchers. Lay researchers were employed to conduct the community interviews; we thought it more likely that people would respond to someone they knew. By involving users in evaluation it was hoped that a sense of ownership would be fostered and provide the opportunity for people to develop new skills.

The approach to data analysis for this research was very much in keeping with this participatory ethos (RP 68). Users were therefore closely involved in determining how the data was to be used and analysed, with guidance from the researchers. Data from the survey interviews was collected and analysed according to key topics of concern agreed with the community group. Preliminary findings were fed back for discussion and for checking against the perceptions of the community representatives. In this way, interpretations of the emerging data was guided by, and tested against, community-based understandings. In the same way, conclusions and recommendations were formulated; this helped to spread the notion of community ownership of the research, something that the researchers considered to be important to the success of the project.

Reflections on Participatory Research

Reflection on the experience of conducting participatory research studies raised a number of issues. On the plus side, there were some clear benefits in using a participatory approach for the research. The research was largely instigated and designed by users of the project, facilitated by the researchers. This engendered a sense of ownership and greatly contributed to the ease

with which the study was implemented. Evaluation research that is truly participatory, where local people are involved from the outset, benefits from local knowledge and experiences. Local knowledge was invaluable in determining access to the community and in achieving the target sample of community interviews. The close involvement of service users with all aspects of project management and the obvious value they placed on the project as a resource also contributed to achieving the target users' interviews. Their enthusiasm for the research helped to sustain community involvement throughout. Having a realistic time frame and clear outcomes for the work were additional facilitating factors. Remuneration for the work of community members also reflected the value placed on their contribution. Difficulties of access to research participants in disadvantaged communities have been documented (see e.g. RP 60) and it is probable that greater efforts would need to have been expended in eliciting the cooperation of participants had more traditional research methods been employed. Issues of trust are crucial in research at community level and with vulnerable populations: getting a 'true' picture is more likely if a relationship with the community has been established.

On the minus side, there were some methodological issues. In terms of quality assurance, it was not possible to conduct quality checks throughout the course of the interviews. There may also have been problems of bias in using local residents. Problems can also arise in terms of confidentiality: there may have been a reluctance among some people to disclose certain aspects of their lifestyle to people who may be known to them, however distantly. Finally, participatory research is not necessarily a cheap option: sufficient time and resources need to be committed to ensure a robust design and reliable outcome.

My research is a valuable contribution to knowledge in the field of community development because it is one of the few articles not only to report a piece of research but also to reflect on the pros and cons, and to demonstrate the added value of the participatory research approach.

In the next chapter, I go on to consider the empirical focus of my conceptual and methodological developments.

Chapter 3   Empirical Settings and Applications

In this chapter, the empirical settings and applications of my research as contained in my publications are discussed, along with a consideration of the advantages and disadvantages of these settings.

The empirical contexts

My work has had a range of related foci for empirical settings, determined by the core themes of vulnerability, risk and resilience in socially excluded groups and communities, along with social policy responses and forms of welfare provision. This is in part a reflection of a long career in research, policy and practice that has included work in a variety of related settings in the UK and the rest of Europe, particularly Eastern Europe.

It has long been my contention that the application of middle range concepts, such as the "management of personal welfare", "risk", "resilience" and so on are relevant whatever the context, though some tailoring in their application to specific circumstances may be required. This argument is developed in my publications such as RP 14, RP 26 and RP 44.

This applies irrespective of the policy setting, whether it is the health, social care, voluntary and private sectors, or whether it is institutional or community care settings. Moreover, this pertains to both UK and international contexts; the latter has included Eastern European countries. The argument is that these different contexts and settings can strengthen the design of the research and the validity of conceptual approaches being deployed. In RP 14, it is emphasized that comparative social policy is a valid enterprise, though it is pointed out that we require better intermediate forms of theory.

My work, therefore, has included a range of related empirical contexts and research populations. There is, though, a particular concern with disadvantaged groups and communities, such as children and young people at risk, people with mental health problems, Gipsy/Travellers and young

parents in deprived settings. In addition, there is also a concern with the non-governmental sector and its potential and limitations, along with the changing relationship between state action and voluntary action.

This has allowed for testing of the concepts and methodologies discussed in the previous sections on theoretical themes and methodological approaches. It is these themes that help bind together this range of empirical settings and vulnerable or 'at risk' groups.

My work in Russia has taken place in diverse settings: on the streets of Moscow, in prisons, in the *internats* or residential institutions for orphans, and in schools. These are key risk settings and encompass children and young people, prisons, young female commercial sex workers and people with mental health problems. The work has also embraced educational settings such as mainstream schools, residential schools and technical schools, which have a broad set of similar needs but which have specific requirements in addition. Some of the key lessons from this work were summarized in the article RP 14.

In Bulgaria, the work described in the research article RP 44 took place in a Roma community in Plovdiv and in NGO offices in Sofia, Plovdiv and Targovishte. This was linked to concerns about the social exclusion of a minority ethnic group (see also RP 24; RP 67) and state-NGO relationships, the latter being of one of the key themes in respect of social policy responses throughout my work. In Bulgaria, excluded communities suffer a double whammy, in that the NGOs that represent them are badly under-resourced and find it hard to influence political and social opinions.

In the UK, there has been a range of empirical settings – health, social work and housing contexts, both community care and residential care (RP 2; RP 8; RP 10; RP 22-23; RP 25; RP 27–34; RP 45-47; RP 74-76; RP 80-94; RP 96-104; RP 118-121) – and prison (RP 60) too. In addition, disadvantaged communities and community health projects have also been included in my research (RP 38; RP 40; RP 67; RP 69; RP 71-72; RP 124). In Edinburgh, these have included Craigmillar (RP 38; RP 69) and Greater Pilton (RP 59; RP 61). These have

involved both the voluntary and statutory sectors, and their interrelationship and partnerships.

The changing context of welfare

One important aspect of my work has been to account for and explain the implications of the changing context of welfare, particularly in relation to the key areas of interest described above. I explored and researched what I called the "missing dimension of Scottish social care policy" (RP 11; RP 27; RP 99), along with the uncertainty of responses to the needs of vulnerable people and groups at risk. The voluntary sector has already been mentioned above; the author has considered the complex relationship between statutory and voluntary action (RP 6; RP 20). I undertook research into the issues for voluntary sector organisations in the wake of the momentous changes brought about by changes in health and social care, such as those brought about by the implementation of the NHS and Community Care Act 1990 (RP 2; RP 7-10; RP 22; RP 27; RP 87; RP 90; RP 99). The latter has been extensively discussed by myself in several publications (such as RP 27; RP 99). One publication, written jointly with Stephen Maxwell, was based on research into the implications of changes in the purchaser/provider split, and in assessment and management arrangements, for voluntary sector providers (RP 6). Recent issues for the voluntary sector in relation to establishing partnerships for health promotion were explored in depth by research publications such as RP 43 and RP 70).

Later the empirical focus was on localities and their local authorities, health boards and voluntary organisations in Shetland, Western Isles, Orkney and Highland, where these themes were picked up and their implications explored for developmental work and further research in the field of community-based care. The theme of risk was also explored in rural empirical settings (RP 80-83) and the balance of intervention and preventive strategies.

Welfare, vulnerability and risk

Key thematic issues of welfare, vulnerability, risk, society and the intermediate processes were explored further in different country contexts such as Bulgaria, Armenia, Romania and Russia. I have also had a chance to consider the Europe-wide level in research and developmental work conducted for WHO, Health Scotland, DFID and other agencies. At the local level of analysis, localities such as Pilton and Craigmillar provided the empirical setting for participatory research with local communities.

Research and development, and training on risk taking took place in selected areas in Scotland that comprise urban and rural places, such as Edinburgh, Melrose, Glasgow, Dundee, Aberdeen and Inverness and later in Fife, East Renfrewshire, and Midlothian. Sometimes this has been health-led, as in the case of Dumfries and Galloway primary care trust. Voluntary sector settings have involved charitable organizations such as the Archdiocese of Glasgow (now Mungo Foundation), Cairdeas, Penumbra, Fife Society for the Blind, Salvation Army, Crossroads, and Sense Scotland.

Strengths and weaknesses

There are strengths and weaknesses associated with this range of empirical settings and research populations. The strengths include a wide diversity of situations and contexts, with which to study and apply concepts and approaches, as well as methods. However a weakness can be keeping track of and trying to make sense of the sheer diversity of organizations and groups represented: government bodies, local authorities and NHS bodies, which can be broken down into primary and other settings, NGOs, community-based organizations, and service users' and carers' groups. These different organizations, especially in the independent sector, deal with a rich diversity of issues and problems. Nonetheless, there are several common threads that help keep the empirical focus intact, such as those of risk and vulnerability.

The impact of my research, and its influence, is discussed in the following chapter.

Chapter 4   Impact and Influence

In this chapter the impact of my research, and the influence it has had, are assessed and discussed. A major achievement of my research and associated publications has been their impact on policy and practice in health and social services, as well as on theoretical and methodological development in the field of social science.

This impact has occurred at three key levels – the theoretical, the methodological and the empirical - and is now discussed according to these levels.

Theory

First, in terms of theory and concepts, my new paradigm for welfare research led directly to the setting up of a large ESRC/Joseph Rowntree Foundation research programme. This work was published in the Journal of Social Policy article and made available the ESRC report, as well as discussed in seminars and conference presentations. Outputs from researchers involved in the programme included the publication of two books and numerous articles based on this paradigm. The concept, 'management of personal welfare', helped influence work on new research models and directions in welfare research. My research has additionally shaped the understanding of personal welfare, including the management of personal and social problems. My work has influenced the ESRC and numerous research units and researchers (see, for example, the collection by Williams et al. 1999). This approach has also remained a constant motif throughout my research, with different aspects being examined in interrelated but diverse settings and a range of social policy issues.

Second, my work on the development of the concepts of 'risk' and 'risk taking' has, moreover, helped to generate a new and innovative model for researchers. New and improved definitions and understandings of risk and risk taking have been developed and will assist researchers and practitioners alike. This has had a considerable impact on how welfare professionals and their managers think about risk. The influence upon those working in the

academic field is reflected in the work of the British Academy International Collaborative Network on Risk and Ageing Populations (see e.g. Clarke 2006), where my critique of the 'safety first' approach in welfare and my proposed positive risk taking model have been very well received. Moreover, my concept of 'welfare dilemma' has been helping both academics and professionals conceive of dilemmas associated with risk situations. It is has been proving a valuable tool in unpacking the factors and issues that lie behind the problems that vulnerable people often present to health and social work authorities. This has been taken up by those practitioners and managers attending training sessions, evidenced by analyses of their evaluation questionnaires and informal feedback. Some of the findings from these evaluations have been published (see RP 1, especially Chapter 8; RP 4). Additionally, my arguments have been filtering into official reports touching on risk, from the likes of the Better Regulation Commission to the Department of Health (Better Regulation Commission 2006; Commission for Social Care Inspection 2006; Department of Health 2007a; 2007b).

Methodology

My published research has had an impact on methodological approaches, especially for applied social research, and includes the development of the Facilitated Discussion Group Method (RP 43) described in Section 2. This method directly influenced the outcome of research and development. It was undertaken under the authors of health in Scotland and influenced the development of a strategy for the voluntary sector in health promotion activity. It has also been used in other contexts, including young people in Russia and other settings such as deprived communities in the UK and Eastern Europe. The Facilitated Discussion Group model has also influenced researchers interested in trying out a new qualitative methodology, relevant for a range of research situations. These have also included university students of research courses I have taught since the initial work was published.

The participation research approach (RP 38) directly influenced a community health project in a disadvantaged area of Edinburgh and has also influenced

practice in applied settings with young people at risk in Moscow, Russia. It is also influencing work in disadvantaged communities elsewhere in Edinburgh, such as Pilton. Here both Helen Smart and myself have recently finished a research project involving young female teenagers, including teenage mothers. It has also been taken up by Community Food and Health Scotland (formerly Scottish Community Diet Project) and a participatory appraisal programme for food-related projects in Scotland has been under consideration (Community Food and Health Scotland 2007). In addition, my clarification of the participatory research method has been a useful addition to the growing literature on the subject, along with increased clarity about its relationship to empowerment, especially in relation to disadvantaged communities.

Empirical

The third level is the empirical, where both policy and practice in health and social welfare have been influenced by my research. In the previous section, there was a discussion of empirical settings. The impact of my research within such settings is now considered below.

The impact of my research work on the risk policies of local authorities and voluntary organisations has been notable. As noted in the previous section, these agencies have been both urban and rural authorities, and councils include Fife, East Renfrewshire, Shetland (including Shetland Health Board), Western Isles, Aberdeen and Midlothian. Social work services in particular have been under intense pressure to work more effectively in situations where risks are posed for people who are vulnerable, for the local community, and for the staff employed to help the former. There is intense media pressure in addition. This is most obvious in cases where children are involved, but all groups can be affected, including those with learning disabilities and older people.

My work has also influenced practice, particularly among welfare professionals in the UK and in Eastern Europe. An example is provided by the Person-Centred Risk Assessment and Management System (PRAMS) approach, which has provided a systematic framework for decision making

for practitioners in risk work and helped to redefine good practice for social workers and other practitioners in risk work. In their review of the risk literature, the authors of the Social Policy Research Unit paper mentioned earlier (Mitchell and Glendinning 2007) discuss two of my research publications (RP 1 and RP 4). They highlight the fact that my PRAMS model is 'frequently noted' (Op. Cit, p. 58). The authors cite some of my findings that a sample of social workers reported benefits in the shape of increased confidence and awareness, due to using the PRAMS model.

Examples of organisations influenced by my approach include the following. The Mungo Foundation, by way of illustration, provides care for an impressive range of groups, which include young parents, drugs and alcohol misusers, mental health, dementia, and different forms of care including respite and short stay projects, as well as long stay residential projects. Other voluntary organizations include Penumbra; Sense Scotland; and Albyn Housing Association.

Some areas have sought to fashion a multi-agency approach to defining risks and agreeing, influenced by the PRAMS model. It is interesting to note that these have been primarily rural areas, where there is in my experience a sharper recognition of the benefits of multi-agency working. For example in Dumfries and Galloway, attempts have been led by community hospital staff, primary care staff and carers. In the Western Isles, on Uist and Lewis, participants included those not usually invited to such discussions, such as GPs and local councillors. The most notable illustration perhaps comes from Shetland, where the risk course was developed at its early stages, and joint training was provided for a mix of participants from social work, health, housing and the independent sector. This led to a number of changes, such as residential centres like Viewforth developing a risk policy and a risk schedule, as well as an 'open door' regime; in other words where residents were free to wander where they wanted to go.

One of the biggest impacts, though, has been on Fife Council and its Social Work Service. My research and development work has directly contributed to policy and practice for social workers (Fife Council 2007). The key elements of this work have been labelled the 'Fife Model', which is explicitly based on

my research, especially my publications (RP 1, RP 4, RP 17, RP 18). The main elements of this model can best be described as follows:

The Fife Model

Along with key officers, including lead officer Sheena Robertson, I helped develop:

- Policy and Process
    - develop a risk policy and a process for assessing and managing risks, along with
- Guidance and Procedures
    - write up professional guidance for staff
- Training of Staff
    - provide the training events
- Evaluation & Research

    of training
    - gather and report on feedback from staff

    of impact on staff and service users
    - design the research into the effects

This work has involved the designing and testing of guidance for staff facing risk situations, the specification of procedures and testing of assessment forms. Staff have been trained, using the PRAMS model, with evaluations conducted of the training. A research colleague, Helen Smart, has helped me with some of the training and with the training pack. This approach covers services for adults and older people, and is presently being extended to services for children and families, where training has got under way with short-term and long-term teams. Thorny issues relating to child protection and safeguarding are now being discussed, within the parameters set out by the PRAMS model.

This is also currently follow-up research, led and, as noted above, designed by myself, into the effects of the training and the risk model itself on social work practice by staff and on the users of social work services, including community, residential and home care services.

There is also the notion of the 'risk pyramid' for the processing and filtering of risks, according to their severity. The principal elements of this are laid out below.

The Risk Pyramid

This consists of:

- Multi-agency Public Protection Arrangements (MAPPA)
- Sex Offenders Scrutiny Group (SOSG)
- Significant Risk Advisory Groups (SRAGS)
- Filtering of risks according to the level of severity

For example, in view of the potential of adverse risks posed by high profile sex offenders with learning disabilities, the new Multi-agency Public Protection Arrangements would come into play. Adverse risks of a lesser nature, for example posed by an older person with alcohol problems, would be dealt with by arrangements further down the pyramid, for example by the Significant Risk Advisory Groups.

My PRAMS model remains at the very heart of the Fife approach and it is to be the centrepiece of a launch by Fife Council, involving senior managers of the Social Work Service and Health Services in late 2007. This launch is aimed at raising publicity about risk with the public, with other agencies and with the media. This is part of a strategy I have been arguing for in my research and work with local authorities such as Fife Council. The argument about the need for the sharing of risks and increasing the ownership was made in my book (RP 1; see e.g. chapter 4).

I have also been involved in an attempt to develop a similar model and process in Aberdeen City Council Social Work Services. This has involved both managers and social work staff across different services, from children and families through to older people with dementia. In Midlothian, moreover, another trial by myself and Helen Smart is being conducted to see if the PRAMS model and the Fife approach can be made to work, starting with training for a wide range of staff, including community-based teams.

My work is, furthermore, having an impact on the training of mental health officers who work with mentally disordered offenders; the Scottish Executive commissioned me to devise and conduct training on risk taking with these staff in the spring and late summer of 2007. Latterly, Western Health and Social Care Trust in Northern Ireland commissioned training based on my published approaches for child care and child protection staff, where Helen Smart and I forged links with the promotion of mental health agenda relevant for the specific context of Northern Ireland (RP 1; RP 42).

My research in the field of health promotion has also made an impact. The reports for HEBS (RP 69) and the published article on Supporting Health Promotion Activity in the Voluntary Sector (RP 43) had a highly significant effect on shaping people's understandings of the issues affecting the voluntary sector, in terms of its contribution and potential in relation to health promoting activities. The setting up of Voluntary Health Scotland came about as a direct result of the work. The research helped to raise considerably the profile of the voluntary sector and was praised in a letter to me by the lead civil servant for the Scottish Executive.

Similarly, the reports and articles arising from the research work for Mental Health Promotion and the Early Years (RP 41, RP 42) helped raise the issue of children and adolescent mental health. However for the first time in a Scottish and indeed UK context, the topic of mental health promotion in relation to preschool and early years children received research attention. In addition, the researchers were able to raise some of the policy and service development issues with NHS, local authority and central government staff.

International influence

The research behind my article on social policy and social welfare in Russia (RP 14) has helped influence and shape the debate about the most appropriate strategies for developing policy and practice for health care and social services in the Russian Federation. It has directly influenced the practice of NGOs, particularly those working in the field of HIV and drug misuse prevention, attempting to reduce the prevalence of adverse risk behaviours

among young Russians.

This work included participatory research with young Russians, who were graduates of *internats*. These are orphanages for Russia's many "social orphans". This work combined a Facilitated Discussion Group to involve the young people and engage them in discussion about sensitive issues affecting health behaviours and risk taking. Then I and another worker from an NGO worked alongside the young people to train them in what is involved in research, designing questionnaires and carrying out their own research.

Another key area, which my work has influenced, is that of health education and health promotion, especially health education in schools in Russia. This involved consultancy work, research and project management. I was asked to become project manager and so had a direct influence on the shape and direction of a national programme aimed at schools in Russia (see e.g. RP 53; RP 54). I also gave lectures at Moscow Humanitarian and Pedagogical Institute on the topic of healthy schools and risk taking, explaining my approaches.

My work for the World Health Organisation and the European Community, as well as the European Network of Health Promoting Schools (e.g. RP 41), has been inspired by concepts and developmental work undertaken on risk and resilience (RP 41; RP 42). This includes work in school settings in health education and health promotion.

Reflections

Some reflections are certainly worth making at this point. East European cultures can seem quite impenetrable and strange for the Western-educated at times, while at other times the issues are shared with Western societies are more readily apparent. A key issue is whether a method and approach developed in the West would be relevant and suitable for countries in the Eastern part of the world, particularly those who have had 70 years of Soviet-style "communism". Thus there is not really a tradition of questioning and of getting actively involved and volunteering for things. People needed time to get used to these ways of working. However, they were, in many cases,

enthusiastic to try out these different approaches. I also learned much from this unique and valuable experience, in terms of the need to develop suitable conceptual approaches and more effective ways of working with the diverse risk groups in countries like Armenia, Bulgaria, Romania and Russia. Some of these lessons in relation to the key challenges for public health and social services were spelled out in my article on social policy in Russia (RP 14), one of the few published pieces that attempt an overview of such a difficult and complex topic.

Finally, a reflective comment on what affects the impact of one's research work requires to be made. I have had to consider what are the most effective forms of disseminating research and facilitating its impact. In my experience, this depends not only on the audience one is trying to influence, but also on the *form* of influence the researcher wishes to pursue. For example, for welfare practitioners, I have found that being able to draw on both an authoritative research production, such as a book, and more accessible, short pieces in professional magazines, is a very effective way of impressing key research messages on this audience. Latterly, more use is being use of the world-wide web and electronic forms of communication, so I have also invested time in contributing to 'e-bulletins' and similar formats. This is particularly useful for communicating research results to those working outwith the UK, as well to those within different sectors in the four countries that comprise the UK.

Conclusion

In this critical review, I have discussed the principal themes that are to be found in my research publications. I have sought to draw together the main strands of these publications into a coherent account of these themes and the major issues raised in the course of my research.

This review has also offered what has been, for me, a welcome chance for a reflective account of my record of published research and to discuss the progression and interlinking of its principal themes.

These publications, and my other research work, have focused on risk behaviours and the management of the personal and social problems underpinning these forms of behaviour, including policy responses. The themes that have been singled out for attention are these: vulnerability, risk and resilience in socially excluded groups and communities; social policy responses, including prevention strategies and forms of health and welfare provision; and shifts in the context for welfare, particularly in state-voluntary sector relations. These themes, and their interconnections, were laid out in the diagram of the Risk, Resilience and Vulnerability Model presented in the first chapter. In order to improve understanding of these problems and responses to them, my research work has also entailed the development of conceptual and methodological approaches, applicable in UK and in international settings.

It has been my contention that my research publications form a coherent body of research, which has influenced both theory and practice in social policy, particularly in relation to the fields of health promotion, health care and social work. As part of the reflective overview mentioned above, some of the strengths and limitations of my approaches in, and my contributions to, these fields have been discussed.

At the outset, I indicated that this account was also an intellectual journey, with the rewards, as well as some of the pains, that an exciting voyage can hold. As with any journey, an element of fortune can make or break the traveller. I have been fortunate in my choice of fellow companions, who have

occasionally joined me for sections of the journey, and in the routes I have chosen to explore and map out. These routes have been selected according to the themes set out in this review. From the streets of disadvantaged communities in Edinburgh to the *ulitsi* of impoverished groups in Moscow, following these routes has led me to numerous, intriguing adventures of an intellectual nature, as well as of a physical nature. This review has dealt with the former; those of the latter must await another form of publication.

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Appendix 1: Research Publications March 1979 - June 2008

Books

RP 1 M. Titterton, *Risk and Risk Taking in Health and Social Welfare*, London: Jessica Kingsley Publishers, 2005.

RP 2 M. Titterton (ed.) *Caring for People in the Community: the New Welfare*, London: Jessica Kingsley, 1994.

RP 3 D. Rowley and M. Titterton (eds.), *Local Collaboration in Implementing Community Care*. Edinburgh: Scottish Office and NHS Management Development Group, 1994.

Chapters in books

RP 4 M. Titterton, Training professionals in risk assessment and risk management: what does the research tell us? In P. Parsloe (ed.) *Risk Assessment in Social Work and Social Care*, London: Jessica Kingsley Publishers, 1999.

RP 5 M. Titterton, Community Care Policy in the United Kingdom. In J. Johnston (ed.) *Community Care: History and Policy*. Milton Keynes: Open University, 1998.

RP 6 S. Maxwell and M. Titterton, Assessing and managing care: what future for the independent sector? In C. Clark and I. Lapsley (eds.) *Planning and Costing Community Care*, London: Jessica Kingsley Publishers, 1996.

RP 7 M. Titterton, Introduction. In M. Titterton (ed) *Caring for People in the Community: the New Welfare*, London: Jessica Kingsley, 1994.

RP 8 M. Titterton, Managing change and innovation in community care. In M. Titterton (ed. *Caring for People in the Community: the New Welfare*, London: Jessica Kingsley Publishers, 1994.

RP 9 M. Titterton, Conclusion: the new agenda for action. In M. Titterton (ed.) *Caring for People in the Community: the New Welfare*, London: Jessica Kingsley Publishers, 1994.

RP 10 D. Rowley and M. Titterton (eds.), *Local Collaboration in Implementing Community Care*, The Inter-Change Programme. Edinburgh: Scottish Office/NHS Management Development Group 1994. Chapters written by M. Titterton include:

M. Titterton, E. Palmer and P. Bradley, Developing multidisciplinary arrangements for longstay hospital discharges.
M. Titterton, E. Palmer and C. Maclean, Contracts in community care: problems and opportunities in Central Region.
M. Titterton, Developing community mental health services in Caithness.
M. Titterton and E. Palmer, A comparison of the community care needs of two communities in Fife.

M. Titterton, Assessment, risk taking and advocacy for older persons in the Western Isles.
M. Titterton, E. Palmer and P. Bradley, Ensuring quality in community care for older persons: a case study approach
M. Titterton and H. Smart, What Is It Like To Be Old in Lockerbie?

RP 11 M. Titterton, The missing social care dimension in Scottish social policy: a commentary on the Griffiths Report and the Wagner Report, *Scottish Government Yearbook*, Edinburgh: University of Edinburgh, 1989.

RP 12 M. Titterton, Evaluating social work services for the poor: an agenda for research. In S. Becker and S. MacPherson (eds.) *Private Lives, Public Issues*, London: Insight Books, 1988.

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Single author

RP 13 M. Titterton, Review of P. Vanhuysse, *Divide and Pacify: strategic social policies and political protests in post-communist democracies.* Budapest: Central European University Press, 2006, *Social Policy and Administration*, forthcoming.

RP 14 M. Titterton, Social Policy In A Cold Climate: Health & Social Welfare In Russia, *Social Policy and Administration*, 40, 1, 2006, 88-103.

RP 15 M. Titterton, Review of *Gender Regimes in Transition in Central and Eastern Europe*, G. Pascall and A. Kwak, Bristol: Policy Press, 2005, *Social Policy and Administration*, 40, 5, 2006, 564-565.

RP 16 M. Titterton, Living interestingly: Russian user groups for depression, *OpenMind*, May 2005, 12.

RP 17 M. Titterton, One step at a time: 10 steps to better risk taking, *Community Care*, 26 May- 1 June 2005, 42-43.

RP 18 M. Titterton, The fine art of risk taking, *Professional Social Work*, February 2005, 12-13.

RP 19 M. Titterton, *Combatting HIV and AIDS in Russia*, BEARR Trust Newsletter, January 2004.

RP 20 M. Titterton, Statutory action and voluntary action: a review article, *Health & Social Care in the Community*, 3, 6, 1996, 389-392.

RP 21 M. Titterton, Review of H. Kemshall and J. Pritchard (eds.), Good Practice in Risk Assessment and Risk Management, London: Jessica Kingsley, 1996, *Health and Social Care in the Community*, 4, 4, 1996, 266-267.

RP 22 M. Titterton, Responding to the challenge? The voluntary sector and hospital closures, *Care Report Scotland*, April, 1995, 6-7.

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RP 25 M. Titterton, Hopes riding high, *Care Report Scotland*, No. 13, May 1994, 4-5.

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RP 31 M. Titterton, Scotland, *Insight*, March 1990, 11.

RP 32 M. Titterton, £167m more needed for care, report says, *The Scotsman*, March 3rd 1990.

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RP 36 M. Titterton, The Local State and the Cuts: the struggle over your rates. *Citizens' Rights Office Newsletter*, May, 1980.

Joint author

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RP 38 M. Titterton and H. Smart, Can participatory research be a route to empowerment? A case study of a disadvantaged community. *Community Development Journal*, published online Autumn 2006, published in hard copy January 2008, 43, 1, 52-64.

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RP 55 M. Titterton, *Promoting Mental Health and Self-Help to overcome Depression among Service Users in Russia,* End of Project Report, London: Department for International Development, 2005. (Joint project with Gamian Europe and Russian NGO Public Initiatives in Psychiatry).

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RP 96 D. Hunter, G. Wistow, M. Titterton, *See table 11: an audit of NHS and community care in Scotland*, Leeds and Edinburgh: Nuffield Institute for Health and Scottish Council for Single Homeless (with David Hunter and Gerald Wistow), 1990.

RP 97 M. Titterton, *Caring For People in Scotland: the implications of the Caring For People White Paper and the NHS and Community Care Bill*, submitted to House of Commons Social Services Committee, February, 1990.

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RP 110 M. Titterton, *Health Behaviours and Body Image*. Paper based on lectures presented at Queen Margaret University, Edinburgh, January-March, 2007.

RP 111 M. Titterton and C. Clark, *Social Policy in Europe*, Unpublished manuscript, 1997.

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RP 115 M. Titterton, *The New Right and Consumer Choice in the Personal Social Services*, Department of Social Administration and Social Work, University of Glasgow, 1988. Paper presented to University of Newcastle Department of Social Policy Seminar Series, May 1988.

RP 116 M. Titterton, *The Effectiveness of Community Care for the Mentally Ill: evaluative guidelines for practitioners*, Department of Social Administration and Social Work, University of Glasgow, November 1988.

RP 117 M. Titterton, *Health and Social Welfare in Scotland*, working papers and chapters intended for publication, 1987-1988.

RP 118 M. Titterton, *Evaluating Community Care Projects for the Mentally Disabled*, paper presented to 'The Evaluation of Social Work Effectiveness' Conference, June, 1987.

RP 119 M. Titterton, *Policy Outcomes and the Mental Health Services: prospects for evaluation*, Social Work Research Centre, University of Stirling, 1987.

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RP 123 M. Titterton, *Needs of Elderly People and the Costs of Care*, miscellaneous working papers for Social Work Services Group, Scottish Office, 1985. Includes *Home help: targeting of provision* and *Estimating unit costs for social work services*.

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RP 126 M. Titterton, Theoretical Issues and Empirical Research in the Study of "Urban" and "Local" Polities and Politics. Paper presented to the Political Economy of Edinburgh Group, University of Edinburgh, April 1981.

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RP 128 M. Titterton, Monetarism and the local state: the development of new forms of domination. Paper presented to the CSE State Group, University of Edinburgh, May 1980.

RP 129 M. Titterton, Thatcherism and the restructuring of the Welfare State. Paper presented to the CSE State Group, University of Edinburgh, April 1980.

RP 130 M. Titterton, Notes on the Marxist Theory of the State. Paper presented to the CSE State Group, University of Edinburgh, March 1979.

Appendix 2: The sample publications

In my book, *Risk and Risk Taking in Health and Social Welfare* (London: Jessica Kingsley Publishers, 2005), I examine risk and risk taking in the field of health and social welfare and offer an innovative model of developing theoretical and applied approaches. Research into the perceptions of professionals about risk, and their concerns about risk work, is included. Following the convention adopted for this critical review, this text is referred to as RP 1. I was the sole author and researcher for this publication; the research was mainly conducted in the UK, and principally in Scotland.

Additional research into the perceptions of welfare professionals concerning risk, including an assessment of the effectiveness of training, is presented for discussion in the chapter, *Training professionals in risk assessment and risk management: what does the research tell us?* from Phyllida Parsloe's edited collection on Risk Assessment in Social Work and Social Care (London: Jessica Kingsley Publishers, 1999. This is referred to as RP 4. I was the sole author and researcher for this publication. The research for this chapter was mainly carried out in Scotland.

In these paired articles on the evidence base for mental health promotion in the early years, the focus in the first paper is on the complex interplay of factors associated with risk, protection and resilience (M. Titterton, M. Hill and H. Smart: *Mental Health Promotion and the Early Years: the evidence base. Risk, Protection and Resilience.* Journal of Mental Health Promotion, 1, 1, 2002, 20-35). This was part of a larger analysis of the evidence base and includes, in the second paper, a study of the effectiveness of interventions (M. Titterton, H. Smart and M. Hill, *Mental Health Promotion and the Early Years: the Evidence Base for Interventions.* Journal of Mental Health Promotion, 1, 4, 2002, 10-24.) These articles form RP 41 and RP 42. For both articles, I was lead author and responsible for overseeing the literature reviews, and refining the conceptual framework for discussion with the other authors and presentation.

Research that covered risk groups such as young people, people with mental health problems and people in prison was used as the basis for my article, *Social Policy In A Cold Climate: Health and Social Welfare In Russia* (Social Policy

and Administration, 40, 1, 2006, 88-103). Methods used included participatory research and focus groups. This article is RP 14. I was the sole author of this publication and was the lead researcher with responsibility for design, conduct and data analysis for the research, on which the paper is based. Fieldwork was conducted in Moscow, St. Petersburg, Pskov, Tver and Nizhny Novgorod in Russia.

The article, *Supporting health promotion activity in the voluntary sector: research findings and strategic considerations,* (M. Titterton, H. Smart, L. Curtice and S. Maxwell in Health Education Journal, 59, December 2000, 364-372) is based on research into the role of the voluntary sector, where the Facilitated Discussion Group Method was developed. A national survey of voluntary organisations, local authorities and health boards and NHS trusts is also included. This is RP 43. For this paper I was lead author and responsible for overseeing the design and conduct of the research, including conducting three of the five facilitated groups mentioned, and including overseeing the analysis of data.

Working with socially excluded Romani communities in Eastern Europe: lessons from Bulgaria, (M. Titterton and C. Clark in Social Work in Europe, December 2000, 7, 3, 38-45) is taken from research I carried out in Bulgaria. This included a study of the issues for Romani communities at risk of exclusion. This paper is RP 44. I was lead author and responsible for the design and conduct of the research and fieldwork in Sofia, Plovdiv, Targovishte and other towns in Bulgaria.

This article, *Can participatory research be a route to empowerment? A case study of a disadvantaged Scottish community* (M. Titterton and H. Smart, in Community Development Journal, published online Autumn 2006, published in hard copy January 2008, 43, 1, 52-64) is based on field research carried out in a deprived estate in Edinburgh. In this paper, an analysis is provided of the challenges for participatory research, which was the approach adopted for this community-based evaluative study. This article is referred to as RP 38. I was lead author and responsible for overseeing the design and conduct of the research, including data analysis, as well as discussions and training sessions involved in the work, which took place in Craigmillar in Edinburgh.

Risk and Risk Taking
in Health
and Social Welfare

Mike Titterton

Contents

Introduction

The topic of 'risk' is an exciting one and interest in it is well established. This is due to a variety of reasons, ranging from the impact of the restructuring of health and community care to professional concerns about the quality of life of people in hospital and community settings. 'Risk Taking' is an idea which will become increasingly important for health and social welfare professionals. However it has to be recognised that risk also poses important dilemmas for professionals and their colleagues, for people who require care, for their families and kin, and for other members of society and their communities.

There is a growing expectation that work in the field of health and social welfare, including health promotion, should involve helping people to have a greater say over their lives and to take more responsibility for their actions. This involves the exercising of choice and will mean that some people will want to take risks in their lives. There is much talk at present of empowerment and the facilitation of choice for vulnerable individuals and communities. Risk provides an innovative and challenging way of bringing about genuine change in the way health and social services are conceived, planned and delivered.

In this book the author examines some of the issues behind these dilemmas and proposes a framework for addressing these issues in a systematic yet person-centred way. The book contains a discussion of risk and risk taking; an analysis of the social construction of risk-taking behaviour; guidance on good practice in risk assessment and management; and case studies and examples in the area of risk taking. There is a discussion of

What is Risk and Risk Taking?

Introduction

One of the major changes in health and social welfare of late is the growing emphasis on risk and the development of a risk-taking approach in working with vulnerable people. In this chapter the concepts of 'risk' and 'risk taking' are examined. Different perceptions of risk and understandings of these concepts are also considered. It is evident that conceptions of these notions have been changing and it is useful to chart some of these changes, as far as they affect practice in health and social care, and to identify some of the key influences on these shifts. A positive view of risk is argued for, one which promotes the idea of risk as an essential ingredient for improving the quality of life.

First of all, the literature is reviewed and the development of academic and practical understandings of the concepts of 'risk' and 'risk taking' is described. A definition is then put forward, based on the consideration of the arguments contained within the literature and one which resonates with professionals' perceptions of the issues. Then recent thinking on these notions, as reflected in recent studies, is examined and some of the pressing issues which arise for welfare professionals and vulnerable people are considered.

Risk and welfare professionals

There are numerous pressures on welfare professionals to go for a 'safety first approach' rather than a 'risk-taking approach' in their work, with clients. The pressures on a profession such as nursing have been discussed

In this book, the author sets out to explore the dilemmas of risk, to look at its conceptualisation and definitions: he considers why it is important and he attempts to examine issues of good practice in risk assessment and management. Some key dilemmas for professionals, carers and users are explored and some case studies are provided. A model, the PRAMS approach (or Person-centred Risk and Management System), is outlined as a framework for risk decision making.

First, the concepts of 'risk' and 'risk-taking' are examined, along with preceptions of these crucial notions; definitions of these notions are put forward and used throughout the discussion in this text. Recent developments in thinking about risk are also considered. In Chapter 2 the issues of rights, responsibilities and the law are examined: these provide the essential context which welfare professionals have to work within. The thorny issue of restraint in relation to risk taking is also discussed.

Next, the notion of a welfare dilemma is explored and there is a look at some practical examples of risk-taking situations; some preliminary steps for weighing up the risks involved are considered. In the following chapters a more systematic approach for risk decision making is presented. Chapter 4 sets out the PRAMS model and goes on to deal with key principles and policies for risk taking. A systematic approach to risk assessment in provided in Chapter 5, along with a review of the relevant literature. The management of risk is tackled in Chapter 6 and key steps are presented. In Chapter 7, assessment and management are linked together within the PRAMS framework. The effectiveness of training for welfare professionals is examined in Chapter 8, along with the kinds of skills which both practitioners and lay people require for risk taking.

Finally, concluding thoughts are presented on the way forward for a progressive and enlightened approach to risk taking in the field of welfare. Some key messages for policymakers, managers, practitioners, users and informal carers, educators and researchers are spelled out. Appendix 1 provides a note on assessing risk of harm and danger in health and social care settings, using the examples of child protection and sex offenders; Appendix 2 outlines a sample risk assessment and management plan; Appendix 3 contains some case studies relating to welfare dilemmas and risk decision; and Appendix 4 contains a note on health and safety issues.

the key issues involved in making decisions about risk and some guidelines for improving risk assessment and risk management.

A systematic approach is put forward to help care and other staff, vulnerable individuals and their families. This is called PRAMS – Person-centred Risk Assessment and Management System – and has been used and adapted by a range of different agencies in the field of welfare. In addition, there is a discussion of the effectiveness of training and its limitations; some recent research is put forward in order to throw some light on this topic. The subject of developing skills for professionals and for laypeople is also examined here.

Risk taking is very much a developing topic: it remains under-researched and has yet to be given the priority it deserves. There is no foolproof system of guidance and this statement applies to the guidelines contained here. Indeed, almost by definition, 'risk' cannot be simply quantified and predicted; uncertainty lies at the heart of the enterprise. What the welfare professional can do is systematically to review his or her practice and ensure that he or she takes sensible steps to avoid negligence.

Why has there been such preoccupation with risk of late? The topic has moved to the forefront of our society in various ways: concerns about risks to children facing potential harm, risk to the public from community care cases, but also a broader set of concerns: HIV/AIDS, BSE, Chernobyl, environmental disasters, pollution and accidents. The public perceptions of risks and realities of risk have been the subject of comment; Franklin and others provide a helpful overview of what they see as the 'politics of risk' (Franklin 1998), while other authors such as Joffe (1999) focus on the need to consider emotional responses to such risks. Managing risk has become 'a priority for the health service' (Bowden 1995, p.1). Kemshall *et al.* (1997) claim that the concept of risk is becoming a key organising principle in the social services and probation services.

Some academic commentators have gone as far as to claim that we are now living in a 'risk society' (e.g. Beck 1992.) This notion has influenced much recent academic discourse (see e.g. Taylor-Gooby 2001; Duff 2003; Powell and Edwards 2003; Scourfield and Welsh 2003), as will be seen in the first chapter. In Chapter 1 aspects of this discourse will be considered, with a view to considering whether there are implications for policy and practice in health and welfare settings.

For welfare professionals, risk is part of their daily professional lives and has long been so. However recent shifts in policy and legislation in welfare have meant that risk has been moved significantly higher up the agenda. The principle and philosophy of care in the community and of encouraging vulnerable individuals to lead ordinary lives in the community and out of residential and institutional settings is one such example. The rhetoric has to do with choice and taking risks but the reality has meant pressures on practitioners and managers at the front line.

At the same time as the rhetoric has increased, practice has lagged behind, for various reasons. There is also in residential and hospital settings a search for improved quality of care, involving greater individual say over choices, with implications for the taking of risks. The emergence of the clinical governance agenda has meant that both policymakers and practitioners in the NHS are increasingly required to think about risk; as Suckling, Ferris and Price note, 'the continuing identification, assessment and management of risks are key themes for clinical governance' (2003, p.138).

There have been, moreover, developments in field social work, which have combined to push the topics of risk and risk assessment to the fore. In Scotland for example, these drivers include the evolution of an honours social work degree and educational standards, the issuing of guidance by the new Social Services Council and the pressures on social work in the wake of recent tragedies in Lothian and the Borders (see for e.g. Scottish Executive 2003; Scottish Social Services Council 2003; Scottish Social Work Services Inspectorate 2004). Social service employers are being advised to fashion written policies on risk assessment as a matter of priority (Scottish Social Services Council 2003). Some Scottish illustrations are used throughout this text, since Scotland is taking a progressive lead on several fronts in social policy (see also Titterton 2000). National care standards are being developed that are raising a standard, so to speak, north of the border in favour of a risk approach (Scottish Executive 2004b, 2004c, 2004d). Mention is made of other parts of the UK; for example, in Northern Ireland guidance has been issued to social care workers (Northern Ireland Social Care Council 2002) that explicitly raises the topics of rights and risk taking, topics which are examined in depth in this book.

CHAPTER 9

Training Professionals in Risk Assessment and Risk Management
What Does the Research Tell Us?

Mike Titterton

> Sometimes it is necessary to take a gamble – to put something at stake in the hope of gaining a better quality of life. (S. Pritchard and P. Brearley in Brearley 1982, p.93)

Introduction

A noticeable resurgence of interest in 'risk' in the welfare field can be detected after a period of relative neglect following pioneering forays by Brearley (1979, 1982) and Norman (1980). The relationship between training and risk work has, however, received little scrutiny. Training is often advocated as *the* solution to the difficulties and dilemmas faced by welfare professionals. Reed (1997) and Stanley and Manthorpe (1997) have, for example, drawn our attention to the 'chorus of demands' for training emanating from recent inquiries in the field of mental health. In this chapter we explore the contention that training provides us only with a starting point, and that training needs to be acknowledged in research accounts of risk work, rather than as something which is simply tacked on as an afterthought.

Concerns about the training of social workers surface regularly, particularly after adverse publicity in cases of child abuse (Parton 1996; Parton *et al.* 1997). Issues relating to training and risk work tend to emerge surrounded by a powerful set of negative connotations, arising from the risk situations which are singled out for media attention: where children have been severely abused or

killed, when people have been discharged from mental hospital into the community with unfortunate consequences, or when social workers have been attacked or even killed by clients in the course of their duties. The impact of the negative construction of 'risk' for the training and development of social workers and other professionals provides a key motif for this contribution.

Some central issues for the training of welfare professionals, including social workers, in the fields of risk assessment and risk management will be addressed here. The chapter consists of two parts. The first half provides a short review of some of the relevant literature on risk; some of the implications for the training of practitioners and managers are concidered. The second part briefly outlines an approach to assessing and managing risks used in the training of over 300 staff in Scotland and then reports some findings from some modest research into the effectiveness of this training. Finally, an attempt is made to pull together some emerging issues and offer some tentative conclusions.

Overview of the literature

This part provides a brief review of the knowledge base as represented by the diverse literature on risk assessment, risk management and related topics. Some of the implications for training professionals in the welfare field are unpacked. The original intention had been to explore research findings on training and risk work, but this topic produced such a singularly unpromising yield that the limits of the search were broadened to incorporate a number of key topics.

The literature search was undertaken online using BIDS social science databases for the periods 1988–93 and 1994–97 and a health database held by the library of the Development Group of the NHS in Scotland. Keywords selected for the search included risk assessment; risk management; risk and training.

There is a startling absence of solid, empirical research on the topic of risk and social welfare, particularly in relation to vulnerable adults. This chapter would be better subtitled 'what the research does *not* tell us'. There is insufficient evidence of a robust nature about how practitioners in a range of settings conceive of risk, how they operationalise the concept, the problems they face in

so doing, the impact on practice and the outcomes for the individuals for whom they are responsible.

Instead, the researcher is forced to widen his or her search, to dip into a range of readings, to make connections and comparisons and to make sense of findings from diverse sources. This is a major task in itself and what follows is but a small and modest start in this enterprise. It does not pretend to be comprehensive but instead picks up on some selected findings of particular relevance for social workers and other professionals.

Five topics are examined: definitions and conceptions of 'risk'; risk assessment; risk management; the law, rights and responsibilities; risk and training.

The definition and conceptualisation of 'risk'

The first topic is that of the definition and clarification of the concept of 'risk'. The practical aspects of this should be clear: how we deal with a social problem is influenced by how we define that problem (Manning 1987). The clarity of our language is essential, particularly for the training of practitioners. Yet the term 'risk' is often used indifferently at best and carelessly at worst.

Risk, we are told, has 'always been central' to professions like social work (Manthorpe *et al.* 1995, p.20). However 'risk' in the care of vulnerable people is typically taken to mean the threat to the wellbeing or welfare of the individual, their relatives and members of the public and staff alike. The concept is often interpreted as dealing with the probability of an unfortunate incident occurring. Such incidents result from a conjunction of circumstances which may have harmful consequences. According to this view, the likelihood of such an incident occurring represents its risk (East 1995).

A key development has been the changing perception that risk is 'not, as it is often taken to be, an evil in itself' (Norman 1988, p.82). In her study of the risks older people can face, Wynne-Harley writes: 'Risks and risk taking are commonly seen in a negative light. For example, a thesaurus identifies risk with hazard, menace, peril and danger' (1991, p.1; see also Douglas 1992 and Prins 1996). Equally it can be argued that an 'over cautious life style can bring its own hazards', so an appropriate balance between risk and safety is desirable (Wynne-Harley 1991, p.1). However, as Norman (1980, 1988) has noted, this

negative view of risk can also be accompanied by stereotypes and prejudices about old age and old people. One of the authors of the opening quote, Paul Brearley, explicitly rejected the conflation of the term 'risk' with 'hazard' in an influential analysis (Brearley 1982; Carson 1995; Pilgrim and Rogers 1996). Brearley argued that risk taking should be recognised as important for the quality of life of older people. This applies to all contexts of living, whether residential or non-residential.

According to Norman, people take risks every moment of their lives, 'weighing the likely danger of a course of action against the likely gain' (1988, p.82). For the authors of the Counsel and Care document, *The Right to Take Risks*, life is full of risks; risk taking 'adds a sparkle' to people's lives (Counsel and Care 1993, p.1). Some writers suggest that we now inhabit a 'risk society'; risk has become a central category for understanding contemporary society (Beck 1992, 1998; Douglas 1992). Risk is being, in that inelegant jargon, 'normalised': it is being redefined as part of everyday discourse in a way which challenges rational scientific assumptions about prediction and control of the natural and social worlds (Lash *et al.* 1996; Parton 1998).

A more balanced definition of 'risk' is called for, one which emphasises its positive as well as its negative nature. The early cues provided by Brearley and Norman are at last being picked up by some of the more recent texts on risk taking (Alberg *et al.* 1996; Carson 1995; Manthorpe *et al.* 1997). Risk taking can have beneficial as well as harmful outcomes. The task for professionals is to identify the types of benefits and harms which may occur, as well as their likelihood. Further, they need to be more specific about the range of factors which affect the likelihood or probability of certain kinds of outcomes; we can also attempt to specify the timescale within which the risk taking activity is intended to take place. A particularly helpful definition of 'risk' is: 'the possibility of beneficial and harmful outcomes and the likelihood of their occurrence in a stated timescale' (Alberg *et al.* 1996, p.9).

As pointed out by various writers, risk taking is all about uncertainty (e.g. Parton 1996, 1998). The possible outcomes of a proposed course of activity could in theory be infinite and it is impossible to predict something with absolute certainty. In the complex world of human interaction we should not expect to do so. Instead, the professional art of risk taking lies in the weighing

up of likely outcomes and the use of professional judgement, guided by a systematic method of risk assessment and management.

Language is important: the terms 'children at risk' or 'elderly at risk' really mean that they are 'at risk of harm'. For people to grow and develop as creative and autonomous beings, they have to engage with risk. The concept of risk taking as a 'right' has been discussed by Counsel and Care (1993) for older people and explored further by Herring and Thom (1997) in the case of older people and alcohol. The implications of this have still to be thought through and can provoke lively debate in training sessions, particularly in the fields of dementia, learning disability and children.

There is a pronounced problem in the literature which was surveyed: while a growing number of authors acknowledge the potential for differential outcomes in risk situations, they often then proceed to analyse 'risk' as a threat. The implications of defining risk in a more positive way are rarely explored. There is a dearth of materials for professionals and their trainers to get to grips with. This is particularly marked in the mental health and psychiatric literature, where risk is treated as equivalent to a threat of violence or harm.

Four points emerge from the foregoing review.

- risk is undergoing a process of 'normalisation', identified as necessary to life, and as part of ordinary living
- risk as having differential outcomes is still to be explored
- a more positive conception of risk is called for
- professionals have to be careful about the language we use, e.g. 'risk' is used interchangeably with 'danger' or 'hazard'.

Risk assessment

A burgeoning literature can now be found for risk assessment in health and social care but the overwhelming emphasis remains on assessing for the risk of harmful or adverse outcomes. In the field of mental health, risk assessment has become, as Gunn (1997, p.163) notes, a 'fashionable buzz phrase'. Here the concerns are with 'dangerousness' and risk in terms of violence to self or others (Monahan 1988; Steadman *et al.* 1993; Potts 1995; Howlett 1997; Reed 1997).

Discussions of suicide risk can readily be found (Gunn 1997; Lyon 1997 Rossau and Mortensen 1997; Inskip *et al.* 1998). Latterly there has been a increase in interest in assessing negative risks in relation to 'deviant populations: sexual offenders (Barker and Morgan 1993; O'Callaghan an Print 1994; Campbell 1995; McEwan and Sullivan 1996; Scottish Offic 1997a); those who are or who have been involved in the criminal justice systen and who may reoffend (Kemshall 1996; Scottish Office 1998); and dru misusers (Griffiths and Waterston 1996; Argall and Cowderoy 1997).

This preoccupation with assessing negative risks such as potential harm o danger is particularly marked in respect of children (Department of Healt 1988; Berkowitz 1991; Waterhouse and Carnie 1992; English and Pecor 1994; Corby 1996; Scottish Office 1997b; Scott 1998). A greater ambivalenc about risk may be discerned for adolescents in relation to 'risk behaviours (Plant and Plant 1992; Maggs *et al.* 1997). A more limited literature is to b found for people with learning disabilities (Manthorpe *et al.* 1997; Tindal 1997) and older persons (Counsel and Care 1993; Lawson 1996; Littlechilc and Blakeney 1996; Pritchard 1997; see also the bibliography compiled by Jackson 1992) but here there is a readier acknowledgement of the need to asses for positive or beneficial outcomes.

There are, in general, few research accounts of positive risk assessment, with guidelines to match. While Alberg *et al.* (1996) set out with a balanced under-standing of risk as quoted above, the risk assessment guidelines that follow thei discussion are based on negative risks, as are the accompanying case studies Some of the difficulties evident in the risk assessment literature arise from definitional problems and a failure to clarify rigorously the concept of risk to be operationalised. The problems are compounded by a preoccupation with checklists, often divorced from the values and principles which informed them in the original context; sometimes clinical and actuarial models sit awkwardly together.

An influential model for risk assessment has been that provided by Brearley (1982) with its differentiation of 'strengths' and 'hazards', and 'background hazards' and 'situational hazards', which can be listed alongside the feared, undesirable outcome, i.e. 'dangers'. This has been taken up by Sheppard (1990) and Prins (1996) for mental health and simplified somewhat by Kelly (1996)

for child abuse. The advantage of this approach is that it encourages practitioners to be more analytical in their approach. A disadvantage from the training point of view is that practitioners can get confused by the terms, a finding also noted by Stanley and Manthorpe (forthcoming). A further difficulty identified by Kelly is that it is a static approach. A key challenge for trainers is getting practitioners to take on board the importance of dynamic risk assessment: as Grubin (1997) points out, risk changes over time, place and circumstances.

The trainer is also faced with professionals working with a diversity of guidelines. There is much reinventing of wheels and duplication of effort: one of the biggest problems is to produce guidance which is clearly linked to a coherent policy framework. Another issue is the growth of assessments involving multidisciplinary teams. A major problem for such teams is the need for standardised procedures for identification of risk and response among team members; Feaviour *et al.* (1995) have proposed a common checklist approach to iron out inconsistencies in assessment and follow up. In the author's experience, the question as to where responsibility lies in multiagency and multidisciplinary settings is increasingly being raised. Kennedy and Gill (1997) have asked: are team members equally liable? These writers point out that while, for example, the psychiatrist and social worker are responsible under the mental health legislation, in circumstances of voluntary care it is less clear.

Some authors argue that the apparent concentration on risk assessment in the literature is misplaced. This argument has two main forms. First, writers like Carson (1995) argue that the emphasis needs to shift to the managing of risks, away from an obsession with assessment. Second, authors such as Wald and Woolverton (1990) writing about child protection contend that risk assessment methodologies are deficient and caution against the view that there is a magical cure-all. Moreover, they criticise the inadequate research basis on which such methodologies rest. However they are generally supportive of the concept of risk assessment.

It is important to be clear about what risk assessment is, what it does and what it cannot do. It may be defined, following Brearley (1982) and Alberg *et al.* (1996), as the process of estimating and evaluating risk, understood as the possibility of beneficial and harmful outcomes and the likelihood of their

occurrence in a stated timescale. Risk estimation includes a) estimating the probability that an outcome will occur and b) recognising that a number of possible outcomes will occur. Risk evaluation involves attaching a value to each of the identified outcomes and balancing the relative values of each outcome. Risk assessment cannot offer certainty or precision, as was emphasised above; it does offer challenges for professional judgement making. The trainer has to encourage practitioners to work with the ambiguity which authors like Parton (1998) highlight, but to do so within a systematic and principled approach.

Practitioners can, furthermore, be helped by the trainer to identify the assumptions which underpin risk assessment models. For example, two models of risk assessment can be contrasted, the safety first model and the risk taking model, each with a range of distinguishing features. The first model, safety first, has traditionally been dominant in the case for vulnerable people. This approach is subject to growing criticism (Counsel and Care 1992, 1993; Crosland 1992). The second model, risk taking, attempts to build on key principles developed in response to perceived deficiencies of the first model. The focus of this model is primarily on the *person* and his or her needs. There has to be a balance in looking at what he or she can do, their potential for change and managing their own lives, alongside whatever difficulties he or she might have in day-to-day activities.

'Taking risks', according to Carson, 'involves deciding that the potential benefits of a proposed act outweigh the potential drawbacks' (1988, p.248). The whole process of risk assessment involves this weighing up. Decisions about risks, the Counsel and Care (1993) authors note, are a balance between the right to choice and the competence of the individual. Staff can try to enhance competence, or compensate for it or offer extra support to allow the individual to do an activity with an acceptable degree of risk.

The important point to make here is that there should be a clearly understood and shared policy and philosophy to provide a supportive framework for staff and vulnerable individuals alike to make informed decisions about risks, however large or small. What has been missing from the literature is a sense that risk taking is a learning experience, entailing the sharing of key experiences within and between professions.

The key points emerging from this review are as follows:

- the implications for more positive conceptions of risk are rarely developed, leading to unbalanced assessment frameworks
- a clearer conception of risk assessment, in terms of its limits and function, is called for
- the need for multidisciplinary inputs into the risk assessment framework is essential, and training formats need to reflect this: however clarification of responsibilities is needed
- research accounts have neglected developing risk assessments as a learning experience for practitioners and their clients.

Risk management

Risk management remains a relatively under-developed area of study compared with risk assessment. One of the key problems here is that identified by authors such as Ryan (1996) who argue that risk management is often seen as minimising risk. Ryan then proceeds, as he admits, to deal with risk minimisation as synonymous with management of danger to the public. The problem is acute in the field of mental health where whole models such as the care programme approach are based on a restrictive view of risk (Harrison 1997). There is though a different, and more radical, view emerging according to Davis (1996), the risk taking approach; this has been developed by practitioners with an explicit agenda to involve and empower mental health service users with a more positive perception of risk. These two approaches provide 'contrasting orientations to risk' for social workers (Davis 1996, p.116).

Negative definitions of risk management abound in the literature. This can be evidenced in the mental health field, which Soltys argues has 'unique risk management challenges' (1995, p.473; see also Kaliski 1997). Soltys cites and deploys Reed and Swain's definition of risk management as the 'systematic ... effort to eliminate or reduce harm to persons and the threat of financial losses' (p.473). Similarly Secker-Walker (1997, p.367), writing more generally about health care, focuses on the need for a framework which addresses the 'varied causes of latent and active human failure'. It is hard to find a view of risk management which encompasses achievement as well as failure. Similarly the

Royal Society (1992) has produced a rather limited conception of the potential of risk management.

The research literature has little to say about the limits of risk management; its stages, including where assessment stops and management starts; practical guidance about intervention; and, importantly, when not to intervene. The challenge facing trainers is considerable. Lawson (1996) rightly notes that risk management is not equivalent to getting rid of risk. As Tindall (1997) points out, it can provide a more systematic way for helping people with learning difficulties take more control over their lives. There is a need to work to increase benefits, as well as minimising harms, and this needs to be emphasised in training for managers and practitioners.

Managing risk in the lives of vulnerable people, then, should not mean elimnating risk. This would run counter to the whole philosophy which is being advocated in the risk taking model. Instead it means providing a *process* for ensuring that potential benefits identified by the risk assessment are increased and that the likelihood of harms occurring as a result of taking a risk are reduced.

Nor does risk management mean anticipating every single potential risk and responding accordingly. This would be impossible and again would run counter to the risk taking approach. Rather it involves developing a systematic approach which allows for the planning of risk taking strategies and for monitoring and reviewing. A good risk management process will help to ensure accountability, clarity and support for staff involved in decisions concerning risk. The risk management process must both facilitate risk taking and empower care pro-fessionals to make key decisions. What it can do is to place risk management issues at the heart of considerations in the assessment of health and social care needs, care plans and care programmes. The management of risk, as Littlechild and Blakeney (1996) state, must be adaptable. People do not stay constant: changes can take place in the ability to cope. The risks can change too, as has been noted. Monitoring is important to keep abreast of any such changes. This involves working closely with the individual, with their family and carers and with other care staff. Everyone should have a clear idea of what the main risks are and what can be done about them. This is about clarifying expectations and arriving at a realistic, negotiated understanding of risks and how they can be

managed. This is where the professional expertise of the welfare worker needs to be focused: *not* on a futile attempt to identify every single potential problem and to control the situation to reduce every single danger.

The key points emerging from this review are these:

- risk management is more than simply risk minimisation: it involves working to increase potential benefits

- it is about providing a process for planning risk taking strategies and for monitoring and reviewing the results

- any risk management process must be flexible and adaptable: trainers and teachers face a key challenge in promoting achievement-oriented visions of risk management.

The law, rights and responsibilities

In promoting a more positive approach towards risk taking, trainers and educationalists have to encourage welfare professionals to take into account the legal implications of risk decisions. As Brearley (1982) argues, the best protection for the social worker lies in good practice and in recognising the potential of the law for use in dangerous situations. The law not only protects clients, it protects the worker and the agency too. Carson (1996) goes further to suggest that use can be made of legal concepts and the operation of the legal system to help improve risk decision making and justify decisions. He contends that practitioners can use the concepts of the law and its procedures for their own purposes, before harm occurs. The law will not yield direct answers but it can help provide procedures and frameworks.

One area which remains under-studied is the legal implications of risk taking. One writer who, with determination, has ploughed something of a lone furrow is David Carson (1994, 1996, 1997). Carson has been influential in promoting the positive side of risk taking and encouraging professionals to use the concepts of the law to justify and improve their risk decisions. He supplies useful arguments for overcoming the 'cover our backs' attitude so prevalent among managers in the social services: he contends that such managers may well find themselves sued for not tackling risks and for not ensuring that their staff are trained. He is a critic of the defensiveness and unimaginative practice

which such an attitude produces. However, Carson may under-estimate the resistance of professionals and managers which may have its roots in cultural and organisational factors, rather than just a lack of clarity about the law.

The notion of a 'duty of care' is ripe for exploration. Kennedy and Gill (1997) explore legal considerations arising from patient homicides and speculate on some of the implications for assessment and management of risk. They point to the danger of defensiveness, particularly if patient-as-plaintiffs cases succeed. Since this article was written the outcome of the Christopher Clunis case has been decided: the Court of Appeal has just turned down Clunis's application for damages, with no leave for further appeal. However more claims along similar lines will no doubt be put forward for consideration by the courts.

Harrison (1997) has written about the problems facing risk assessment in a 'climate of litigation'. She argues that there has been a 'seachange' in the attitudes of professionals towards the use of litigation in medicine, and towards the assessment of risk to themselves of an untoward incident. She criticises the tendency of a new form of institutionalisation, where patients become 'entangled in webs of overcautious surveillance by mental health professionals' and the new bureaucracy arising from the care programme approach and defensive practices (1997, p.37). An instructive debate has been taking place in the United States, where concerns about professional duties and responsibilities, litigation and risk assessment in 'managed care' settings have been mounting (Simon 1998).

There are differences within the UK and this is often overlooked, in terms of policy and legal learning. Scotland, for example, has a distinctive legal framework, although some of the issues remain the same. There have also been concerns expressed about the need to revise the Mental Health (Scotland) Act 1984 and the need to tighten up the law around the rights of 'incapable adults'. The Scottish Law Commission (1996) recently published a report which sets out general principles for intervention in the life of someone unable to make decisions for him or herself and which received a favourable welcome.

Social workers and other welfare professionals have to operate within a patchy and ill-defined context. There are two issues to consider here. The first is that much of the legislative provision that does exist tends to deal with constraints and restraints on individuals, such as compulsory admission to care.

'Risk', to the extent that it features at all, is largely conceived of in a negative and constraining manner.

The statutory framework of rights governing vulnerable adults tends to be defined in a likewise manner. For example, there is no clear statutory framework for older people. The problem, in the eyes of some people such as those who lobby for the rights of older people, is that there is no coherent legislative framework for vulnerable adults comparble with that which exists for children. There is nothing equivalent to the Children's Acts, which are based on principles which have been widely agreed and which rely, at least in part, on internationally defined agreements such as the United Nations Convention on the Rights of the Child (Hill and Aldgate 1996).

The second issue, considered in Chapter 8, concerns the question as to whether there are lessons from the field of children's rights, legislation and risk for the field of vulnerable adults. Some people have attempted to draw out the messages from child protection for the protection of older people from abuse or for mental health risk management (Stevenson 1996; Bond 1998). It is important to be clear about the kinds of risk models imported from the area of child abuse. Attempting to protect older people from risky situations would be contrary to the risk taking model. Indeed, it is possible to go further and criticise some child protection approaches as limited in their narrow focus on risk as 'danger'. The rights and risks for older people and other vulnerable adults have to be considered, before there is a rush to accept an all-embracing framework for the 'protection' of adults.

At the heart of many of the issues arising from risk taking lies the issue of rights. Should these form the framework for risk taking to work successfully? There are some provocative issues for policy makers and professionals to consider here.

The main points from this section are as follows:

- professionals need to be trained to be familiar with the law and be prepared to use it in risk decisions
- the notion of a 'duty of care' deserves further study
- the concept of 'the right to take risks' remains to be developed and tested

- caution is required in the extension of prevailing models of child protection to vulnerable adults.

Training and risk

The literature is largely silent on the topic of the effectiveness of training in risk work with vulnerable individuals. The searches produced little of direct relevance. Some general writings on health and safety issues can be found (Toye 1992; Corfield 1994; Oakley and Taylor 1994; Murphy 1996) and there is a growing body of work on training effectiveness and evaluation (Rae 1986, 1995; Talbot 1992; Fowler 1993; Pearce 1995, 1997; Oliver and Scott 1996). In a relatively unusual article, Walton (1978) explores some of the issues of training staff in residential care in taking risks. Stanley and Manthorpe (forthcoming) also present a rare account of a short training course in risk assessment in mental health work. The authors suggest that risk assessment can strengthen communication between professionals and others. However, the impacts of the training were not explored by the writers.

As was noted at the outset, many calls for training have been emerging from inquiries (e.g. North West London Mental Health NHS Trust 1994; Ritchie *et al.* 1994) as Stanley and Manthorpe (1997) note, and from other literature (Harrison 1997). Indeed, Reed claims, in his review of the lessons from recent inquiries, that '[a]ll these reasons for failure are, essentially, amenable to better training – and particularly training in a multidisciplinary, multiagency setting' (1997, p.6). He pinpoints the areas of risk assessment, the use of the Mental Health Acts and the use of security. Sometimes this is targeted towards particular groups such as keyworkers. Harrison calls for a modularised curriculum which is 'applicable to all professional groups' (1997, p.39).

Little of substance in the literature can be found concerning the kinds of training, including methods and formats, which work most effectively with different kinds of professionals. The issue of training of trainers is also a key lacuna. Harris (1997) looks at this problem in relation to psychiatrists. He raises a concern about the wide variation in the methods of teaching; he also claims there is a lack of audit of the effectiveness of the training. Harris points to the value of including other professionals in this training, such as community psychiatric nurses. However he limits himself to three methods, lectures,

seminars and national conferences, which represent a limited view of training methods.

Taylor and Meux (1997) note that translating research findings in the area of risk assessment into daily practice is problematical. They write, for example, that different clinicians will interpret research findings and act differently in risk assessment and management, since they are individuals whose judgements are shaped by their own temperament, experiences and professional backgrounds. This point can be extended to other professionals such as social workers, who rely on fine judgements. Taylor and Meux also contend that decisions will be affected by factors such as culture, health care and legal systems and the availability of resources. These authors use a case vignette method to compare and contrast approaches to risk assessment in psychiatry by three different professionals from different countries for each of three case studies. They found that, despite the variety of professional and national backgrounds, all recognised some degree of risk but there were differences of emphasis which 'illustrate again that aspect of risk management which can never be under-emphasised: the importance of a multidisciplinary input' (p.301). This again points up the importance of multidisciplinary and multi-agency training for practitioners and managers across a range of settings using imaginative formats (Titterton 1994).

The issue of appropriate social work competences has still to be properly considered: a recent collection on the topic by Vass (1996) contains no references to risk work in its index. Kelly (1996) has highlighted some of the core competences for social workers, for example those advocated by CCETSW's Revised Paper 30; these include assessing and planning, communicating and engaging and so on (see also the further revision by CCETSW, 1996). However, a more explicit acknowledgement of the specific kinds of competences required for risk work (reflected in the sort of skills which are discussed in the second part of this chapter) is now called for. This lack of explicit recognition by CCETSW is mirrored in the absence of discussion in general social work texts, as Alaszewski and Manthorpe (1991) have noted.

As suggested above, training of professionals is frequently invoked as the answer to problems associated with risk situations with potentially adverse outcomes. The sheer weight of expectations now placed on training is alarming,

not least at a time when training budgets are being cut back in the social services. Training has to be seen as part of a longer process of learning. The trainer will often furnish the trainee with reference points for the start of this process. Training has also to be recognised as only one piece of the bigger puzzle that constitutes good practice in risk work. Other pieces include: the development of risk policies; the involvement of informal carers and users; the influencing of professional standards and expectations; and the changing of public and media perceptions of risks. There is, moreover, a range of organisational issues to consider (Alaszewski and Manthorpe 1998; Kemshall *et al.* 1997), as well as a broader set of cultural and political factors (Franklin 1998).

From this section, these key points have emerged:

- there is a pressing need to find out more about appropriate training methodologies in risk work; in particular, there is a necessity to test the effectiveness of training in relation to different kinds of professionals

- training which is multidisciplinary and multiagency in nature can be particularly beneficial; this should be protected from budget reductions

- a better understanding of the learning process and development of risk competences is required

- realistic perceptions of training and its context are needed.

Training and its impacts

Description of the training

This section describes an approach to training and developmental work with social work and other staff. The course has been developed over the last four years and over 300 professionals have participated in Scotland; in addition variations on the course have been run outwith Scotland, and have included both carers and users in workshop sessions. The learning objectives of the course are: to examine issues of risk taking; to explore ways of assessing and managing risks; to develop a multiagency awareness; to provide guidance for managers, workers, users and their carers; to help increase choice in the daily lives of service users.

The course introduced the Person-Centred Risk Assessment and Management System, PRAMS, which is a systematic approach developed by the author for the assessment and management of risk in community and long-stay settings. It provides a comprehensive yet flexible framework for promoting good practice in risk taking in the field of welfare with which care professionals and other staff, vulnerable individuals and their families can work. It is based on research and training exercises with a range of welfare professionals from different disciplines in social work, health care and housing. It embodies an explicit philosophy of risk taking which seeks to enhance the quality of life of individuals in need of support and to improve the quality of risk decisions made by practitioners. It is intended to cover all vulnerable persons, however severe their disability or illness.

PRAMS involves work on five distinct yet related stages. The first stage entails the establishing of principles; participants discuss and agree key statements intended to guide the assessment and management process and its intended outcomes. In the next stage, issues for developing risk policies in the workplace are examined and the rationale, function and content of these policies are discussed. The third stage involves participants considering different assessment models, as well as the key steps for the identification and assessment of risk. They also work on specially constructed vignettes, case studies and scenarios designed to explore dilemmas and develop skills for making decisions. In the following stage, the notion of 'risk planning' is introduced and participants devise planned responses to assessments. The fifth stage deals with models of risk management and the key steps for managing risks; here again participants are set to work on cases designed to test decision making skills. PRAMS is an interlinked system; participants are encouraged to consider the connections between the stages and to continually review what they have learned. Another key theme is that of developing skills: each stage entails work on particular skills. To take an example, the art of making 'judgement calls' is explored in depth at the assessment stage.

Evaluation of the training

This section describes an evaluation of the training course outlined above and addresses some issues from a piece of small-scale research into the effects of

training in risk assessment and risk management. The first part describes the feedback from participants in comments written on evaluation forms used by the trainer, filled in immediately on completion of the course.

The great majority of participants who completed an evaluation form felt the course met the aims and objectives stipulated and found it enjoyable and challenging. However, some did not feel it lasted long enough, particularly the short (one-day) version of the course, since the difficult dilemmas which were emerging needed longer time for discussion. They enjoyed coming together and learning together; in this respect it is evidently important that the training format encourages this. Participants benefited not only from working in small groups with colleagues but also with those from different settings and those dealing with different care groups.

What participants found most helpful were: a logical and systematic approach to risk assessment and management; a clear focus on practical understanding; exchanging ideas; well-structured and well-presented information. They also enjoyed listening to different views of risk and the involvement of different professions. Participants also reported that they enjoyed: risk planning; how to develop an effective policy; defining boundaries between risk assessment and risk management; the right to take risks and treating people as individuals; not being afraid to take risks; thinking through the issues. Case studies, group work and the training manual for further reference were also identified as helpful.

The aspects which some training participants found the least helpful were: the negativity of some people who were not prepared to take risks; people raising issues specific to their workplace; grey areas and boundaries; a mix of backgrounds making it hard to discuss specific issues. However, there were other respondents who evidently found the latter two situations useful.

Other points raised by participants were: senior managers also needed training; training needs to be on a continuing basis; managers need to discuss policy expectations with workers; agreements on confidentiality wanted. There was also a demand for involving the different sectors in training: social work, health, housing and voluntary. Participants also wanted feedback on cases where something 'goes wrong', as well as support of workers by managers on these occasions.

The follow-up evaluation

The second part of this section describes research to examine some of the longer-term impact of the training on professionals and the individuals they look after. The following analysis is based on 40 completed returns from a self-completion questionnaire distributed to social work, health and housing professionals who had attended the course in the preceding nine months. Respondents were asked about the effects of the training in a number of areas. The first of these concerned the impact on practice. How far was the training incorporated and what examples could they provide? Next, what effects did the training have on their clients? Again, could any examples be provided? They were then asked about obstacles to taking risks. A question was also posed about other training or support which might be useful. Finally, they were asked to comment on the difficulties in involving users in risk decisions.

THE IMPACT ON PRACTICE

The respondents for the most part suggested that the training had made a 'substantial impact' on practice. This can be divided into effects on individual practice and on agency practice. On the former, comments included: it 'forces you to work through things in a logical order'; it 'made me more confident in dealing with other professions, made me feel more secure'; it 'allowed me to view risk in a new light', and encouraged the assessing of positive benefits as well as dangers.

Comments on agency practice included: 'found the key steps a very useful tool in carrying out assessments'. Some informants noted that the benefits of training were being passed on to others in the agency and in some follow-up training that was being planned; others reported the production of informal guidelines; others stated that there was a search for consensus on risk taking in multidisciplinary settings, as well as for ways of dealing with conflicting views. Consideration of risk was reported by at least one informant as being a regular part of discussions about and with service users. Some others stated that their agency's definition of risk was being broadened to include more positive risk taking.

THE EFFECT ON CLIENTS

A small number reported that it was still 'early days' for risk taking, others were prepared to comment about the effect on clients. One of the social workers noted that a risk taking approach, developed following the training 'has helped build self-esteem and confidence' and another that her 'client is more relaxed, with a more positive attitude and awareness'. One of the most notable findings was that some social workers and care staff claimed to be involving clients more and consciously making efforts to allow them to take decisions, pointing out the consequences of actions but encouraging them to feel in control. Another worker stated that he was 'now more likely to ask service users to identify risks for themselves' and to work with users' perceptions of risks.

Some respondents said their clients were making more choices for themselves. One support worker pointed to an example of a young female tenant having more control over budgeting and shopping; the tenant was occasionally over-spending and getting into debt which may lead to the decision being reviewed in the future, but the worker still felt it right to allow the young person to try to manage by herself.

One respondent gave the example of a client assuming a role supporting others in a project and becoming more confident, which was seen as important for the individual's self-development; another used the example of a young man with learning disabilities and severe epilepsy being encouraged to do more with less supervision, while yet another pointed to the example of an older client taking risks with cooking. More than one informant pointed out that calculated risk taking was boosting the self-esteem and confidence of their client. A few respondents emphasised that this approach was no easy option and, in the words of one, that it is 'difficult to move with some clients and carers'.

OBSTACLES TO RISK TAKING

A small number of informants stressed that there were no obstacles to risk taking in their work settings, and noted that they had good management support. However this appeared to be a minority view, with most replies detailing a number of barriers. These can be grouped into four main categories.

First, respondents pointed to general fears about letting people make choices, and here cultural and professional factors were implicated. One social

worker complained about 'the tendency to wrap people in cotton wool', while a housing support worker wrote about 'our own fears of letting tenants take risks'. Second, the lack of support from management was identified as a major stumbling block. Third, differences between professionals and the lack of a shared enterprise between disciplines were highlighted. More than one person asked for more joint training, for example involving home care and health care professionals such as GPs, consultants, and hospital staff, as well as more training 'at different levels'. Fourth, organisational factors were cited: one informant noted that the 'culture of the organisation' can militate against a risk taking approach, with another arguing that the 'whole organisation needs to take on risk taking' before it can succeed.

In addition, a range of miscellaneous factors was identified. Difficulties in devising standardised policies due to the diversity of clients and their needs and abilities were mentioned. Some pointed to problems with registration and inspection staff who were reluctant to countenance risk taking, as well as 'difficult parents'. One person wrote that a key barrier was the attitude that 'staff were there just to "look after" and not to let people face risks'. Others stated that senior management tended to have a more reactive approach to risk and one respondent complained of the 'feeling of being out on a limb' when taking a risk decision. The influence of the media was commonly cited as an obstacle.

SKILLS FOR RISK TAKING

Respondents were asked about the kinds of skills which they felt were important for developing risk taking approaches.

The first group of skills involved communication skills, such as the 'ability to communicate risk calculation effectively to others, and provide support for risk taking partnerships'. One informant noted that 'the word "risk" is alarming for staff and clients', while another identified the need to put over issues in a way which clients can understand as essential, and yet another emphasised the importance of getting family and friends to see the benefits of risk decisions. A second set of skills involved 'identifying what risks are and what has made them risks'; judging risks and weighing up benefits; analysing risky situations; cultivating new ways of thinking for risk taking; 'thinking things through in

greater depth'; and developing the ability to look at the consequences of decisions from a long-term perspective.

Another group of skills consisted of interprofessional and interagency skills, including working with other professionals on risk decisions and, in the words of one informant, 'how to convey our perception of risk to other agencies'. A fourth set concerned planning skills such as forward planning and developing suitable risk plans, as well as the writing of and documentation of plans. The final cluster can be termed negotiation skills, such as balancing the various, and sometimes conflicting, rights of clients and their carers and reaching agreements over decisions about risks.

OTHER TRAINING AND SUPPORT REQUIRED

Respondents made a variety of comments under this heading. Some made clear a desire to expand the basis of the training, with comments like the 'whole organisation needs to get involved'. Joint training was commonly cited as a potentially valuable exercise, for practitioners and managers alike. There was a demand to know more about 'what works and what does not work'. One informant advocated workshops to allow people, working in similar situations and with similar clients, to discuss issues. Some requested updates on the risk taking practices of other staff: what they have found and what have been the clients' views afterwards.

Further training was identified as desirable in specific areas: individual support and risk plans; overcoming difficulties in securing risk decisions and agreements; recording; group leadership skills; and helping clients develop risk taking skills.

Finally, continuing support from peers, supervisors and managers was emphasised for workers and teams where a risk taking approach was being developed. This was identified as particularly important 'where complex risks are involved' and 'especially when things go wrong'.

DIFFICULTIES IN INVOLVING USERS

A small number of staff reported no difficulties in attempting to get users involved in risk decision making. The features which were identified as helpful here included the presence of multidisciplinary discussion with users; the clear

recording of decisions; and taking into account the relevant guidance and legislation. The majority of respondents, nevertheless, pinpointed a range of problems. These can be grouped as follows.

The first group of problems involved communication difficulties, for example in not being able to explain risk taking well enough to clients. Involvement was found to be very difficult where users have profound mental and physical disabilities, with little or no verbal communication, and there were issues raised by staff acting as advocates for risk. One informant noted that it depends on capacity relative to the stages of risk management; another 'gloomily' noted that it was difficult to support people in choices which were likely to fail. Others pointed to factors such as: possible difficulties with management; developing methods of common understanding of processes used in assessment; difficulties in reaching consensus.

Conflict with carers and parents, such as in those instances involving 'relatives disputing risk decisions', formed the second set of difficulties. Negative attitudes held by carers could act as a major stumbling block for client and staff. A third group consisted of the difficulties entailed in negotiating acceptable risk. Continuing support was seen by some respondents as necessary for people to accept decisions and the consequences; it would also help overcome problems caused by fear, lack of knowledge, disempowerment and unrealistic expectations. The fourth and final group revolved around problems with public perceptions, where the risks of harmful or dangerous occurrences were often wildly exaggerated, making it sometimes difficult to engage constructively with local communities. This theme often appeared in training sessions and provided much scope for discussion and debate.

Conclusions

In the first part of this chapter, the literature review revealed some significant gaps in research in the area of risk work and some of the implications for training were discussed. How a positive risk taking approach can develop good professional practice and enhance the quality of life of vulnerable individuals remains a particularly pertinent question to answer. The small-scale research reported in the second part suggests that training in risk work can have a

substantial impact on practice in at least two ways: it provides individual workers with the confidence and knowledge to take risks; and there are benefits for agency practice, which can be passed on to others. There were direct benefits for clients as reported by social workers and other staff: these included the building of self-esteem and confidence, as well as greater involvement in decisions and choices. However it is clear that there are difficulties in involving users meaningfully in risk decisions, because of communication problems and conflicts with carers and parents. Risk taking approaches could be enhanced through recognising the need for management and the whole agency to take risk taking seriously and the need to develop a shared enterprise with other professionals. The social workers and other staff wanted to develop skills in communication, risk decision making, planning, working with other agencies and negotiation. In this respect, joint training and continuing support for practitioners from peers, supervisors and managers were identified as important.

There are lessons also for the training and development of professionals, of which two may be singled out. First, the things they find most helpful are the chance to think through the issues clearly with colleagues and professionals from other agencies and exchange ideas, and to do so in the context of a systematic approach to risk work. The experience of the training described here has revealed that there are some difficult and complex dilemmas for risk taking for which there is no easy resolution. The fine art of professional judgement involved is still being developed in both residential and community settings. The competences which underpin these 'judgement calls', and the processes by which the latter are made, have yet to be properly researched.

Second, the question of how practitioners can best learn risk assessment and management skills has to be addressed by managers, trainers and educationalists alike. Practitioners learn from each other and from working with other professions, and they require more learning opportunities involving imag-inative formats and stimulation through a variety of training methods. A judicious mixture of theory and practice is essential; the need for supervision must also be acknowledged (Burke 1997). Risk taking is not an area which can be learned theoretically; experiential learning is best. Reflection is a critical skill for risk takers, as captured by the notion of the 'reflective practitioner' (Schon

1983; Gould and Taylor 1996). The idea that the development of risk assessment and management skills should be part of a gradual, and reflective, learning process has to be emphasised. A system such as PRAMS encourages people who use it to focus more sharply on skills development and to constantly review what they have learned.

Training is merely the start, not the end, of this process. Research studies of how practitioners learn and develop risk taking skills, and what contribution trainers can make, would make a welcome addition to the literature surveyed in this chapter.

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Mental Health Promotion and the Early Years: The Evidence Base: Risk, Protection and Resilience

ABSTRACT

This paper presents selected findings from a review of mental health and the under-fives', with emphasis given to mental health as multi-faceted and multiply determined. The authors identify some key challenges for mental health promotion in the early years and argue that greater attention should be paid by policy-makers and health promoters to this key population group. The evidence relating to risk, protective and resilience factors for young children is examined. It is concluded that researchers should now focus their efforts on understanding interactions and processes associated with such factors and should work with health promoters to spell out the practical implications of their work.

Introduction

A major challenge for professionals and policy-makers, both in the UK and in the international context, is addressing mental health promotion for children (Walker, 1999; Mental Health Foundation, 1999; Dulmer & Rapp-Paglicci, 2000; Armstrong & Hill, 2000; Zubrick & Silburn, 2000). Until recently, there has been little emphasis on mental health promotion for the general population as a whole. The early years, defined here as girls and boys between the ages of 0 and 5, has still not received the prominence it deserves as a field of study and as a site for positive interventions for mental health promotion. The reasons for this are various, but six may be highlighted.

* First, mental health has been subsumed within a more general interest in the health of children overall; this is compounded by a tendency, where mental health is considered, to focus on mental illness rather than mental well-being.

* Second, there has been a lack of conceptual clarity in respect of the early-years group, for example in terms of specific needs and attributes.

* Third, while there has been growing interest in the relationships between parents and carers and children under five, and in parents with mental health difficulties, there has been less emphasis on young children themselves.

* A fourth consideration concerns the uncertainty about the evidence base for welfare interventions and gaps in knowledge.

* Fifth, policy-makers and planners have been slow to develop frameworks and policies that raise the mental health agenda for the early years. This is in part related to a tendency to work with aggregate categories in social policy, such as the 0 to 18s, a trend criticised by Titterton (1992). Such a broad category has heterogeneous characteristics, making it difficult to generalise about the needs and characteristics of the group

as a whole. It also makes it hard to spell out clearly the implications for mental health promotion, a criticism that might be levelled at the inquiry into mental health of children and young people by the Mental Health Foundation (1999). Some encouragement can be taken from the Government's launching of the Sure Start schemes in England and in Scotland, which aim to promote social inclusion through a positive start in young children's lives (Scottish Executive, 2000). However, the mental health promotion component of Sure Start still needs drawing out and making more explicit, perhaps along the lines of Early Head Start in the USA (Mann, 1997; Fenichel, 2000).

- A final point is that awareness of research on the early years has mostly taken place within other policy discourses such as child care, early education and specialist areas of child psychiatry.

This paper attempts to redress the balance. It is based on a wide-ranging review of mental health and the under-fives commissioned by the Health Education Board for Scotland, as part of its Evidence into Action initiative. The aim of the review was to provide professionals and others with evidence-based knowledge of policy and practice in the field of mental health and the under-fives. The review examined the following areas: understanding mental health and the early years, policy and legislative context, risk, protective and resilience factors, interventions in the early years, parenting and implications. In this paper, findings from risk, protective and resilience factors have been summarised and elaborated upon. A second paper giving findings from the review of interventions in the early years is planned.

Method

The strategy for gathering information for the review consisted of computer and manual searches, principally using the on-line and catalogue resources of three libraries: the Health Education Board for Scotland, the University of Edinburgh and the University of Glasgow. Searches were conducted using on-line databases such as Medline,

Applied Social Sciences Index and Abstracts and Cinhal. Additional information was obtained from the Scottish Executive and the Information Services Division of the NHS. Because of the nature of the topic, it was necessary to undertake extensive search of literature across a wide number of fields, including child health and welfare, child psychology, child psychiatry, infant care and maternal health, education, social policy and social work and bio-medical. The topics examined were:

- child development
- attachment
- children and mental health
- assessment of need
- children of parents with mental illness
- risk and resilience
- children and poverty
- parenting and parental education
- early intervention and prevention
- health inequalities
- child mental health services
- partnership working.

A small reference group provided advice and guidance on the direction of the research. The literature included books, articles from academic journals, professional magazines and reports from the so-called 'grey literature'.

Second, discussions were held with a small number of key contacts to elicit information about mental health and other types of data, including statistical data. The research was conducted between April 2000 and April 2001, with an update for this present paper.

Mental health and the early years

The concept of the 'mental health' of children is contested and searches of the literatures reflected this fact. The focus was not primarily on 'mental illness' or 'mental ill-health' as such, though these were considered as a part of the review. Instead, 'mental health' was considered in the broader sense of mental well-being and positive

mental health. All too often, it has proved difficult for researchers, policy-makers and practitioners to break away from models which focus on poor adaptation and instead to embrace models which deal with issues of competence and resilience (Rutter, 1982; Anthony, 1987; Titterton, 1992). It is necessary to encourage an interest in 'wellness' and what welfare professionals and health promoters can do to foster it.

In promoting this broader conception of positive mental health and well-being, it has to be recognised that there are many possible determinants and factors which impinge on and affect the under-fives. In brief, the researchers adopted a model of mental health for the under-fives as multi-faceted and multiply determined. At the core of the model is located the child's emotional, behavioural and physical development, as well as the child's creative abilities to cope with adversities and stressful life events and circumstances. In addition, a distinction is made between 'protective factors', 'resilience factors' and 'risk factors'; the latter in turn are broken down into social environmental factors, parental and family factors and child factors. These factors can lead to risk, protection or resilience, depending on their direction and strength. The factors impinge upon the vulnerability states of the individual child, having either an enhancing or a reducing effect, and can lead to positive or negative outcomes for mental health. The model also allows for the specification of key determinants (factors which could be said to impinge directly or indirectly on mental health) and mediators (factors which could be said to mediate the effects of, for example, stressors on the mental health of the infant). In addition, a distinction can be drawn between 'immediate outcomes' which relate to the child's current well-being, and 'eventual outcomes' which refer to the long-term well-being of the individual.

Those factors which can lead to risk, protection or resilience in young children, according to their direction and strength, are described in detail in the next section.

Risk, protective and resilience factors

Much research has sought to identify key factors affecting young children and to measure the impact of those factors on children's current mental health or subsequent outcomes in later childhood or adulthood. In the main, quantitative analysis has been used to assess statistical associations between characteristics of the child, family or environment which are associated with particular 'good' or 'bad' outcomes. Immediate outcomes for young children have been assessed using a number of social, emotional and behavioural indicators, which vary with age and stage (Ward, 1995; Vostanis & Cumella, 1999). For instance, positive indicators in the early years include seeking and liking proximity to familiar adults, initial wariness of strangers, reaching developmental milestones within the 'normal range', co-operative play and forming friendships by age 3-4 years. Negative indicators include aggression, hyperactivity, high anxiety, fearfulness and a 'frozen' demeanour. Failure to grow or thrive when there is no organic explanation is also often an expression of unhappiness (Iwaniec, 2000).

Caution is needed in interpreting the different factors. Even when statistical associations have been firmly discovered, it must be remembered that they are still based on probabilities and proportions. For instance, in some respects boys are more vulnerable to negative outcomes than girls, so gender is a factor, but clearly not an absolute determinant, since many boys turn out well and many girls have unhappy outcomes. Children brought up in poverty are well-known to have high risks of health, educational and behavioural problems compared with materially advantaged children; in addition, there tends to be a clustering of inequalities and accumulation of risk factors, particularly for those in the most disadvantaged and socially excluded groups. By no means, however, do all poor children have difficulties. This is of course partly because of the influence of other factors, ranging from parental supervision and support to the socio-economic conditions of the neighbourhood. Some researchers have been giving attention to the cumulative effects of factors that help to protect children from adversity (Landy, 2000).

Three main types of factor have been distinguished (Rutter, 1985; Rutter & Rutter 1993; Gilligan, 2000; Armstrong & Hill, 2000).

- **Risk factors**[1] are those characteristics that are statistically associated with poor outcomes. They are sometimes known as 'vulnerability factors'.
- **Protective factors** promote positive mental health and help shield children from difficulties.
- **Resilience factors** are those that enable some children to do well even though they have experienced adversity in early life.

Most early research focused on risk and protective factors, but over the last decade much attention has been given to resilience. This has been defined as 'the process of, capacity for, or outcome of, successful adaptation despite challenging or threatening circumstances' (Masten *et al*, 1990 p426). Resilient children are those 'who, against all the odds, develop into competent, confident and caring adults' (Mental Health Foundation, 1999 p9).

By and large, protective and resilience factors are quite similar, so they may be grouped as positive factors (see *Tables 1* to *3*, below). Sources for these tables include Garmezy (1985), Rutter & Rutter (1993), Fonagy *et al* (1994), Hill & Tisdall (1997), Mental Health Foundation (1999), Cleaver *et al* (1999), Buchanan (1999) and Wadsworth (1999).

The operation and interaction of positive and negative factors

Often the factors affecting outcomes are considered individually, but attempts have also been made to assess the interactive or cumulative effects of a cluster of factors. Risk factors do not occur in isolation from each other and their impact may be cumulative; that is, the presence of more risk factors increases the likelihood of a greater number of negative outcomes (Seifer *et al*, 1992). Some have conceptualised this in terms of human and social capital, ie the extent to which children acquire emotional, social and cognitive resources which help them respond to life's opportunities and cope with challenges (Coleman, 1988; Wadsworth, 1999).

As **ecological approaches** to child development suggest (Bronfenbrenner, 1979; Simeonsson & Covington, 1994; Boushel *et al*, 2000; Sameroff, 2000), it is necessary to understand the interactions among the different systems which surround a child. Not all children exposed to risk factors go on to develop mental health problems (Vostanis, 1999). This has promoted interest in protective or resilience factors which can offset an accumulation of vulnerability. Of particular importance are the positive influences that are malleable; in other words, they can be 'added' to a child's life through services or teaching. They include support, educational opportunities and problem-solving skills (Daniel *et al*, 1999; Gilligan *et al*, 2001; Hart, 2001).

It has also been increasingly recognised that children are not passive products of their environment. Individual temperamental and cognitive factors shape the way in which they interact with their environment, carers and peers (Gross *et al*, 1995; Rutter, 1989). As they mature, their environment is increasingly determined by their own behaviour and choices (Scott, 1998).

Evidently, risk, protective and resilience factors can act at different points in a child's life, and often they change over time. A **pathway** or **career perspective** helps take into account either the persistence of circumstances or significant alterations (Rutter, 1989; Little *et al*, 1995; Boushel *et al*, 2000). A child's life-course may be characterised by both continuities and discontinuities of factors and outcomes. This is most evident when there are major changes in household composition or other life events, such as parental separation, re-marriage and entering or leaving foster care. One advantage of the pathway approach is that it avoids a sense of inevitability about good or bad outcomes. It also helps to focus on crucial turning-points or decisions, where great care is vital to ensure that a child has supports and options which maximise the chance of a good outcome.

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[1]'Risk' has a number of different senses. Here it means 'a heightened chance of potential harm'. Risk can also indicate the probability of any kind of outcome (positive, negative or neutral). Moreover, even hazardous situations can offer opportunities for success, learning and development.

Specific factors

Different authors have generated many lists, but there is considerable concordance about the main factors. Understandably, risk factors are often the opposite of positive factors. Therefore in *Table 1*, below, two columns are used to identify positive and negative characteristics along the same dimension. Some of the research and factors relate to older children (eg in relation to the influence of school), but there is evidence that in modified form they apply to younger children. For instance, high-quality pre-school facilities have been shown to be particularly helpful for vulnerable children living in poor neighbourhoods and/or with an unstable home environment (Roberts & Macdonald, 1999).

Income and poverty

Material advantage tends to promote well-being, although of course it does not guarantee it. Conversely, a large body of epidemiological evidence demonstrates that poverty is a risk factor for poor mental health (Effective Health Care, 1997). The incidence of mental health problems among poor children is much greater than among non-poor children. A study by McLeod and Shanahan (1996) has shown that the duration and intensity of family poverty affect children's mental health. The longer a child's family is poor, the greater the likelihood of developing mental health problems. Children with early histories of persistent poverty have higher levels of depression. The links between poverty and psychiatric disorder in children are

TABLE 1	Social and environmental factors	
Dimensions	Risk or negative factors	Positive (protective and resilience) factors
Income	Low income	Reasonable income
Housing	Poor housing	Good housing
Social networks	Limited or unsupportive network	Supportive network
(Pre-)school	Strong negative peer influences	Positive and inclusive ethos; range of academic and non-academic opportunities; structured child-centred programmes
Recreation	Few leisure opportunities	Good opportunities to develop talent

Factors can be loosely grouped into those residing in the child, in the family and in the outside world. While some are relatively fixed (eg IQ), many are susceptible to change.

Social and environmental factors

The mental health of children is affected by their exposure to structural factors, which operate at the societal level, and environmental factors in their local neighbourhoods. The main risk and protective/resilience factors are set out in *Table 1*. Often, of course, children tend to experience a cluster of favourable or unfavourable factors related to the areas in which they live (Macintyre *et al*, 1993).

generally indirect, acting through variables such as nutrition, housing, medical care, lifestyle and attitudes, accidents, exposure to toxic substances, parenting skills, maltreatment, marital disharmony and quality of care (Vol. IV). The experience of poverty creates other risk factors such as parental depression, and is a major factor in child abuse (Corby, 2000).

In addition, other factors associated with poverty, such as homelessness, increase the risk of mental health problems (Mental Health Foundation, 1999; Vostanis & Cumella, 1999). Pre-school children living in high-rise housing were found to have levels of behaviour problems well above average (Richman, 1977).

Social support

Much research has shown that social support helps to reduce
pressures on families or acts as a buffer when they are facing stress
(Cochran et al, 1990). This can be especially important for lone
parents (Fuchs, 1995) and families with a large number of high-risk
factors (Luther & Zigler, 1991). Some neighbourhoods have
supportive and open networks, whereas in other areas relationships
are fragmented, closed or dispersed (Warren, 1980; Hill, 1987;
Trevillion, 1999).

Most of the evidence about beneficial effects on children
from their own networks tends to relate to older children. In
families and areas with several high-risk factors, youngsters have
been shown to have good outcomes when they are adept at
choosing resilient models and sources of support (Murphy &
Moriarty, 1976; Pines, 1979). Other resilience support factors
include the presence of a network of informal relationships of
friends of the same age, older friends and other role model
figures such as ministers and even teachers (Werner & Smith,
1982). Peers can play a very positive part in young children's lives
(Rubin, 1980; Hill, 1987; McGurk, 1992), but we are not aware
of studies documenting the precise impact on well-being.

(Pre-)school and leisure opportunities

There is considerable evidence that access to well-resourced pre-
school nursery school provision with structured programmes is
beneficial for children, not only intellectually but also in terms of
social maturity. It can be particularly effective in helping children in
disadvantaged areas (Maughan, 1998; Roberts & Macdonald, 1999).
The literature indicates that a range of intervention programmes
which offer support services to high-risk children and their families
can be of benefit in providing protective functions and promoting
positive outcomes (Berrueta-Clement et al, 1984; Consortium for
Longitudinal Studies, 1983; Copple et al, 1987; Price et al, 1989;
Hill, 1999).

Families living in poor neighbourhoods tend to experience
most stress and so arguably have greatest need for respite, yet
recreational opportunities for both adults and children in such
areas are often very limited (Macintyre et al, 1993).

Parental and family factors

Parents affect children profoundly through inheritance and because
they are usually the main shapers of the child's early care
environment (*Table 2*, below). It must be remembered that siblings

TABLE 2 Parental and family factors		
Dimensions	Risk or negative factors	Positive (protective and resilience) factors
Parental behaviour during pregnancy	Parental smoking, violence, mental health problems	Harmonious family relationships
Attachment quality	Insecure attachment or emotional detachment	Secure attachment
Parental supervision	Lax supervision	Attentiveness
Discipline	Authoritarian or lax forms of control	Authoritative forms of control
Support for education	Indifference to child's education	Commitment to child's education
Family relationships	Discordant or violent relationships	Generally co-operative relationships
Adult mental health	Severe mental health problems of a lone parent or both parents	No significant mental health problems
Substance misuse	Severe drug or alcohol misuse	No significant drug or alcohol problems

also have a great influence on each other (Dunn, 1993; Kosonen, 1997), while other family members can also have a significant impact (Hill, 1987). The behaviour and attitudes of parents vary significantly according to income, occupation and educational background. For instance, Wadsworth (1999) states 'Smoking and obesity are strongly socially determined' (p47).

Pre-natal parental behaviour

Parental behaviour can affect children before they are born. It is easiest to detect the influence of mothers when the child is in the womb, but fathers may also have an influence (eg through domestic violence). Children's physical and mental health can be affected by smoking, heavy drinking or drug misuse during pregnancy (Cleaver et al, 1999).

Quality of care-giving

Much research, particularly in the realm of attachment theory, has demonstrated the vital importance of the quality of early relationships. Warm, responsive and consistent relationships with at least one parent or carer are strongly associated with a sense of personal security, confidence to explore and a tendency to trust others (Bowlby, 1988; Schaffer, 1990). Block (1971) found that ego-resilient children lived with competent, integrated, loving, patient and compatible parents who shared each other's values. The capacity of parents to monitor, reflect on and adapt their behaviour towards children also seems to be an important component of successful bonding, which promotes the child's happiness (Fonagy et al, 1994).

Children under five years who have experienced adult attentiveness to their feelings and thoughts usually develop a secure attachment pattern (Bowlby, 1969; Child Psychotherapy Trust, 1999). They acquire an 'internal working model' of relationships which helps them relate positively to new adults and children they meet. Secure attachment also promotes the capacity for empathy and understanding of other people. The benefits of stable, responsive care are cognitive as well as emotional. Five-year-old children who were securely attached at 12 months show greater competence in tasks requiring the

understanding of mental states than those who were insecurely attached. It is possible to anticipate children's later school achievements by looking at the quality of their early attachments and level of outside support (Rutter & Rutter, 1993; Child Psychotherapy Trust, 1999). These emotional and cognitive qualities developed in early childhood can help children adjust better to later traumas.

Children who experience inconsistent and impersonal care in institutions usually develop long-term difficulties in establishing close relationships (Rutter, 1981). A study on the effects of institutional rearing in childhood on adult women found that they fared much worse than controls, with increased rates of personality disorder and poor overall social functioning (Quinton et al, 1984; Rutter & Quinton, 1984).

Children whose family care is very inconsistent, discontinuous, rejecting or abusive develop 'insecure attachment patterns' characterised by a tendency to avoid closeness, be anxious or be demanding (Howe, 1995). A high proportion of children who have developed behaviour problems by middle childhood had earlier attachment difficulties (Scott, 1998). This can lead on to persistent, serious offending (Fonagy, 1998).

A number of long-term studies have shown that adults who had difficult attachment histories as children tend to form problematic relationships with their own children (Sroufe & Fleeson, 1988; Parkes & Stevenson-Hinde, 1991). However, young mothers brought up in institutional care looked after their children more effectively when they had a supportive partner, highlighting again that a single factor is not prescriptive (Quinton & Rutter, 1988).

Disciplinary styles

Parental styles of discipline and rearing are also important for child mental health outcomes. Generally, the best longer-term outcomes for children have been shown to be related to authoritative styles, which are neither too lax nor too harsh, but encourage expectations of coping and achievement (Baumrind, 1971; Steinhauer, 1996). Frequent harsh punishment tends to generate anxiety and aggression

in children, especially in families lacking social support (Belsky, 1984). Poor supervision and low involvement in children's activities place a child at greater risk (Scott, 1998). Laybourn *et al* (1996) showed that working-class children had better outcomes when their activities were monitored and supervised. The significance of family values has also been demonstrated by the fact that, among underprivileged families, the belief in opportunities through education can help children attain success in adult life (Comer, 1988). Parent-child interaction patterns are also of significance here. Parents of children who are anti-social do little to encourage polite or considerate behaviour, but often model aggression. Patterns of aggressive behaviour are reinforced by giving in to it (Maccoby & Martin, 1983). In contrast, children have few psychological difficulties when their families do things together and parents show interest in the children's own activities (Buchanan, 1999).

Parental separation or loss

Children whose parents divorce or separate tend to have lower well-being than children in intact families (Amato & Keith, 1991). However, a number of studies indicate that the crucial factor is family discord, since usually children's negative reactions were evident before separation, while children whose parents part fairly amicably do well (Jenkins & Smith, 1991). Also some children gain from divorce, especially when they have experienced or witnessed child abuse or domestic violence.

Loss of a parent through death is not associated with major negative consequences in children, but bereaved children are more liable to depression (Rutter, 1981; Hull & Johnston, 1999).

The question of whether children's mental health is affected by household size and structure has been much debated. Some argue that children need two parents for optimal development and cite evidence about poorer outcomes for children growing up in fatherless households (Dennis & Erdos, 1992). On the other hand, most of the differences between children in lone-parent and two-parent households disappear when the higher incidence of poverty among the former is allowed for. Many children

brought up by one parent or by gay parents do well (Schaffer, 1990). It appears that when children are ill-treated by one parent, a supportive relationship with the other parent is particularly important (Werner, 1990).

Adult mental health problems and addictions

Children whose parents are experiencing mental health problems have been found to be at increased risk (Kurtz, 1992). Emotional and behavioural problems have been associated with maternal depression, particularly in boys (Richman, 1977; Gross *et al*, 1995; Sheppard, 1994). It has also been suggested that depression in pregnancy may lead to a significant proportion of mental health problems in women, which then also affect their children (Murray, 1995). Living with a depressed parent has been identified as a risk factor for childhood depression (Downey & Coyne, 1990). Najman and Bor (2000) found a major predictor of toddler behaviour to be the mother's mental state, as well as her general health. Mother's victimisation during childhood or adulthood was found by Dubowitz *et al* (2001) to be highly prevalent in high-risk groups and has been put forward as a key factor in affecting the mother's mental well-being and her relationship with her children.

Child factors

Characteristics of children themselves have been found to influence both their current and long-term well-being (*Table 3*, overleaf).

Pre-natal and perinatal factors

It is now generally agreed that it is not helpful to talk in terms of nature versus nurture, since genetic and environmental influences interact inextricably. It has been suggested that genes may turn off or on at different ages and in different contexts. For example, low socio-economic status may inhibit or trigger genetic propensities.

There is a growing body of literature on the role of congenital brain malfunctioning as a cause of later behavioural and psychiatric disorders (Mcleod & Shanahan, 1996). There is evidence that some form of brain abnormality causes

hyperactivity, and links have been established between cerebral palsy, epilepsy and psychiatric disorder (Rutter, 1998). Rutter (1996), however, suggests that any genetic effect is modest.

Peri-natal factors such as premature birth and low birth weight increase the likelihood that children will develop later mental health difficulties. Serious medical illness also has a negative impact. However, social factors affect these apparently biological risks, which are not evenly distributed across social groups. For instance, the prevalence of low-birth-weight babies is much higher than average for children of low socio-economic status minority ethnic teenage mothers.

Temperament

Very young babies have been found to have fairly stable temperamental tendencies. Some are generally placid and easy to

more discomfort in restless than placid young children (Dunn & Kendrick, 1982).

Individual temperament has also been linked to subsequent problems. Kagan *et al* (1988) found that severe behavioural inhibition in young children is associated with psychiatric disorder in school-age children. On the other hand, the development of a positive self-concept is a major factor in promoting other aspects of positive mental health (Armstrong & Hill, 2000).

Several dispositional attributes of children have been shown to help them resist or overcome an early upbringing featuring major separations, disruptions and/or negative family and social environments (Werner & Smith, 1982; Garmezy, 1985). An easy temperament helps children to cope with adversity in childhood (Luther & Zigler, 1991). A higher proportion of girls than of

TABLE 3	Child factors	
Dimensions	Risk or negative factors	Positive (protective and resilience) factors
Peri-natal experiences	Trauma and ill-health	Easy birth and good health
Temperament	Restlessness or anxiety	Easy-going nature
Intelligence	Low IQ	High IQ
Cognitive abilities	Impulsive, external locus	Planning, internal locus of control
Educational achievement	Poor educational attainments	Good educational attainments
Interests	Few interests	Success with hobby, sport or other activity
Attitude	Lacking confidence	Positive attitude, self-belief
Communication skills	Communication difficulties	Articulate communication

comfort. They develop regular sleep patterns and cry less than average (Thomas & Chess, 1977; Bee, 1995). This not only is an indicator of well-being, but makes it easier for parents, so that a positive cycle is initiated. Conversely, other babies are restless (eg crying readily, sleeping fitfully) or slow to respond to adults. In extreme cases, this can contribute to a cycle of negative interaction with the child's care-giver, characterised by frustration and tension on both sides (Fahlberg, 1994; Brandon, 1996). The birth of a sibling leads to

boys appear to manage better when subjected to care outside the home and family stress, though there are many exceptions (Rutter, 1982). Longitudinal studies conducted by Werner (1990) and Werner & Smith (1982) examined the influence of gender at different stages, showing that boys are particularly vulnerable in the first decade. It should be borne in mind that boys are more likely than girls to externalise their difficulties (Gough, 1999), so girls' distress may be less noticed.

TABLE 4   Risk factors and relevant references

actor	Relevant references
ncome	Bartley et al, 1998; Wadsworth, 1999; Corby, 2000
ousing	Macintyre et al, 1993; Wadsworth, 1997; Bartley et al, 1998; Mental Health Foundation, 1999; Vostanis & Cumella, 1999
ocial networks	Werner & Smith, 1982; Belsky, 1984; Cochran et al, 1990; Luther & Zigler, 1991; Fuchs, 1995
re-school factors	Rutter & Rutter, 1993; Steinhauer, 1996; Roberts & Macdonald, 1999; Hill, 1999
ecreation	Buchanan, 1999; Gilligan, 2001
arental behaviour in pregnancy	Cleaver et al, 1999
ttachment	Bowlby, 1988; Schaffer, 1990; Howe, 1995; Rutter, 1995; Murray et al, 1999; Fonagy & Higgitt, 2000
arental supervision	Laybourn et al, 1986; Scott, 1998
iscipline	Baumrind, 1978; Maccoby & Martin, 1983; Belsky, 1984
upport for education	Comer, 1988
amily relationships	Rutter, 1985; Amato & Keith, 1991; Rutter & Rutter, 1993; Wadsworth, 1999; Clarke & Clarke, 2000
dult mental health	Downey & Coyne, 1990; Gross et al, 1995; Sheppard, 1994
ubstance misuse	Velleman, 1992; Besharov, 1994; Laybourn et al, 1996; Hogan, 1998
eri-natal factors	Steinhauer, 1996; Rutter, 1998; Cleaver et al, 1999; Wadsworth, 1999
· Temperament	Werner & Smith, 1982; Belsky, 1984; Kagan et al, 1988; Thomas & Chess, 1977; Bee, 1995
· Intelligence	Werner & Smith, 1982; Garmezy, 1985
· Cognitive abilities	Fonagy et al, 1994; Gilligan, 1997; Wadsworth, 1999
· Educational achievement	Rutter, 1985; Maughan, 1988; Gilligan, 1997
· Interests	Gilligan, 1997; Mental Health Foundation, 1999
· Attitude	Werner & Smith, 1982; Fonagy et al, 1994; Mental Health Foundation, 1999
· Communication skills	Pelligrini, 1980; Gilligan, 1997

Intelligence and skills

Children of higher intelligence have usually been shown to be less vulnerable to stress (Kandel et al, 1988; Masten et al, 1988; Werner & Smith, 1982), but a few studies have found the opposite (eg Masten, 1989). Children who have good social skills tend to be more resilient. Pellegrini (1980), in a study examining interaction effects obtained between interpersonal awareness and stress, indicated that increased stress was associated with poorer competence only among children with low interpersonal awareness. Other studies have found that internal locus of control serves a protective function (Murphy & Moriarty, 1976; Parker et al, 1990). Werner & Smith (1982) found that young people who were most resilient in the face of adversity had high faith in their degree of control over their own environment.

Other individual characteristics such as a positive attitude, a problem-solving approach, the capacity to reflect and the ability to plan, not to mention a sense of humour, all serve as protective and resilience factors (Pellegrini, 1980; Mental Health Foundation, 1999).

Gender

Much of the evidence about gender differences in mental health relates to older children and adults. In general, boys and girls in the pre-school years show little difference in happiness or anxiety (Rutter & Rutter, 1993). From an early age, girls experiencing stress are more likely to internalise their reactions, while boys externalise. Thus, as they grow older, anxiety and depression are more common in females and attention deficit hyperactivity disorder and conduct disorder among boys (Steinhauer, 1996; Gough, 1999). Gender differences have also been found in sexually abused pre-schoolers, boys showing more developmental delay and aggressive symptoms than girls (Fontanella et al, 2000). However, the risk of abuse and maltreatment of both young boys and girls is a fast-growing topic in the literature (Sargent, 1999; Corby, 2000; Cicchetti & Toth, 2000; Horwath, 2001).

Risk factors and relevant studies

Table 4, p29, presents the sources for the main factors discussed in this paper. Many of the sources are either reviews of many specific studies or individual studies which examined a range of factors, reporting those which were (statistically) significant.

Conclusion

In reviewing the evidence for the under-fives, the researchers sought to develop a broader understanding of mental health as contingent on the interaction of key factors, determinants and processes in multi-faceted and multiply determined ways. In this paper there has only been space for presenting findings on 'protective factors', 'resilience factors' and 'risk factors', which in turn were unpacked into social environmental factors, parental and family factors and child factors. It was found that risk, protective and resilience factors can impact at different points in a child's life and often they change over time. Since the young child's life-course may be characterised by both continuities and discontinuities of factors and outcomes, good or bad outcomes are not predetermined. There are then key turning-points or decisions that can increase the chance of a good outcome and it is these on which health promoters and welfare professionals need to focus.

The interaction and interrelationship of these factors have also been stressed, and the authors have sought to avoid treating them as isolated aspects of the mental health of the early-years group. This review underlines the fact that the knowledge base for understanding the importance of risk and protective factors is growing steadily, but it is equally evident that greater understanding of the processes and mechanisms which underpin these factors is required (Rutter, 1993; Werner, 1995; Landy, 2000). Insights into this problem can be gleaned from other fields of study. In undertaking the review, the authors were aware of the tendency of researchers in the early-years field to work in isolation on issues and problems affecting the early years. The planned conceptual paper will take this argument forward.

The case for designing and undertaking preventive and early intervention efforts in nurturing the mental health of children in their early years has also been bolstered by this review. Rather than expend more energy in making this case, researchers should now focus their efforts on understanding interactions and processes associated with risk, protective and resilience factors and should work with health promoters to spell out the practical implications of their work. The implications for mental health promoters and for those wishing to develop effective interventions will be examined in a second forthcoming paper.

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EVENTS DIARY

Title: **What is Mental Health Care All About?**
Pavilion in association with The University of Bradford present two major one-day conferences
Date: 17 April 2002
Venue: ORT House Conference Centre, London NW1

Title: **Psychiatric Patients in Secure Settings**
Effective Strategies for treating substance misuse
Date: 24 April 2002
Venue: Local Government House, London SW1

Title: **Munchausen Syndrome by Proxy**
Date: 13 and 14 May 2002
Venue: London Voluntary Sector, Holloway Road, N7

Title: **Munchausen Syndrome by Proxy**
Date: 16 and 17 May 2002
Venue: The Posthouse Hotel, Glasgow

Title: **Mental Health and Education**
Pavilion in association with Skill and University of Hull
Date: 16 May 2002
Venue: The Ramada Jarvis Hotel, York

Title: **Eating Disorders & Obesity**
A Pavilion conference
Date: 24 May 2002
Venue: ORT House Conference Centre, London NW1

Title: **Aspergers's Syndrome and High Functioning Autism** (HFA)
Across the Life Span
Understanding insights interventions provision
Date: 7 June 2002
Venue: Regent's College, London

Title: **Promoting Mental Health in Later Life: Meeting the Challenge**
Pavilion in association with the Mental Health Foundation
Date: 14 June 2002
Venue: ORT House Conference Centre, London NW1

Title: **Advocacy and Mental Health**
Date: 17 June 2002
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Title: **Food and Mood**
Pavilion in association with the Food and Mood Project
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Mental health promotion and the early years: the evidence base for interventions

ABSTRACT

This paper presents selected findings from a review of programmes and interventions designed to promote mental health in the under-fives. Examples of interventions and characteristics of best practice and successful programmes are presented, with under-pinning evidence of effectiveness. The authors argue that further research into the effectiveness of programmes is needed and call for interventions designed to address and explore interactive processes and mechanisms of risk and resilience. There is also a need to increase awareness of the importance of children's mental health and build partnerships between the many professionals and agencies concerned. For programmes to work, a wider range of public policy measures need to be in place, including initiatives to reduce health inequalities.

A burgeoning literature is now available postulating the value of, and rationale for, interventions with the early years. Sylva (1994) has argued that the impact on later behaviour of investing in interventions that focus on children themselves in the early years must not be under-estimated. Karoly *et al* (2001) argue that the infant and pre-school years lay a critical foundation for later growth and development and that it is important to target positive interventions to meet the needs of very young children. They contend that early childhood interventions can generate government savings and benefits that exceed the costs of programmes. A Europe-wide review of effective programmes states: 'There is strong evidence that the early years of life have a crucial impact on mental health throughout the life cycle. The development of strategies to promote the mental health of young children is therefore of fundamental importance' (Mental Health Europe, 1999). The government's Sure Start initiative rests on the premise that research 'has demonstrated the benefit of directing support to families with very young children to help

children fulfil their potential and be in a position to get the most from subsequent opportunities' (Scottish Executive, 2000). In particular, the literature identifies preventive interventions as desirable and indeed necessary to stop problems occurring in the first place or worsening later. As Robin Balbirnie (1998) argues, prevention is not only better than cure; it is also kinder, quicker and cheaper. For Fonagy, early preventive intervention has 'the potential to improve in the short term the child's health and welfare ... while the parents can also expect to benefit in significant ways' (Fonagy, 1998). He adds that in the long term 'children may further benefit in critical ways behaviourally... educationally... and in terms of social functioning and attitude...'

However, as Rutter (1982) warns, interventions must have a clear purpose. There is a tendency, both within the literature and in government pronouncements, to assume that early intervention is always positive (Hirst, 1998). It is therefore timely to review the evidence base for interventions in the early years. The background and

ethods have been described in our previous article on
k, protection and resilience (Titterton *et al*, 2002). This
view builds on earlier work that has taken place over the
st decade (Kurtz, 1992; Roth & Fonagy, 1996; Durlak,
98; Child Psychotherapy Trust, 1999; Mental Health
oundation, 1999; Osofosky & Fitzgerald, 2000; Bower *et*
2001). It considers different approaches to mental
alth promotion in the early years and presents examples
interventions. Interventions have been categorised as
ose focusing on the individual, the family, pre-school
terventions and developments in policy and strategy. The
thors contend that the effectiveness and suitability of
terventions intended to promote and support mental
alth in the early years need to be carefully considered and
at further research, particularly into interventions
signed to affect processes and mechanisms of risk and
silience, is a pressing requirement.

vidence, effectiveness and explanations

rly evidence to alleviate harm for children was based on a
oral confidence and a belief in the extreme pliability of
ildren on exposure to environments, as Jarman (1995)
otes. Actions were seen as self evidently right at the time,
t some came to be seen differently later: for example, the
ipping out of children to Australia and America to start a
w life or the evacuation of children during world war
o. Jarman argues: 'We need to exercise humility in
cognising that what is absolutely "known" to be right at
ne time will be "known" to be wrong at another.'

The authors of the European review cited earlier state
at in order to 'justify social and financial investment in
ildren's mental health promotions we need to be able to
ow evidence of positive outcomes' (Mental Health
urope, 1999). However establishing and documenting
idence of effectiveness is a complex process and itself
quires long term investment. The definition of what
unts as 'effective', moreover, is contentious (Hill, 1999;
ewman & Roberts, 1999; McDonald, 2001) and interest
s been stimulated by publications such as the 'What

Works' series produced by Barnados (for example,
Buchanan, 1999; Lloyd, 1999).

McDonald and Roberts define 'effectiveness' in terms of
'robust evidence that the services we provide are achieving
the stated aims in supporting young children and their
families' (1995). The Mental Health Europe review takes a
broader view, arguing that 'there are many different criteria
and it depends on the position and the perspective of those
making the assessment' (1999). Mental health promotion
may have health, social, economic and political impacts
(Hosmann & Llopis, cited in Mental Health Europe,
1999). The review produced high quality criteria for the
inclusion of 'model projects' that embody good practice
and offer guidance on factors to consider when planning
and implementing the evaluation of interventions. These
criteria included:

* having positive, evidence based effects on determinants
  of mental health and/or social outcomes
* being based on sound scientific knowledge about
  childhood development
* having clearly defined goals
* being focused on clearly defined target groups
* being replicable.

Evaluation is an important issue. McDonald and Roberts
write of their concern that the 'vast majority of
interventions are not evaluated before they are introduced'
so that much of the work we do with children has the
status of an 'uncontrolled experiment' (1995). These
authors argue that practice needs to be based on evidence
that a particular intervention is better than doing nothing
and better than alternative approaches. They also claim that
certain kinds of research designs produce more secure
findings than others. Randomised controlled trials (RCTs)
(where there is a random allocation of those receiving
services to one of two groups, only one of which receives
the intervention) are favoured because they involve less bias
relating to selection and external factors such as class or age.
These studies have 'attributive confidence'; in other words,

we can be reasonably sure that it is the help offered to those in the experimental group that accounts for their improved outcomes. Large scale RCTs are less common in the UK than in the US, where a growing number of studies have both experimental components and a longitudinal design (eg. Schweinhart et al, 1993; Karoly, 2001. For a recent example of a UK controlled trial, see Scott et al, 2001).

While it remains the case that more experimental research is required, researchers should nonetheless remain open minded about the selection of research designs. Experimental designs such as RCTs are undoubtedly powerful but they are arguably less successful at taking process issues into account. Searches undertaken for this review found many studies devoted to outcomes but few showed concern for the process of the intervention and the types of factors that may have contributed to different outcomes. Examples range from simple factors such as practitioner characteristics (for example, in relation to training and qualifications) to more complex factors such as the interactive effects of process determinants (Belsky, 1984). RCTs have their uses but they are not the only designs to yield valuable results.

Explanatory problems need to be addressed if we are to develop a better understanding of why some interventions work more effectively than others. We need to evaluate the effectiveness of methods to tackle interactions and processes that underpin risk factors. We need to consider how to measure the effectiveness of interventions that are intended to work at a number of different levels and that cut across policy fields and service boundaries.

Different intervention methods

Public health identifies three standard levels of prevention: primary, secondary and tertiary. The literature emphasises the importance of different levels of interventions: for example, individual, community and structural. The Mental Health Europe report describes different aspects of interventions as follows:

'The site, agents, focus, strategies and methods aimed at promoting children's mental health and accomplishing prevention may vary. The site can be the family home, clinics or specialists' centres or key community locations (such as the school or family centre). The focus or primary target may be the children, the parents, the family or various agents in the field of education, health care and social services' (Mental Health Europe, 1999).

The range of methods used includes psychotherapy and counselling, group work, home visiting schemes, family centres, nursery school interventions, clinical diagnosis and monitoring and educational methods. Each approach is outlined below and specific examples are discussed. The importance of social and economic strategies and policies is also considered.

Clinical diagnosis and monitoring

The two main purposes are:

* early detection of risk, disability and/or medical conditions (including deafness, visual deficits, neurological dysfunction, learning disabilities, autism)
* early detection of dysfunction in families and parental couples (including violence, child abuse, child maltreatment, child neglect).

A review of effective interventions in primary care settings by Bower et al (2001) highlights the lack of a reliable evidence base. However Tsiantis and colleagues describe an EU/WHO multi-centre study into the promotion of children's early psychosocial development through primary health care services (Tsiantis et al, 2000). The programme aims to develop training for primary health care workers to improve their ability to assess factors relevant to children's psychosocial development, and provides preventive approaches to foster that development. The programme is taking place in Cyprus, Greece, the former Federal Republic of Yugoslavia, Portugal, Slovenia and Turkey. Nonetheless further research would be welcome, including

on the role of generic and specialist staff in hospital, primary care and other settings. For example, the role of midwives and their capacity for interventions at the very early stages of life is something that deserves further examination.

Psychotherapy and counselling

These are distinct ways of working to improve relationships. Psychotherapeutic interventions can be used to good effect in primary, secondary and tertiary prevention and include child psychotherapy, parent-toddler psychotherapy, therapeutic work with individual parents, couples or parent groups, family therapy, art therapy, play therapy and drama therapy (Roth & Fonagy, 1996; Child Psychotherapy Trust, 1999).

The Easterhouse Centre for Stress Management is an example of an initiative using a psychotherapeutic approach. The centre uses management and personal development therapies to resolve some of the unique tensions experienced by people living in deprived neighbourhoods. The goal of these therapies is to 'identify main points of tension and facilitate the ability to change response patterns; to build confidence through one-to-one assertiveness training; to enable people to resolve their conflicts at the personal, family and neighbourhood levels...' (Richards, 1996). Improving the ability of parents to communicate positively, consistently and effectively reduces the negative effects on children, thereby decreasing the risk of outcomes such as depression, drug and alcohol abuse and criminality.

Educational and awareness-raising methods

Health education takes many forms and may include courses and the dissemination of books, leaflets and videos (Mental Health Europe, 1999). These interventions may be combined in various forms and have different training requirements. While some projects rely on volunteers with little training, others may need professionals who have been through long term and intensive training programmes. The

European review concluded that disparate measures can contribute to decreasing risk and vulnerability and increasing resilience.

Interventions focusing on families

The report 'Bright Futures' on the mental health of children and young people (Mental Health Foundation, 1999) reviews a range of family interventions that can take place with any age but mostly focus on the early years. Some are provided shortly after birth, particularly for women experiencing post-natal depression and for severely depressed mothers and their babies. Others cater for families with young children, including families of children showing early behaviour problems. The most common types of intervention are intensive home visiting and centre-based support. The report highlights the success that such initiatives have in reducing physical maltreatment and neglect, which in turn helps prevent mental health problems. However it is noted that those families in greatest need are often the ones least likely to take part. The authors conclude that, to be successful, initiatives must begin early, be long term and target risk factors. Local projects with scope for maximum community participation are also more likely to succeed, particularly if they are handled in a sensitive manner. One example given is the St. Michael's Fellowship. This runs four residential family assessment units working with four different 'at risk' groups: adolescent mothers, parents with drug and/or alcohol dependencies, families where there is child abuse and families where the parents have learning disabilities or mental health problems and/or there is child abuse.

Parenting programmes

The field of parent education and support is complex. Armstrong and Hill (2001) note the difference between informal parenting support groups with supportive as well as educational functions and programmes that follow a pre-set curriculum and have a primary focus on learning. US studies suggest that parenting programmes make an

Parenting programmes

The Link Up Support Centre is an example of an initiative that provides both informal support and an educational function. The centre is based in Edinburgh and works primarily with women experiencing social isolation and mental health problems. The values of the project are underpinned by the principles of community development. The staff work with women to identify their health needs and enable them to acquire the skills to address these. The initiative:

- provides a safe caring environment for women
- seeks to enable women to achieve their full potential by providing support, education, confidence building, health education and health promotion
- enables women to take more control of their lives in their families and communities and find a voice individually and collectively
- provides work on parenting skills.

important contribution to the development of participants' skills, understanding and self-confidence and, through these changes, enhance the lives of their children.

Webster-Stratton (1999) claims that clear guidelines are available about the main elements of successful parenting programmes. Parenting programmes need a broad-based content focusing on individual and family interpersonal issues as well as specific parenting skills. While there is evidence of increased interest in parent education among parents themselves, this appears to be mainly among middle class parents (Pugh *et al*, 1995). Absence of childcare, lack of transport and programmes' failure to be tailored towards need all contribute to the exclusion of parents in greatest need (Pugh *et al*, 1995). As Pugh and colleagues contend, it is unlikely that one approach will always be best for all parents and the type of programme offered should reflect the needs of individual parents.

An evaluation by Smart (1999) found:

- improved health and well being of women
- increased confidence and self-esteem of women
- gains for children and other family members
- therapeutic work with women and children highly valued by statutory agencies.

The Regional Intervention Programme is an example of an intervention where parents pass on skills to other parents. Comprehensive training is offered to families whose young children are on a trajectory toward enduring emotional and behavioural difficulties. The programme helps parents with instructions from other parents who have participated on how to interact with their children. The evaluation of the programme, involving a follow-up of a cohort of former clients, has revealed positive outcomes and it is reported to be a well-established option for preventing aggressive behaviour in early childhood (Strain & Timm, 2001).

Group work

These methods may involve:

- regular meetings of small groups of parents aimed at increasing sensitive responsiveness and understanding of their parental role and parent-child relationship
- regular sessions with small groups of children, giving opportunity to express concerns and develop self-awareness, creativity, resourcefulness, self-expression, peer communication etc.

Miller (1998) provides an example from the US that includes children's playgroups as part of a preventive intervention for families of at risk pre-school children. Activities include peer play, small group activities, reading, clean-up and snack time. The group serves two functions. First, on a practical level, it provides free childcare for parents with limited financial resources so they can attend

Parenting programme

The Community Mothers Programme is a support programme to develop the skills and self esteem mainly of parents living in disadvantaged areas. Started in Dublin in 1998, the programme has an international reputation because of its significant impact on health and parenting outcomes demonstrated through positive evaluation (Johnson & Molloy, 1995; Johnson et al, 2000). The programme aims to empower parents, develop their skills and talents and restore confidence and self esteem so they can tackle their life problems in their own way. The model is one of parent-capacitating empowerment. Community mothers programmes in Dublin and the Netherlands were selected as effective model projects by the European Project and there are examples of the programme as far afield as Australia and the US.

the parenting education programme. Second, by providing a controlled setting in which children play with their peers, it demonstrates to parents the importance of helping

The programme provides:
- mothers supporting mothers
- a semi-structured monthly home visiting programme
- a community development approach.

Benefits have been found in terms of health, nutrition and developmental stimulation (Johnson et al, 1993). The programme has been expanded to include breastfeeding support, mother and toddler groups and the needs of travellers (Johnson & Molloy, 1995). A follow-up study conducted in 1997 found that the beneficial effects on parenting skills and maternal self-esteem had been sustained and the benefits extended to subsequent children (Johnson et al, 2000).

children form positive peer relationships and shows them ways to help children problem-solve. The children's strengths and weaknesses are identified and project workers

Family centre

The New Fulford family centre is an example of an initiative adopting a variety of approaches including parenting education, group work, psychotherapy and counselling. The centre is a Barnados project, and also receives funding from Bristol City Council. The centre offers a range of interventions for children under five years and their families who can access a package of services tailored to individual and family need. The activities include intensive one-to-one work with parents, play therapy for individual children, family play sessions and a range of therapeutic, educational and support groups. Intervention models are psychodynamic, behavioural and cognitive. The centre integrates family support and community development work and is

committed to the promotion of inclusive services for black and multi-racial families and families with a disabled child, both within the centre and the local neighbourhood.

The following benefits have been reported:
- responds to identified needs of children, families and communities
- promotes children's rights
- challenges abuse and violence in families
- allows children to remain at home
- increases parent/child involvement
- relieves isolation/stress of parents
- promotes self-help techniques among parents
- enhances individual strengths and support for parents.

provide positive parenting techniques to parents. To ensure consistency, workers use the same techniques with the children.

Family centres

Family centres have been developed over the last 30 years, some evolving out of traditional nurseries, others planned from the start to provide a wide-ranging service. They place considerable emphasis on working with the whole family although in reality the work most often focuses on mothers and young children. Family centres are usually located in deprived communities and target families deemed to be 'at risk' (Warren, 1990; Walker, 1991). The review by Armstrong and Hill (2001) of the literature on family centres found a number of benefits to both parents and children from attendance, although it was not possible to attribute the benefits exclusively to links with centres. The gains included increased social networks for mothers, improved ability to cope with children, increased self-confidence of mothers and opportunities for children to mix with others and to play in a safe environment. Centres with open access were found to be more popular than ones relying exclusively on referral; these were seen by some to carry a stigma. Smith (1993), in a study of Children's Society family centres, cites the importance of examining process in determining the effectiveness of provision. It is contended that attributes such as worker style, the range of activities, educational approaches and the provision of resources in neighbourhoods otherwise lacking facilities may be more important than the type of project.

Home visiting schemes

These can be provided by a range of workers, including volunteers, social workers, health visitors, teachers, psychotherapists and professionals working in disability (such as speech therapists). The purpose of these visits may be to provide support and/or education and to ensure early detection of medical, developmental and/or

psychological conditions. Video filming of parent-child interactions and subsequent discussions of these videos may be used.

Hirshberg (1997) describes an example from the US of an early mental health intervention programme undertaken by a range of health professionals including social workers, psychologists, speech and language therapists and occupational therapists. Hirshberg advocates the inclusion of a mental health evaluation as standard in any early intervention assessment. He describes a process whereby professionals work together to discuss cases with a view to identifying mental health needs. These consultations include:

- listening to details of the infant's and family's experiences and reflecting on sequences of events
- paying careful attention to all relationships, infant-parent and parent-practitioner
- toleration of ambiguity, deriving answers as part of a group process rather than from the expert opinion of one person
- embracing complexity, including taking into consideration complexities arising from the practitioner, the early intervention programme as a system, the family's relationship to the staff and the centre as a whole
- taking account of the practitioner experience of working with individual families.

Balbirnie (1998), describing his visits to infant mental health centres in New Orleans, noted the extensive use of video recordings of home visits for both therapeutic and teaching purposes. He quotes Osofsky (2000) who outlines the main objectives of the Harris Centre for Infant Mental Health as: 'To raise awareness that even very young infants can have mental health problems and that early identification, intervention and prevention can have a significant positive impact on their lives and those of their families.'

Home visiting schemes

Home Start supports more than 17,000 families and 40,000 children each year through a network of more than 275 community-based schemes, making it the UK's leading family support agency organisation (Frost *et al*, 2000).

Trained volunteers, all parents themselves, offer regular friendship, support and practical help to young families in their own homes. This support can lead to parents' renewed interest in their children, an improved response to their child's needs and greater confidence in accessing other community services, all of which promote the long term health of children.

The Home Start scheme in the Netherlands was selected as an effective model project by the European Review (Mental Health Europe, 1999). An evaluation by Kirkaldy and Crispin (1999) found the benefits of the service to include:
- increased self-esteem and confidence
- decrease in loneliness
- improvements in health
- reduction in depression and use of medication

Intensive health visiting

Health visitors are regarded as being at the forefront of health promotion because of their access to vulnerable and hard-to-reach groups. Armstrong and Hill (2001) identify a number of studies focusing on health visiting programmes that offer a more intensive service to mothers and families considered to be vulnerable in relation to adult mental health and/or the quality of parenting. Intensive services have been found to help mothers with postnatal depression (Holden *et al*, 1989) and to reduce behavioural problems in children. A comparative longitudinal study by Oakley *et al* (1996) found that children born to mothers who received the intervention showed fewer behavioural problems at the age of seven than those in the control group. Also notable here is the

- reduced need for medical support
- reduction in reported instances of behavioural problems.

The Parent Adviser Service is a local project serving the area surrounding two separate health centres in south east London. It employs four health visitors and two paediatric community medical officers for one day a week in the role of parent adviser. Referrals are taken from any families of pre-school children with psychosocial problems. Criteria include psychosocial problems in children, emotional problems in the parents, relationship difficulties within the family and the presence of stressors such as chronic illness or disability.

Parent advisers receive training in counselling skills and processes. Families are usually seen at home. An evaluation by Davis *et al* (1997) found that the service was:
- a feasible option for work at the community level
- acceptable to both referrers and parents
- beneficial to families living in a very deprived inner-city community.

work of Murray and colleagues on post-natal depression and on health visiting (Murray, 1992; Seeley *et al*, 1996; Murray *et al*, 1999).

Nursery school interventions

These may aim to identify children with special needs, introduce creative ways of working with young children, train children, and monitor standards and procedures.

The High Scope Perry Pre-school Project is a well known pre-school intervention that has been subject to rigorous evaluation (Schweinhart *et al*, 1993). In summary, for every $1 invested in high quality, active learning pre-school education and home visits, some $7 was saved on welfare expenditure and other costs by the time the group reached the age of 27.

Home visiting scheme

Newpin is a UK-based volunteer befriending service that provides home visiting by volunteers on a national scale. The initiative offers support in the home for parents who have themselves experienced high levels of adversity in childhood. The national Newpin project provides a network of friendship and skilled help to families in these circumstances who need nurture, support and respect. It provides a stable and safe supportive environment and one-to-one attention for the children.

The programme is one of empowerment. Members explore their personal and parental skills and play creatively with their children to gain insight into their emotional needs. Through the personal development programme parents move from being victims to taking charge of their lives and their relationship with their child/children. The core values of the programme are empathy, equality and respect. The project also works with other agencies.

Evaluation of the project has shown that volunteers can be involved who have experienced and are currently experiencing adversity. They may also develop confidence and self esteem. Those befriended are more likely to enter as volunteers (Cox et al, 1991). An evaluation by Oakley (1995) found that Newpin had helped women with parenting problems: some parents considered that contact with the organisation had helped them not to hurt their children and others that it had prevented their children being taken into care.

Head Start and Early Head Start are other US initiatives. The first has received federal support for over two decades and both have been subject to evaluative research (US Dept of Health and Human Services, 2002). The primary goal of the Early Head Start project is 'to enhance the infant and toddler's overall social, emotional, physical, cognitive and linguistic development' (Mann, 1997). Strong partnerships with the child's caregivers are seen as an important means of accomplishing this goal. A seven-year national evaluation of the federal Early Head Start programme has shown positive results. Children have better performance in cognitive and language development and improved behaviour patterns, while parents display more positive parenting behaviour and provide more emotional support for their children (US Department of Health and Human Services, 2002). Head Start has recognised that mental health issues are becoming increasingly evident among the families served by its programmes and performance standards require that programmes have access to well-trained mental health consultants.

The Starting Early Starting Smart (SESS) programme is based at 12 sites across the US and has recently been evaluated to endorse the message from other research that early investment is critical (Karoly et al, 2001). This provides an integrated system of child-centred, family-focused and community-based services to at-risk children from birth until age seven. Evaluation has shown that the programmes increase access to and use of services, help strengthen families, decrease drug use among care givers, improve positive interaction between care givers and infants and strengthen the development of young children in ways crucial for success at school (Karoly et al, 2001). A longitudinal extension phase where babies and toddlers are asked to meet escalating emotional and cognitive demands is currently under way and will shortly be evaluated. Evaluated examples from the US also include the Prenatal/Early Infancy Project and the Chicago child-parent centres.

Social and economic policies and strategies

The literature also acknowledges the impact of material and social factors on mental health. As the Joseph Rowntree Foundation report (Utting, 1995) on parenting pointed

A systems approach to early intervention

The Starting Well health demonstration project
run by Greater Glasgow Health Board provides an
example of an ecological approach to early
intervention that, in addition to behavioural and
psychological factors that influence child health,
takes account of systems of a material and social
nature. The project aims to demonstrate that child
health can be improved by a programme of activities
to support families, coupled with access to enhanced
community based resources for parents and their
children.

The project is working with 1,000 families and is
concentrated in two areas of socio-economic
deprivation in Glasgow, one of which has a high
proportion of black and ethnic minority families.
There are two principal components of the
initiative:

- generic initiatives intended to be universally
  applicable using classical community
  development methodologies
- intensive home visiting intervention by health
  visitors and lay workers.

The programme is designed to improve the health of
vulnerable families in vulnerable communities
through a programme of family support and
development of parenting skills. Interventions are
pitched at a variety of levels, including:

- the child, involving early educational inputs in
  family learning centres, dental health education
  and childhood nutrition initiatives
- the family, through parenting skills development,
  including use of the Triple P parenting

programme developed by Sanders (1999), mental
health support and addiction services for parents
- the community, by providing childcare facilities,
  mother and toddler groups, toy libraries and
  training and employment opportunities. Lay
  workers, called health support workers, have been
  recruited from local communities and work
  alongside health visitors and other workers
- service agencies, for example by the establishment
  of appropriate structures and organisational
  leadership to support other interventions
- local health care co-operatives currently being
  developed by the health board and the
  implementation of specific health promotion
  programmes such as the Healthy City Partnerships
  food action plan and the oral health strategy.

The project is currently being evaluated by researchers
at Glasgow University in a study that involves a
control group and cohort follow-up. Anticipated
benefits from the Starting Well programme include:

- quantifiable gains, for example in dental health,
  diet and use of services
- qualitative improvements in family functioning,
  organisational development and inter-agency
  partnership
- community participation in planning,
  implementing and refining the project.

Informal evidence gleaned so far by project staff
indicates that the services being provided are
considered appropriate by parents involved (Killoran-
Ross, 2002).

out, there is still too great a contrast between the political
rhetoric about the importance and value of the family and
the reality of the economic circumstances in which many
parents have to live. The Mental Health Foundation

(1999) welcomes recent government initiatives such as Sure
Start, National Priorities Guidance, the National Child
Care Strategy and the work of the Social Exclusion Unit.
The Mental Health Foundation recommends that:

'All government initiatives on children, the family and education explicitly address mental health issues and that there is a clear cross-departmental government commitment to early intervention for children experiencing mental health problems which should include a commitment to:

- develop the capacity of mainstream services, under fives provision, schools and primary care to recognise and begin to meet the needs of children and their families when difficulties arise

- engage with, not reject those children and families who are hardest to reach

- early intervention, not just early in the child's life but early assessment and intervention whenever difficulties arise throughout a child's life

- long term intervention for those children with more intractable problems

- assess the value of innovative programmes across departmental boundaries where cost savings may be long-term

- identify long term funding for successful interventions whether based within local authorities, health authorities, the voluntary sector or those falling between agency responsibilities.'

Best practice and successful programmes

Our review has identified a range of characteristics that are commonly associated with successful interventions and best practice. Preventive interventions should begin early, be long term and be directed at risk factors and also, we would add, at risk processes. Outcomes can be affected not only by the type of intervention but also the manner and location of delivery. The Bright Futures review (Mental Health Foundation, 1999) highlighted the importance of:

- community participation
- local interventions
- effective assessment of needs
- the need for long term security for programmes such as Sure Start, as well as stable funding.

Parenting programmes

The review has identified a wide range of approaches and some evaluative studies that show, albeit in a limited way, widespread enjoyment and satisfaction on the part of parents, and reported improvements in relationships and in children's behaviour. Good practice initiatives include the following features:

- broad-based content
- a focus on individual and family interpersonal issues
- a focus on specific parenting skills
- accessible to those most at risk.

Group work – children's playgroup

Good practice initiatives provide:

- a controlled setting to allow children to play with and develop relationships with peers
- opportunities for children to problem solve
- opportunities to identify children's strengths and weaknesses
- useful links to parent education programmes.

Family centres

Good practice initiatives:

- benefit mothers and children
- address issues of stigma attached to centres with restricted access criteria
- consider process issues such as worker style and the range of activities on offer, as well as outcome measures
- focus on individual and family support needs as well as skills development
- are accessible to those at greatest risk
- are broad based and provide a range of activities (eg. the New Fulford Centre)
- are community based, accessible and provide a crèche.

Community Mothers and Link Up

Good practice initiatives:

- adopt empowerment approaches aimed at raising

parents' confidence and self esteem
* are underpinned by principles of community
development.

When reviewing the lessons from successful programmes it is important to consider added value and to recognise that wider approaches can address linked problems rather than dealing with specific problems in isolation. In addition, interventions should tackle underlying issue(s) as well as immediate problems. In this way families and individuals learn knowledge and skills that make future problems less likely or less severe:

'A strong case can be made to go beyond a presenting adversity, such as low self-esteem or depression, and develop programs that promote all the resilience factors, provide practice in how to use them in resilience behaviour and acquire the ability to assess the outcomes in terms of benefits and continuing problems.'
(Grotberg, 2002).

Grotberg points to the need for a broader approach where resilience is flexible and adaptable to enable us to address the continuing series of adversities that all of us face. Also broad programmes involving the community can more adequately address shared issues as well as isolated problems in individuals. The implications for service providers are to network a range of services and programmes so that clients benefit overall and not just in one area.

Successful interventions for very young children must meet the multiple behavioural health, physical health and educational needs of families (Karoly et al, 2001). Integrated health services must be made more accessible to families with multiple needs that are often difficult to meet in a fragmented service system.

Nonetheless, while arguing that all parents should have access to a range of support services, including programmes such as those described here, we would also stress the importance of parent support as part of a wider strategy. This should recognise that if children are to reach

their full potential, parenting programmes must be developed in association with high quality early childhood services and closer links between parents and schools. If parents are to be 'good enough' parents they will also need the 'permitting circumstances' of adequate employment, housing and financial support. They may also need continuing support in their role as parents.

Conclusion

When contemplating the topic of interventions in the early years, it is worth bearing in mind this warning from an overview of recent studies from the US (Zigler and Styfco, 2001):

'A year or two of attending pre-school is not an inoculation against all past and future developmental risks imposed by living in poverty. Just as one year of good nutrition is not expected to make a child healthy for life, it is foolish to assume that any brief intervention will lead to academic success and a good-paying job.'

Intervention programmes for the early years group are most likely to succeed when there are four elements in place. First, when they are of a long term nature; second, when they are sustained by committed funding and third, when a wider range of public policy measures is in place, including initiatives to reduce health inequalities. These should include initiatives aimed at fundamental and long term change of the determinants of childhood poverty and disadvantage (McLeod & Shanahan, 1996; Eaton, 1999). A fourth element is where integrated approaches to multiple problems are in place and where multi-disciplinary and multi-agency interaction is encouraged. The charitable and voluntary sector where, as our review has shown, many innovative approaches originate, still faces barriers to joining partnerships for health (Titterton et al, 2002).

This review of interventions to promote mental health in the early years indicates that further research into the effectiveness of programmes is needed and calls for

interventions designed to impact on processes and mechanisms of risk and resilience. In our previous article (Titterton *et al*, 2002), it was argued that more effort is needed better to understand interactions and the processes associated with risk, protective and resilience factors. The interventions reviewed here are, in terms of this criterion, still only partly successful. This is partly due to the division between process and outcome evaluations and the failure to link the two in integrated research programmes. We still have much to learn about how elements interact in the way they do and why. There is, moreover, a pressing need to ensure that interventions designed to promote resilience also develop skills that are essential for coping with a range of problem areas and underlying issues.

The practical implications of the studies and projects reviewed here need to be better spelled out and disseminated more widely, if wheels are not to be reinvented.

The general need to increase awareness of the importance of children's mental health is evident. Specifically, more effective ways of learning are required among practitioners. Another message from our review is that the number of key actors in the promotion of mental health of young children is potentially very large. They come from statutory and voluntary settings, embrace hospitals and communities and include professionals and laypersons alike. The training of practitioners, as Hoagwood and Olin (2002) rightly contend, must no longer act as a stumbling block to interdisciplinary exchanges and, we would add, to building alliances and partnerships among these different settings and players.

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Social Policy in a Cold Climate:
Health and Social Welfare in Russia

Mike Titterton

Abstract

The Russian Federation faces multiple challenges for its health and welfare systems and for the development of social policy responses. This article provides a review of some of the key challenges for social policy in Russia and assesses the adequacy of the responses to date. The author surveys recent developments in health and social welfare and makes recommendations on priorities for Russia's policy-makers and international funders. A range of public health challenges including drug and alcohol misuse, health in prisons and mental health is discussed; HIV/AIDS is singled out for particular attention. While Russia is increasingly attracting the attention of social scientists in the West, there is uncertainty about models and concepts suitable for the analysis of this complex society. Although empirical trends are largely discussed in this article, it is argued that theoretical development is required and some suggestions are made about concepts of the 'middle range' to assist in future analyses. Intermediate theories, such as those relating to the management of personal welfare, and development of resilience in a formerly collectivized context, are identified as having explanatory potential for this task.

Keywords

Social Policy; Health; Social welfare; Social theory; Russia

Introduction

As it continues into the second decade of the post-Soviet era, the Russian Federation faces multiple challenges for reform of its health and welfare systems and the development of social policy responses. This article provides a review of the knowledge base in relation to Russian social policy and evaluates some of the key challenges and the adequacy of the responses to date. In particular, the author surveys recent developments in health and social welfare and makes recommendations on priorities for Russia's policy-makers and international funders. While social policy writers are in agreement over the particularity of Russia as a case study (Standing 1998; Pascall and Manning 2000; Thomson

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2002), there is less of a consensus on models and concepts suitable for the analysis of this complex and enigmatic society. It is argued that, while empirical trends are largely discussed here, theoretical development is required and some suggestions are made about concepts of the 'middle range', which may assist in understanding how people are coping with change.

Russia is often described as a state and society in transition, but what it is moving to is less clear than what it is moving away from. As Remington (1997) has noted, few people would claim that recent attempts to transform political life in Russia are either decisive or irreversible. In comparison to its neighbours in central Europe, the post-communist evolution has been turbulent and far from conclusive: the war in Chechnya, the attack on the parliament building in 1993 and, we can add, recent terrorist incidents in Moscow and Beslan. Remington even argues, as do some Russian commentators in publications such as *Novy Mir*, that Russia will only reach democracy after passing through a period of authoritarianism. If this seems a harsh judgement, it serves to highlight the difficulties in deploying terms loaded with such normative connotations in connection with a country like Russia.

In this article, the principal challenges for public health and social welfare are discussed, along with a consideration of coping responses. While these issues include a range of blood-borne and respiratory illnesses and addictions in settings from the streets to prisons, the example of HIV/AIDS is given particular attention. Some explanatory problems are then raised. Finally, requirements for the development of effective social policies in the Russian Federation are spelled out.

Background

With the break-up of the USSR into 15 separate states and the setting up of the Federation in 1991, Russia has been attempting to leave behind the Soviet socialist welfare state, which has dominated the country since 1921. This model involved centralized planning with subsidized welfare provision, with free or very low-cost education, health care and housing; the model was exported, with some variations, to other regions within the Soviet bloc (Manning and Shaw 1998). It would be misleading to indicate that there has been a systematic shift or that the legacies of the past have been thrown over completely. On the contrary, there are powerful residual currents, reflected within public demands for the state control of services and renationalization of newly privatized resources. This mix of values, and the links to health, have rightly been the subject of study by some social scientists (e.g. Bobak *et al.* 1998; Rose 2000; Cockerham *et al.* 2002).

Even bereft of its old boundaries, Russia is still a very large territory, covering some 17 million square kilometres and with some 143 million people as of 2003. In addition, it should be remembered that Russia is a federation comprising 89 subnational members, including 49 *oblasts*, 21 republics, 10 national districts, 6 territories and 2 big cities. In Russia, relations between the central state and the regions are still evolving and at present constitute a potential instability for the federation (Hahn 1997). The dynamic is currently tilting towards a new centralism under Putin's presidency, as will be seen below, in the wake of the 2004 presidential elections and terrorist excesses (Politkovskaya 2004).

Key changes have been taking place in the legal basis of welfare, in public health and in the development of health and social care. The next sections provide a review of some of the principal trends, in order to indicate the impressive range of major social issues confronting Russia's policy-makers. The survey has been conducted on the basis of the author's experience of developing health, social care and education projects in the Russian Federation in the period from 2000 to 2005. Before outlining the main challenges to public health, the political, legal and economic contexts are considered.

Recent Political Changes

To some extent, Russia in the middle of the first decade of the new millennium is a different place from the Russia of ten years ago. In relative terms, there is now a greater sense of political and social stability compared to the 1990s. However, Vladimir Putin has used the recent terrorist excesses to centralize and consolidate his own power. Regional governors will no longer be voted in by the local electorate and will instead be nominated by the president. Critics claim that his avowed campaign to reduce the effects of the nepotism, oligarchism and corruption of the Yeltsin years has been self-serving and has smacked of authoritarianism. Internal criticism and opposition to the president's domestic and foreign policies are difficult to mount (Politkovskaya 2004). While external complaints about the lack of free and independent media have been vocal, Putin has nonetheless been given an easier ride than expected by Western governments. In answering the question 'can there be reform without democracy?' Jack (2004) concludes that Putin is the best that Russia can come up with for the moment. Other commentators take a far harsher view of the man and his policies (Politkovskaya 2004; for other views see Shevtsova 2003; Sakwa 2004). Whatever the disparate opinions on the Russian presidency, it is clear that the absence of democratic debate is at present providing one of the major stumbling blocks to the development of more consensual social policies.

The Law and Human Rights in Russia

Russia has passed a raft of legislation and decrees affirming rights to education, health and special protection against the hardships and upheaval of economic reform. Russian law regards education and health as fundamental human rights. The Health Protection Law (Fundamentals of the Russian Federation on Health Protection no. 5487) passed in 1993 and amended in 1998 declares unequivocally that health protection is an inalienable right and forbids discrimination on any grounds. Article 20 requires medical care to be free of charge in state and municipal health systems. The law also specifies the rights of particular groups such as minors and older people.

The Federal Law on Education guarantees accessible and free primary and secondary education and the government is obliged to provide financial assistance for impoverished families and those with handicaps since birth. There is also a Law on Social Protection for Invalids, which is intended to guarantee invalids the same rights and opportunities for realizing economic,

political and civil rights as other citizens. The law, moreover, criminalizes failure to fulfil obligations in childrearing (see also Butler and Kuraeva 2001). The Law of the Russian Federation on Psychiatric Care and Guarantees of Citizens' Rights in its Provision governs mental health legislation and was passed in 1992. The Law is a response to criticisms of abuse of psychiatry in the former Soviet Union (Bonnie and Polubinskaya, n.d.).

A key development has been an amendment to Article 230 of the Russian Criminal Code. For the first time, harm reduction programmes have been given legal recognition in a move designed to remove problems created by rigorous interpretation of the old law. This will have major consequences for those advocating harm reduction measures for dealing with social problems such as drug misuse and HIV/AIDS. With respect to the latter, the federal HIV law of 1995 includes provision for free medical treatment and guarantees the civil rights of those with HIV/AIDS.

Despite this plethora of legislation in the post-Soviet era, the position of Russia's vulnerable groups such as children and young people in institutional care is increasingly a difficult one. However, as Human Rights Watch (1998) has noted, Russian authorities have impeded efforts to study and reform orphanage institutions. The worst is the position of abandoned children, who have been treated as an underclass. There are now more than 600,000 children defined as being 'without parental care'; these are the 'social orphans' of whom 95 per cent have a living parent somewhere. At least 30,000 are committed to locked *internaty* for 'ineducable' children, some of whom live in very primitive conditions (Human Rights Watch 1998).

The legal framework for non-statutory action is still developing, building on laws on Public Associations (1995), on Charity Activities and Charity Organizations (1995) and Non Commercial Organizations (1995). The fashioning of appropriate relations between the government and NGOs is very much under debate at present. A satisfactory statutory/non-statutory relationship remains one of the elusive keys to a more progressive social policy in the Federation.

Financial and Economic Concerns

Even some of the Western architects of the large-scale privatizations of the 1990s in Russia now admit they were wrong: as Jeffrey Sachs has publicly confessed, the rule of law should have been the first priority. As it was, it led to the greatly underpriced sale of national resources to a handful of well-connected individuals, the so-called oligarchs, and created vast disparities in wealth (Politkovskaya 2004).

Russia suffered a financial crisis in 1998, which severely affected the savings of the middle classes. DFID's Country Strategy Paper (DFID 2001) highlighted some of the underlying features of the crisis and pointed out that a decade of falling GDP had led to a widespread decline in real incomes and to rising inequality. Measuring poverty in Russia is complicated by a number of factors but it is estimated that a poverty rate of 38 per cent exists, with up to 19 per cent of the population in extreme impoverishment, living on half the official poverty line or less. Some recent estimates suggest that Russia is

now one of the most unequal societies in the world, on a par with Latin America. The average subsistence requirements (*prozhitechnii* minimum) for an adult were in the range of 1,100–1,200 roubles per month or about $40. Russia has the lowest minimum wage in Europe – a mere 0.04 pence per hour (Abrams 2002).

Up to 60 per cent of the population may be vulnerable to poverty, with large numbers of people moving in and out of poverty. Wages and social transfers are inadequate to meet the needs of people in Russia. As DFID (2001) notes, there is a whole virtual economy of in-kind benefits and barter; consumption is supplemented by goods and services acquired through social networks which provide a safety net. People draw on household plots and assets from the Soviet era. However, these assets are depreciating. Many ordinary people are following survival strategies that are not sustainable; for example, the housing stock is deteriorating and this will affect the value of assets.

The reform of public finance and the public sector, including reform of the state budget, is currently a priority for the European Commission, which is assisting through Tacis-funded programmes. This wave of reform has also embraced a new system of social security, comprising four social funds based on insurance principles and employers' contributions. These are, however, perceived to suffer from fragmentation and poor coordination (Axelsson 2002), and the development of an adequate safety net for those in poverty or on the economic margins is a key task in coming years.

Public Health Challenges

The health of the Russian population continues to lag far behind that in the West (Tkatchenko *et al.* 2000). The requirement for reform has been recognized but remains poorly defined, and little clarity exists about what is meant by public health and associated key concepts. The capacity for managed change is weak. There is an urgent need to create a shared awareness of evidence on the nature of the challenges for public health facing Russia, and the evidence base for responses and strategies. Data sets such as the Russian Longitudinal Monitoring Survey (RLMS) of health conditions and the Russian subset of the international Health Behaviour of School Children Survey can be found, though arguments exist over the reliability of such self-reported data (see e.g. Nemtsov 2003, 2004).

Demands on Russian health care systems are growing dramatically (Moore 1999). The reappearance of diseases which were virtually eliminated in the former Soviet Union is particularly startling: these include poliomyelitis, tuberculosis, STDs, syphilis, and now HIV infection. Hepatitis is matching HIV for infection rates, but not for publicity (Stephen 2000).

International comparisons (Marmot and Bobak 2000) show a widening gap between Eastern Europe and Western countries in terms of life expectancy. By 1997, this had declined by 10 years for Russian men. This decline has been sharpest in the large cities of Moscow and St Petersburg and in the primary production regions of the north and Siberia. Plavinski *et al.* (2003) have demonstrated that men in the lower socio-economic groups were most affected by the sharp increases in mortality, which persist into old age (Bobak

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et al. 2004). It has been estimated that Russia experienced between 1.3 and 1.6 million premature deaths between 1990 and 1995 (Bennett *et al.* 1998); the mortality rate among men aged 35–44 was four times that in Western Europe (McKee 2001). Cockerham calls this 'one of the most important developments in world health' (2000: 1313).

A range of social and economic determinants has been cited in the literature. Russia has one of the worst records in Europe for risk behaviours like excessive alcohol consumption and tobacco use (Chenet *et al.* 1998; McKee *et al.* 1998; Carlson 2001; Zabina *et al.* 2001; Nemtsov 2002; Malyutina *et al.* 2002; Pridemore 2002; Vermeiren *et al.* 2003). A particular concern has been rising rates of smoking and poor nutrition among young women (McKee *et al.* 1998; Gilmore *et al.* 2004; Grjibovski *et al.* 2004; Averina *et al.* 2005).

Other explanations include growing crime rates and decline in social capital (Kennedy *et al.* 1998); widespread psychosocial stress (Denisova *et al.* 2005; Grjibovski *et al.* 2004); massive environmental degradation (ecocide) (Maimulov *et al.* 2004); low educational levels (Plavinski *et al.* 2003); injuries and violence (McKee and Shkolnikov 2001); and high rates of cardiovascular disease (Zabina *et al.* 2001). The collapse of the Soviet system of health care, which used to provide universal coverage, has also been suggested (Manning and Davidova 2001; see also Shuksin 2004, and Danishevski and McKee 2005). Other writers such as Marmot and Bobak (2000) and Godinho (2005) identify poverty and inequality as root causes.

In terms of explanations for this situation 'without precedence in modern history' (Cockerham 1999: 1), Cockerham (2000) contends that the primary source of this downturn can be traced to the effects of 'lifestyle practices' including a high-fat diet and lack of exercise. He concludes, though, that health lifestyles are shaped not by life choices but by life chances, in other words male norms and values, as well as social and political ideology. McKee and Shkolnikov (2001) also argue that underlying factors contribute to the burden of premature death in men; lifestyle choices are strongly influenced by social circumstances. These points, involving explanatory problems, will be returned to later.

By the year 2015 healthy babies will account for only 15 to 20 per cent of all newborns. In 1991 three-quarters of pregnant women suffered from ill health; normal births constituted only a quarter of deliveries for some Russian territories (Muhamedrahimov 2001). There has been a decrease in the birth rate, from 17.2 to 9.4 per 1,000. This decrease has been accompanied by an increase in illness among neonates. The percentage of neonates suffering from inborn and acquired chronic diseases will increase to 25 per cent if the present trend continues (Muhamedrahimov 2001).

The Russian Federation in 1994 only spent 4.8 per cent of GDP on health, less than Tajikistan and the average of the CEE countries of 5.7, and less than the average of Western Europe of 7.7 per cent. The formal funding of health care in Russia is provided through two mechanisms. The Compulsory Medical Insurance is a levy on employers of 3.6 per cent of the payroll bill; 0.2 per cent goes to the federal fund. The second formal source comes from local authorities. There are in addition various informal methods of funding such as informal user payments and bartering, which are widespread (IHSD 1999).

Drug misuse is increasing within the Federation (Veeken 1998; Fleming *et al.* 2001). While St Petersburg has 6,000 officially registered addicts, it is estimated unofficially that the figure is 80 to 120 thousand addicts (see also Aral *et al.* 2005). Recent surveys of young people are showing increasing substance misuse, particularly by those in more affluent families. Young people from more socially deprived backgrounds are increasingly misusing solvents.

The survey by WHO in its Mental Health Report for 2001 acknowledges some positive changes in prevention of abuse of psychiatry and notes the growing network of reformers in Eastern Europe (WHO 2001). It does nonetheless express concern about suicide and the impact of poverty. There is clearly still a long way to go in terms of shoring up the crumbling infrastructure of institutions such as the special mental hospital in St Petersburg (Denisov 1999). It is recognized that mental health reforms require the changing of attitudes of both medical professions and a close alliance between state psychiatric institutions and NGOs as 'essential for promoting reform' (1999: 18). The experience of relatives' groups in Moscow has also been described: Levina tells how relatives came together to raise the problems of families of people with schizophrenia that had 'fallen out of our government's field of vision' (1999: 11). The value of self-help initiatives for those affected by severe depression in Russia has been discussed by Titterton (2005).

Another major challenge for Russian policy-makers and health professionals is the poor state of public health in the country's prisons. Russia has the highest rate of imprisonment in the world (685 per 100,000 population). There are roughly 2 million prisoners in the Federation, in its remand facilities (SIZOs) and prisons. Some of these are in a desperate state of repair, and overcrowding is rife. A key problem is the spread of infectious diseases, such as tuberculosis (Stern 1999). TB has risen by 40 per cent in the past four years and now affects 57.4 per 100,000 people, one of the highest rates in Europe. Concern has been mounting about the prison population (Reyes and Coninx 1997) with rates of TB some 10 to 50 times higher than in the general population. In some prisons mortality from TB is the commonest cause of death, accounting for about 50 to 80 per cent of deaths. Russia has about 45 TB penal colonies, consisting of 71,000 prisoners, half of whom are under the age of 25 (Farmer 1999).

The challenge most exercising the minds of the Federation's policy-makers and health agencies is that of HIV/AIDS. To illustrate further the nature of the public health challenge and to further raise some explanatory issues, this topic is considered in more detail below.

The Example of HIV/AIDS

While the incidence of HIV/AIDS is not higher than in certain other parts of the world, it is currently spreading faster in Russia than anywhere else. A recent report by the United Nations Development Programme claims that Russia faces the world's fastest-growing epidemic of HIV (UNDP 2004). The spread of HIV is largely driven by rapidly rising levels of injecting drug users, of which Russia has over 3 million (UNAIDS 2004). DFID (2001) suggests that HIV/AIDS could affect as much as 5–6 per cent of the population by the end of the decade.

While the total number of registered HIV cases was 300,000 in November 2004, estimates of 700,000 have been put forward as a more accurate figure for those with HIV (UNAIDS 2004). A recent study of AIDS Centre data has shown that 'HIV infection is exploding in the Leningrad Region' (Krupitsky et al. 2004: 30). The epidemic is worsening; 77 per cent of women with HIV were infected in the period 2000–4 (Russian Federal AIDS Centre 2004). There has been a marked increase in the rates of HIV infection through sexual transmission (Aral et al. 2005).

Responses have often been led by NGOs, such as Return in St Petersburg and Aidsinfoshare in Moscow, which provide outreach, helpline and information provision; others concentrate more on HIV counselling. The development of outreach is a significant step, especially into high-risk communities such as the many commercial sex workers to be found in Moscow. These are mostly young women from regions outside the capital, as well as the Ukraine. Moscow has approximately 70,000 commercial sex workers, many of whom operate in the streets, making it hard for advice and welfare agencies to reach them. Projects run by NGOs are being designed to study the characteristics and needs of this population, to help formulate responses.

The Russian government has been slow to rise to the challenge posed by HIV/AIDS; as Veeken (1998) points out, the government always denied that an epidemic could happen in Russia. Since 2002 a Federal programme, 'Preventing and Fighting HIV/AIDS Diseases', now sets out government commitments on the protection of those living with HIV and AIDS. However, AIDS treatment clinics only get between 20 and 40 per cent of the funds to which they are entitled (Stephen 2000). Despite the recent setting-up of a National Advisory Council, there remains a lack of coordination, and scarce resources are being spent on an ineffectual mass testing exercise, at the expense of preventive health education. Harm reduction measures are gradually being accepted, although the need to build partnerships between law enforcement and public agencies, for example to prevent policing from interfering with risk reduction measures such as needle exchange, has been highlighted by Rhodes et al. (2003).

As Fleming et al. (2001) note, harm reduction approaches are not popular with politicians or the public, and methadone treatment has been prohibited by the law in the past. A recent report has reviewed harm reduction initiatives in the context of both Russian and international law (Butler 2003). As noted above, these programmes have at last been granted some legal recognition in the Russian Federation. This should make the task of those involved in outreach and needle exchange schemes that bit easier.

One needle exchange service in Russia is part of a mobile unit in St Petersburg funded by Médicins du Monde. This was reported closed by Fleming and his colleagues, is now up and running again (visited by the author in May 2001), but still faces hostility from officials and others in the city. Other harm reduction approaches include the peer-driven needle exchange project (Sergeyev et al. 1999). The use of psychosocial approaches to treatment and the use of staff other than doctors are increasing as well. Hostile public attitudes perceive drug misusers as 'undeserving', making it difficult to provide community-based social services and therapeutic regimes.

Russia's overcrowded jails are incubating grounds for HIV and other blood-borne viruses such as hepatitis. The risk behaviours of prisoners are of particular concern and include sharing dirty needles, tattooing and unsafe sex, as a survey of Russian prisoners sponsored by MSF has shown (Frost and Tchertkov 2002). There are some risk reduction and health educational programmes to deal with this, including work in Moscow and in Tver *oblast*, but these are still small-scale and limited projects for dealing with what is a serious, national public health issue.

Tackling the roots of the problem posed by HIV/AIDS requires a public health approach, based on principles of prevention and health promotion (Titterton 2004). Major health education programmes and those targeting harmful risk behaviours are now a pressing necessity. These need to take account of the diverse settings for health promotion, including the streets, residential institutions, prisons and schools (Titterton 2003). Wisely (2000) has, moreover, urged the designing of social policies to incorporate all those living on the margins, including drug addicts. AIDS prevention can be most usefully seen in the context of the prevention of blood-borne viruses overall, including forms of hepatitis, and not as an isolated problem. What this issue does do is draw attention to the need to develop more effective coping strategies and improved understanding of the causes and processes of public health problems.

Explanatory Issues

It is sometimes suggested that the health impacts of transition have been exacerbated by the low level of coping mechanisms among most of the population. However, not everyone has been affected to the same extent and those with strong social support appear to have been protected (see e.g. McKee 2001). Those most affected were those exposed to the fastest pace of change and who have the least well developed coping strategies, perhaps due to a lack of education, employment, family support or social resources. Coping strategies are a crucial link in the relationship between severe stress and welfare outcomes, and welfare models need to take better account of this (Titterton 1992). Management of personal welfare is now becoming increasingly important (Titterton 1992), along with the individualization of social care (Thomson 2002), devising of household and work strategies (Pascall and Manning 2000) and the development of coping responses in the face of hardship (Tchernina and Tchernin 2002).

As research undertaken in Former Soviet Union countries indicates, there is an intimate connection between young people's perceptions of control, health and economic success in the wake of what has been called 'post-Soviet culture shock' (Bobak *et al.* 1998; International Youth Foundation 1999). A recent study by Abbott *et al.* (2005) has shown that while understandings of health and illness are multifactorial, the major factors causing poor health are seen as beyond the personal control of young people. Further work in relation to concepts such as 'social capital' (Rose 2000) could well pay dividends here for both theorists and policy-makers, for example in looking at the role of informal coping resources and how welfare policies could further support these.

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Explanatory problems have been faced by commentators seeking to account for recent developments in public health and welfare in post-Soviet Russia. In their search for causes, processes have been overlooked. Attention has mostly been focused on mortality and the 'principal victims' (Cockerham 1999: 251), at the expense of the wider impacts of the unfavourable conditions, the decline and transition. Another difficulty is the defining and identification of problem groups such as people living with HIV and AIDS, illegal drug misusers or commercial sex workers, while failing to make the connections to underlying social factors (Titterton 1992). Providing more insights into processes and connections should help facilitate the more effective targeting of health and welfare interventions in the future. The changing societies of Eastern Europe offer researchers the possibility of doing this, for example through trying to explain how vulnerable children and adults develop resilience and mobilize resources for coping in unpromising circumstances.

These processes should include the links between stressors, including political and social factors, and poor health outcomes, and how forms of intervention can affect these, for example in the case of HIV/AIDS. These will in turn include coping mechanisms and other mediators. The Russian example helps to show that there is much resilience in the face of adversity. A shift of explanatory focus needs to take place, away from 'victims' and towards those taking active steps to develop creatively their own solutions to welfare problems and towards considering the efficacy of forms of resilience. This should help advocates of the 'health lifestyles theory' (Abbott *et al.* 2005) to avoid accusations of 'victim blaming', while acknowledging the importance of individual responsibility for health.

Manning and Davidova (2001) have suggested that political scientists have made the running in terms of middle-range theory focusing on social actors and institutions. They rightly note that these authors often neglect social policy issues and complain of a lack of the study of welfare regimes (Esping-Anderson 1990). Social policy analysts risk losing sight of important features by remaining at the comparative level; Thomson (2002) has suggested we can benefit from specific studies. However, social policy writers need now to develop intermediate theories, such as those relating to the management of personal welfare in a formerly collectivized context, that allow for a more critical engagement with the issues. This will, moreover, help them to avoid the devil of empirical detail and the deep blue sea of grand theory, a plight to which Mills (1959) drew attention four decades ago.

Future Requirements for Social Policy in Russia

The main requirements for the development of social policy in the Russian Federation are these. First, the economic foundations must be made secure; the link between social and economic policy must be made clear. The tax and expenditure relationship must, as a priority, be made clear and strong, as this provides the linchpin of any viable welfare state. Citizens avoid paying tax and the black economy is massive. The economic position fluctuates but Russia is not, in the eyes of some analysts, a low-income country: there is a great deal of wealth and resources. A major problem is differentiation and

stratification, with a new elite having the lion's share of wealth and the large mass of the population excluded, and with middle-class groups struggling to find security.

Federal programmes such as Children of Russia, Family Planning Programme, and Children of Chernobyl have been financed. However, the International Youth Foundation (1999) complains of the startling imbalance in federal expenditures, with a huge budget for military equipment purchases, which is 25 times more than programmes for children in preschool or with disabilities. A shift in spending priorities towards social programmes within the federal budget is long overdue.

The building of a civil society forms the second, related priority. This is inevitably a long, complicated process and its basis – civil laws and the precedence of the rights of citizens over those of the state – is not yet formed. The rule of law must now be more actively supported by Russia's governing elite. Liborakina *et al.* (1996; cited in International Youth Foundation 1999) have described the state–society relationship in the post-Soviet era where the elite is still fighting for power, riches and prestige, and there is limited interaction between the upper and lower strata of society. A vital source for any welfare state is the supply of informal care and volunteering by its citizens. The reform of the statutory/non-statutory relationship is, as suggested earlier, an essential prerequisite for enlightened reform of health and social services in the Federation. For many observers, non-governmental organizations (NGOs) offer opportunities for organizing multifaceted activities (International Youth Foundation 1999). However, it is important to take note of the difficulties faced by NGOs, problems that are shared with other countries in Eastern Europe (White 1993; Titterton and Clark 2000).

A third priority is that, as Tkatchenko *et al.* (2000) note, a robust public health response to the high levels of diseases is now required. This challenge has attracted attention from international donors, but the health situation in Russia may not be well understood by policy-makers within the country. Prison health and health promotion in schools are just two of the burning issues for them to tackle. A programme of sex education and healthy living for young people must be made a priority, along with effective preventive measures for the early age groups. The role of schools is vital in this respect, including health education for socially disadvantaged young persons with low literacy skills (Titterton 2003). As Godinho (2005) notes, increasing health literacy is needed alongside increases in prices and taxes on alcohol and cigarettes, and bans or restrictions on advertising of the latter. The World Health Organization has strongly urged governments to move towards preventive efforts, including robust health promotion campaigns (WHO 2004).

While social work and personal social services have grown since the late 1980s (Thomson 2002), the coverage across the population and territories remains uneven. Self-help initiatives and informal support of the sort described by Titterton (2005) are hard to sustain in the face of the bureaucratic and hospital-based care system. Few alternatives to the latter presently exist in the community and remain to be developed. Nonetheless, Wisely (2000) points to the emergence of new lobbying forces such as Mothers Against Drugs, groups who are prepared to put pressure on politicians for change.

Reform of governmental organizations is the fourth requirement. Complex organizational and administrative arrangements have contributed to policy stasis and duplication, with ministry responsibilities overlapping (see e.g. Sheaff 2005). Wisely (2000) claims that one of the main obstacles to the development of HIV prevention strategies is Russian bureaucracy. Many different departments hold separate and similar briefs on HIV prevention, so there is potential conflict and confusion.

A fifth requirement is for a more enlightened and empowering relationship with Western governments and Western funders. Major differences exist between Russia and the West in terms of philanthropy and charitable donations, a key source of funds for social activities in the West. There are no big private foundations in Russia similar to those in the UK or USA. Legal and social conditions for the involvement of Russian entrepreneurs have not yet been created (International Youth Foundation 1999). There is a lack of a strategic approach to donations and developmental activities, something that DFID and other international donors need to recognize.

Conclusion

It is difficult at present to talk of social policy in Russia, in the sense of a coherent policy response to the extreme challenges described by this article. Instead, there is a range of initiatives designed to tackle particular problems, but there is little sense of an emerging strategic response. An integration of micro- and macro-level changes is required: the latter must 'encourage and reinforce any forthcoming efforts of individuals to promote their own health' (Cockerham 1999: 80). Social scientists can assist by providing the theoretical and empirical tools for doing this. Intermediate theories, including those relating to the managing of personal welfare and the developing of forms of resilience, were identified above as having explanatory potential for this task.

Countries like Russia, which are undergoing extensive changes amid economic uncertainties, provide useful case studies for social policy researchers for generating and testing social explanations. In following the trend towards globalization studies researchers may be tempted to overlook the value of such examples (see e.g. Deacon *et al.* 2005). The latter need to come issued with the proviso that they should not be seen in isolation, but rather in the context of the study of comparative welfare states (Esping-Andersen 1990).

The challenges described in this article, especially for public health, are pressing ones for the Federation: the example of HIV/AIDS particularly illustrates the size of the task to be undertaken. It helps to demonstrate the need to address the diversity of health settings for prevention and intervention. Moreover, it points up the necessity of developing more coordinated approaches at the strategic level, while also acknowledging the importance of supporting coping mechanisms and processes on the ground.

These challenges require a multifaceted response by Federal, regional and local governments, international donors, NGOs and local communities. Partnership approaches have to be fashioned to facilitate more coherent and integrated health and social welfare programmes for the future. However, there are many obstacles to such an approach, as the UK experience shows

(see e.g. Titterton *et al.* 2000). Time invested in studying enablers and proposing actions to overcome these barriers would be time well spent.

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The support of health promotion activity in the voluntary sector: research findings and strategic considerations

Mike Titterton, Helen Smart, Lisa Curtice, Stephen Maxwell

ABSTRACT

The aim of this research was to assist the Health Education Board for Scotland in the development of a strategic approach for supporting health promotion activity in the voluntary sector. As well as interviews with representatives from the statutory and voluntary sectors, a key research method called facilitated discussion groups was designed to draw on participants' practical and strategic experiences and to develop collective wisdom by encouraging an exchange of views. Issues concerning involvement in health-related activities, funding and partnerships were raised. The strengths and weaknesses of a partnership approach were also examined. Suggestions for a national strategy are outlined: these include the need to tackle the funding problems and capacity building of the voluntary sector. Recommendations for good practice in multi-agency working are also made.

Keywords: voluntary sector, qualitative methods, strategy, Scotland

INTRODUCTION

The White Papers *Towards a Healthier Scotland* and *Saving Lives: Our Healthier Nation* place partnership between the health service, local authorities and the voluntary sector at the core of promoting better health in Scotland and in the rest of Britain[1,2]. The voluntary sector is now a large and growing player in health promotion and in welfare provision. Broadly defined, welfare organisations in Scotland have an income of around £850 million per year. Many voluntary organisations, whether or not the promotion of health is among their stated aims, claim a health role. As well as organisations providing health services or active in health

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promotion, community care providers, housing providers, advocacy groups, sports, arts and recreation groups, and environmental groups can all claim to contribute to the community's mental and physical wellbeing. However, on a narrower definition of health, health organisations probably comprise about 10 per cent of the total, with an annual income of around £105 million[3].

While there has been a steady growth in the literature on the nature and dimensions of the voluntary sector, there remain gaps in knowledge about its involvement in health-related work and about its relationships with the statutory sector in this field[4,5]. The topic of good practice in partnerships between the voluntary sector and local government has begun to attract attention[6,7]. Multi-agency partnerships involving voluntary organisations, and particularly those involving health promotion agencies, have yet to receive similar attention, though some ground-clearing work on health partnerships has been done[8-10]. A recent review of partnerships for health by Whitelaw and Wimbush has found that this field is "complex, varied and generally underresearched"[11]. There has been a lack of research on how health promotion activity in the voluntary sector can be supported and on the constraints and enablers in multi-agency partnership working.

In November 1997, the Health Education Board for Scotland (HEBS) commissioned a major piece of research to identify relevant issues in joint working and to fill in some of these gaps in knowledge. A consortium consisting of independent researchers, the Scottish Council for Voluntary Organisations and the Nuffield Centre for Community Care Studies, University of Glasgow carried out the research.

The aim of the research was to assist the HEBS voluntary sector programme in the development of a strategic approach for supporting health promotion activity in the voluntary section[12]. The specific objectives of the research were to: assess the importance of health and health-related issues within the range of voluntary sector agencies; establish the role of the voluntary sector in health within the current funding context; provide insight into the nature of the relationships between the voluntary sector and its two main funding partners, the health service and local authorities, from both perspectives; and provide guidance to HEBS on how best to facilitate and support relationships between the three groups (voluntary sector agencies, the health service and local authorities) as a way of promoting health[13].

METHODS

The work required both accurate information gathering, analysis and reporting, which is the traditional research model, and the facilitation of a considered response among the main stakeholders to perceived problems or opportunities in the development and support of health promotion activity in the voluntary sector. The emphasis was on helping professionals in the voluntary and public sectors to think through the issues, as well as the systematic appraisal and research of problematic issues. The main method used, which the researchers called facilitated discussion groups, was designed to draw on participants' practical and strategic experiences and to develop some collective wisdom by encouraging an exchange of views. The technique is an elaboration of the focus-discussion interview, but with a greater emphasis on information sharing, both between participants and by the group facilitator. It also permits agenda-setting, identification of priorities and explo-

ration of solutions. The method was appropriate to the research because it required participants to work on a common agenda and develop agreed priorities.

The work involved two stages. Stage 1 consisted of an exploration of key issues, including the nature of partnerships from the perspective of voluntary agencies and from that of their funders in local authorities and the health service. Semi-structured interviews were conducted with respondents from a structured sample of 30 voluntary organisations across Scotland; in addition, a sample of 15 inter-viewees was drawn from all 32 local authorities and all 15 health boards. The voluntary-sector sample was provided by the Scottish Council for Voluntary Organisations' Charities Register in Scotland. The sample was intended to reflect the broad range of topics and issues which come within the scope of health-related activity. The agencies represented therefore ranged from those working nationally to those working in specific localities, from those working with specific conditions or problems, to those which addressed a variety of needs. The results of this stage were used to identify selected issues for the facilitation work in the next stage. The interview schedule was designed to encourage discussion of key topics such as health-related work, funding, partnerships, constraints and enablers to partnership work and the role of HEBS.

Stage 2 consisted of a series of discussion groups, facilitated by the researchers, involving representatives from the voluntary sector, local authorities and the health service. Five facilitated discussion groups were held in various locations across Scotland, involving just over 50 persons from different sectors. A range of staff at different levels were involved, including project workers and managers, senior health promotion officers and managers, local authority policy officers and direc-tors of voluntary agencies. The aim was to obtain the views of participants on the key elements and issues relevant to the development of a national strategy for health promotion activity within the voluntary sector in Scotland.

DISCUSSION OF FINDINGS

Involvement in health-related activities

Illustrations were sought of the extent and types of work undertaken by voluntary organisations in connection to health-related work. Some voluntary sector respondents saw themselves clearly in the field of health promotion. While many respondents could list an impressive range of health-related activities, some were evidently uncertain about whether they could be said to be involved in health promotion. Some had notably limited views of what health promotion was or could achieve, but others revealed that they had a sharper picture. Definitions of health within the voluntary sector were, on the whole, very broad. A number of agencies worked within a social model of health and were guided by a specific ethos or principle, for example community development. Others consciously sought to bring a health and social care agenda together.

> *We operate a dual purpose agenda ... we tend to look at our work on the basis of how it is contributing towards the social welfare and fabric of individuals and their community and how is that impacting on health.*

(VS7)

The work which could be classified as health-related can be grouped into six broad categories: health promotion and health education; provision of support; campaigning and awareness-raising; service provision; training; and research. All of the voluntary sector respondents argued that their agencies were filling specific gaps in provision and most maintained that their services complemented rather than duplicated those of the statutory services.

The role of the voluntary sector within the current funding context

A number of agencies, both statutory and voluntary, had been adversely affected by local government reorganisation. For some in the voluntary sector, this had resulted in an increase in the number of funding partners. For local authorities, over and above the general upheaval, there had been loss of purchasing power, particularly for the smaller authorities.

In some areas, persuading local authorities to invest in health-related work was problematic. Some local authority staff and elected members did not see why they should be doing work that, in their view, the health board was being funded to do. There was evidence of some demarcation disputes between health and social service provision. Overall, the local authorities spoken to showed themselves keen to be involved in health-related work, although budgetary cuts had forced a number to review their funding commitments. The lack of a strategic view was regarded by some as encouraging a 'project mentality'.

Funding issues were of some concern to both the voluntary sector and statutory agencies alike. Budget reductions and short-term funding had caused the severest problems to the voluntary sector. For smaller agencies the constant search for funds diverted staff away from the main purpose of the project.

> *So you have this constant situation of fear: will you get funding? And when you do get funding a lot of time has been wasted really which could have been put to better use in the longer term strategic planning.*

(VS16)

In addition to this, persuading statutory agencies to invest in certain areas of work caused some difficulties.

Relationships between the sectors

Participants were asked to outline the nature of any partnership arrangements they had experienced. They were also asked to identify the factors which in their opinion promoted or prevented the effective working of these partnerships. A great interest in this topic was expressed by respondents in both voluntary and statutory sector settings. A variety of partnership arrangements was outlined by informants, including issue-centred partnerships, funding partnerships and professional working partnerships.

Examples of health partnership models that worked were found; their key characteristics included a consistency of approach between statutory partnerships and genuine involvement of the voluntary sector and community. Some councils had long traditions of partnership working; one council was reported as being 'very

serious about trying to be a good partner'. According to this respondent, this means:

not trying to be the main partner but recognising that in any effective partnership, respect for the different partners is more important than the partners' ability to pay.

(SA4)

One useful example of a health partnership cited was a project for young people which provided advice on sexual matters and contraception. One informant in a joint interview stressed there was a great willingness to make such partnerships work but that people needed to acknowledge the skills that people bring to the partnership, 'also where they're coming from what their philosophy is, what type of services, and how they're trying to deliver it' (SA4). Her colleague suggested that 'partnerships work very well where they're developmental, when there's new money on the table and both partners stand to gain' (SA4). They are threatened if there is less money and a change implied in current spending patterns. The need to overcome topic-related and single-issue working was recognised.

Relationships between statutory and voluntary organisations were reported to be good on the whole, although experiences of partnership working had been very varied. Some evidence of conflict was apparent in areas where substantial budget reductions were being proposed. Consultation processes also came in for some criticism. Better clarity in planning processes was required, as was better publicity for consultation with the public and earlier involvement in consultation for voluntary organisations.

We've heard a great deal about a consultation process, we've read a great deal about a consultation process that was going on and had happened and these were the outcomes, with agencies. Not one of us were involved in this consultation process, so in terms of looking at issues around funding, it seems a very obvious thing to say but the agencies who will be affected in a positive or negative way need to be involved in the process of planning for funding.

(VS4)

Factors which were perceived as obstacles to effective partnerships included: too many changes of personnel in statutory agencies; too many reorganisations; consulting voluntary organisations too late; short-term funding of voluntary organisations; and the power imbalance between statutory and voluntary sectors.

The positive advantages of partnership working, and enablers and barriers, were identified and here the importance of communication and bridge-building was emphasised. Suggestions were put forward as to how partnership working could be improved. Commitment and hard work were seen as crucial, and good communications was identified as the key to effective working relationships. There was some concern that those working within statutory agencies had only a limited understanding of the voluntary sector. It was however acknowledged that there was room on both sides for greater understanding of the needs of other partners.

The strengths and weaknesses of a partnership approach were pinpointed by those from both the voluntary and statutory sectors. The strengths identified were that this approach can foster mutual respect and understanding and facilitate

the clarification of roles and responsibilities. It can provide a more co-ordinated approach to common problems, overcome the sense of working in isolation among agencies and help to cement relationships. Such an approach can also make it possible to address the large and complex voluntary sector at the local level. The weaknesses identified were that this approach requires a high level of commitment, plenty of time, good and open communications, regular contact among key personnel and is easy to pay lip service to. It tends not to work well where funds are tight or drying up.

The need for a national strategy

Participants in the facilitated discussion groups made clear that there was a need for a national strategy supporting health promotion in the voluntary sector, and participants made suggestions about its aims and guiding principles. A strategy should be developed to: forge a national strategic vision for health-related work involving the voluntary sector; promote and facilitate partnership working between statutory and voluntary sector agencies; and assist the voluntary health sector through the provision of advice and support.

The strategy should be based on these guiding principles:

• the voluntary sector has to be seen as an equal partner in health-related work;
• clearer accountability in relation to health-related work is called for;
• dialogue has to be maintained by the partners;
• clarity in consultation processes is essential.

A strategic framework will work best where there is commitment to the development of a strategic vision and designated responsibility for leadership and implementation. Involvement by senior officers, especially chief officers, and elected members will be a key factor. Other valuable elements will be: sharing statutory resources to maximise what is available; joint funding of posts; publishing voluntary sector policy statements and funding criteria of councils and health boards; engaging other key players, such as Enterprise Boards, Scottish Homes, Police; and the provision of mechanisms for consultation with the voluntary sector and local communities.

For the national strategy to be implemented, funding problems have to be acknowledged and tackled, such as the problems caused by short-term funding. Capacity building of the health-related voluntary sector has to be acknowledged as important. Voluntary organisations need to understand the priorities of different bodies and how to feed into planning; flexibility in measuring outcomes of voluntary sector activity is required. Bridges for effective local partnerships have to be built and the lessons from the experience of successful health partnerships need to be learned and disseminated.

RECOMMENDATIONS FOR GOOD PRACTICE

Some key recommendations for good practice in multi-agency partnership working in health promotion may now be spelled out. These are drawn from the discussion in the preceding section and from positive examples of health partnerships which the research uncovered.

Prospective partners need first of all to recognise both the level of commitment required and the sheer amount of time necessary for forging decent working relationships. There are no easy shortcuts and this recommendation underpins the others that follow. The requirement to develop aims and values which are explicitly shared by all partners forms a second recommendation. Time should be taken to work up a common vision with agreed goals. This can work well where a broad definition of health is agreed at the outset, particularly to reflect the role of local authorities as envisaged in the White Papers on Health[1,2]. Some partnerships in the north of Scotland, by way of illustration, have developed wide-ranging alliances which have focused on 'quality of life' and 'wellbeing' in rural areas.

The necessity to develop mutual respect and mutual understanding of each partner's constraints provides a third proposition. This can be aided by such steps as the production of voluntary sector policy statements by local authorities and by the secondment of staff between agencies and departments, for example between health promotion departments and voluntary organisations. Effective communication between partners and within partner agencies is the *sine qua non* of joint working, and forms the fourth recommendation. Hasty and inadequate consultation processes provide a major stumbling block for the establishment of good communications. It is important, for example, that voluntary sector players are consulted early enough in the process in order to have their say and to consult their own membership.

A fifth injunction is that funding issues have to be brought out clearly into the open, and statutory funders have to acknowledge the difficulties created for voluntary organisations by the lack of common criteria for funding applications and by the short-term 'project mentality'. Monitoring and evaluation procedures need to reflect this harsh reality; projects are expected to demonstrate measurable outcomes despite the fact that often only six months of funding is available. The lack of investment in voluntary sector infrastructure also should be addressed. The role that statutory partners can play in developing the latter has to be more fully explored in the future.

A final recommendation is that statutory health agencies need to engage much more proactively with the voluntary sector. The development of voluntary sector policy statements by health boards and health authorities would be a useful step in this direction; it would be even better if this were done jointly with local councils. It would also help if there were nominated officers with responsibility for liaison with voluntary organisations, as is meant to be the case for local authorities. Health promotion departments in particular need to ensure that information from national-level bodies such as HEBS is passed on to local voluntary organisations.

CONCLUSIONS

The voluntary health sector is involved in a wide and varied range of health-related activities and herein lies its strengths and weaknesses. Its strengths are the diversity of need that can be met and the flexibility with which these needs can be met. Its weaknesses are that it has often no single voice and that it is too heterogeneous for planners and strategists within the statutory sector.

The need for the development of a national strategy could not be more pressing. A number of policy initiatives have emerged which have raised the health agenda for local authorities and voluntary agencies, and their relations with health boards, trusts and primary care bodies. The White Papers on public health clearly represent a new opportunity for the participants in this research project for the voluntary sector, for the statutory sector, and for HEBS and the HDA[1,2]. A recent action plan for community care calls for partnerships between statutory agencies but says little about the voluntary sector[14]. Another document issued by the former Scottish Office describes 'good practice' in partnership working in urban regeneration and this time acknowledges the voluntary sector as a partner[15]. It is this lack of co-ordination in central government initiatives which participants in this research project found so frustrating. The development of a national strategy advocated here will help facilitate those connections at national and local levels which are evidently missing at present.

Partnership as a concept is very much the 'in' phrase of the moment, as participants in this work pointed out. The difficulties in putting this concept into practice have been pinpointed by this research, and both the obstructive and enabling factors for partnerships have been described above. Multi-agency partnerships involving voluntary organisations have the potential to transform the way health promotion is carried out in Britain. How that potential is realised is now the major task facing the key players in this arena.

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Working with Socially Excluded Romani Communities in Central and Eastern Europe[1]: Lessons from Bulgaria

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In this article the authors examine the main issues for organisations working with socially excluded communities in one country in central and eastern Europe, namely Bulgaria. The position of one disadvantaged social group, people from Romani Communities, is critically examined. Responses by social policy and social work agencies are considered; in particular, attention is paid to the role of non-governmental organisations (NGOs). Key issues and challenges for NGOs are explored and some practical initiatives in Bulgaria are outlined based on recent fieldwork conducted by one of the authors. Examples of specific projects in Plovdiv and Targovishte are considered, along with a review of their achievements and shortcomings. The article concludes with an overview of the principal lessons to be learned from these recent initiatives.

The Background and Context

"Wherever Gypsies are found, they are from elsewhere. Everywhere from nowhere. Present all over the world, no nation claims or protects them. On the contrary, the general tendency is to consider them as parasites and to reject them on first sight. Described as vagrants, vagabonds, pick-pockets, artful dodgers and even as cradle-snatchers, these nomads... are singular only in the negative. Their language is jargon, their offspring brats, their dress tawdry and their women loose. Not only are their leaders tyrants and their means of subsistence dubious, but their style of life generally seems pathological. Is this negativeness the only force unifying the six to twelve million Gypsies who have been dispersed over the land for centuries? Is the lot of thief, fortune teller, itinerant entertainer, attributed to them by common conviction (an amalgamation of prejudice and stereotype), the only heritage they share? Or can they, on the contrary, escape from persecution and the label attached to them in order to safeguard their cultural specificity?" (Liégeois, 1977: p.87).

In just a few sentences, Jean-Pierre Liégeois captures in his usual articulate manner the history and weight of rejection and exclusion that those groups of people known as 'Gypsies' (Romanies) have faced by settled society. This is as true today as it was in the 15th and 16th Century and as true for those countries in Western Europe as it is for those in central and eastern Europe. The historical and contemporary situation of the Romanies in Bulgaria is, in many ways, no worse than it has been in other European nations. Although our focus in this article is to examine the situation of the Romanies in just this one country, we want to make it quite clear we are not 'singling them out' or unfairly suggesting that they are placed at the top of some kind of Romani / human rights 'league table' of shame (Clark, 1998: p.36). Although we begin by documenting some of the historical and contemporary problems that this community have faced, and are still facing, in Bulgaria, we quickly move on to examine some positive (though struggling) efforts to promote the social inclusion of a marginalised and disadvantaged ethnic minority group. These voluntary sector efforts, in the form of work undertaken by non-governmental organisations (NGOs), contain much potential for a brighter future, though we also cast a critical eye over such

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1.   For the purposes of this article we are using the term Roma / Romani in a broad sense but are also specifically using it in two ways; we use it to talk about those groups found in the Eastern parts of Europe who are known as Kalderash, Lovari and other such groups and speak Vlach, Xoraxanne or Rom variations of the Romani language, *Romanes*. We also use the term when speaking of those individuals / families who are identified by non-Romanies as being 'Tsigane' in central and eastern Europe. In this way, we are using the term Roma / Romani in a similar way to that of Liegéois and Gheorghe (1995:p.6).

activities and illustrate how 'good practice' can best be achieved.

The position of the Roma in Bulgaria

With a total population of close on 9 million people, official figures from the interior ministry suggest that the Roma minority make up just over 6 per cent of the population of Bulgaria (576,927). However, estimates by both the Minority Rights Group, the Organization for Economic Cooperation and Development and the Bulgarian Democratic Union of Roma range from between 700,000 to 1 million Romanies in the country (8-12%) (see Drucker, 1997: pp.22-23; Liégeois & Gheorghe, 1995: p.7; Clark, 1998: p.37). Moreover, a just published survey (January 2000) conducted by the Bulgarian Federation of United Roma Communities estimated the number of Romanies in Bulgaria at 2.6 million (Roma News Network (RNN) / Radio Bulgaria, 2000). The publication of these figures has been met with some scepticism by the government and have also been questioned by other NGOs as they seem inflated. In the same press release, the President of the Federation, Wasil Danew, also stated about 15,000 Romanies died during the winter of 1999/2000 due to cold, hunger and disease. He warned that these numbers will rise further this next winter unless something can be done to improve Romani access to state social services.

Whatever the 'real' figure is behind all these estimates, it is clear that Romanies have been present in Bulgaria since about the 14th century and as Marushiakova (1992: p. 96) has pointed out, there are a number of different Romani groups in the country who each display a variety of identities and cultural / economic practices; to be clear, they are 'not a homogeneous whole'. For example, at a basic level they were split by the Turks into (nomadic) Turks and (settled) Christians. Their 'place' in Bulgarian society at this time was near the foot of the Ottoman social and economic ladder and their 'difference' made them subject to specific taxes (Crowe, 1995: p.2). With Bulgarian reunification in the late 19th century came efforts to control Romani nomadism and immigration. During rule by the monarchy (1878-1946) Romani people were assigned low-status tasks and social duties. However, some positive developments occurred in the 1920s with literacy campaigns and Romani schools emerging in some parts of the country and various cultural societies even being formed. Fascist uprisings from about 1934 challenged this progress but the

Second World War brought with it, somewhat surprisingly, a period of relative calm for the Romani minority (Marushiakova and Popov, 1997: pp.30-32).

In the post-war period there was a Romani cultural renaissance, of sorts, although this quickly dissipated and by the 1950s the Stalinist government started to expel Muslim Romanies to Turkey and assimilating all other Romani groups, attempting to crush their cultural and ethnic distinctiveness. During the 1950s, those Romanies who were nomadic were being forcibly settled and 'Romani ghettos' started to appear in the larger cities. By the 1960s, this process of assimilation (or 'Bulgarianisation') had even reached those Romanies that had traditionally been settled. Once begun, the assimilation drive could not be stopped; it even went as far as the authorities forcing those Romani families with Turkish or Muslim names to change them to 'proper' Bulgarian ones. Romani music, whether played on television, radio or in the streets was banned and even speaking Romanes (the Romani language) in public was forbidden and actively discouraged via fines. Efforts were made to break-up compact Romani communities in large cities and cultural or social organisations were outlawed. In other words, in just a few years, the Romanies of Bulgaria were subject to a kind of cultural attack on their identity that was to have lasting consequences. For all that, in other areas of life, the conditions of the Romanies arguably improved under communist rule; such as housing conditions getting better and educational opportunities rising slightly. Suffice to say, this did little to compensate for the thorough and near-total destruction of Romani self-identity during that period.

Since the collapse of the communist system in 1989, there has been a re-birth of Romani political, economic and media organisations (Hall, 1994; Hancock, 1996). For example, the Democratic Union of Roma, which was founded in 1990, is the largest political group in the country representing a certain constituency amongst the Romani minority. However, they remain politically weak due to a number of reasons, not least the fact that ethnically the split between the Romani Muslims and the Christians remains intact. Likewise, a variety of Romani dialects are spoken in Bulgaria and there are various allegiances based around clan / 'tribe' associations (Popov, 1993). In 1992 a national lobby, the United Roma Federation, was created and together with the Democratic Union of

Roma and other Romani leaders and intellectuals in Bulgaria, a challenge was mounted to the institutional discrimination and human rights abuses that the Bulgarian Romanies were suffering from. Some of these main areas of discrimination are dealt with below and are a major challenge for NGO groups to come to terms with.

In the field of education, many Romani children are still being educated in segregated and poorly-funded technical schools which manufacture goods commissioned by local authorities or so-called 'special schools' which are for those with 'retarded mental development' (Tomova, 1995: p.58). Tomova (1995: pp.57-64) in her comprehensive survey of Romani life in Bulgaria, notes that whilst Romani children make up 9.7% of pupils in mainstream schools, they comprise some 32.1% of those in these 'auxiliary' or 'special' schools; often for no other reason than the fact they are Romanies and therefore 'must have' either behavioural problems or 'special needs'. Opportunities and attainments are very low and few Romani children complete secondary schooling, often due to a fusion of institutional discrimination and cultural factors such as early marriage and having Bulgarian as a second language. Related to educational disadvantage, Romani unemployment levels are high and poverty growing; for example soup kitchens in Sofia see Romanies amongst those queuing (Brearley, 1996: p.16). Traditional Romani craft skills are no longer in demand as they once were and lack of educational qualifications, rampant labour market discrimination and gross racial stereotypes perpetuate high unemployment.

In housing the situation is just as bad with most Romani families now living in run-down areas of the larger towns and cities such as Sliven which is home to some 50,000 Romanies (Silverman, 1995: pp.46-47). The infrastructure around such parts of town often does not even stretch as far as pavements or proper roads and refuse collection can be very irregular (Tomova, 1995: pp.65-70). Such basics as running water, adequate sanitation and mains electricity can be missing from the 'Roma districts' of such towns and overcrowding is also a serious problem with post-1989 land privatisation schemes merely compounding the problem (Barany, 1995: p.5).

Anti-Gypsyism and violence towards Romanies in Bulgaria has taken some horrific forms during the 1990s. Violent attacks on Romani individuals, often with the tacit support of local officials, police officers and the press, are often justified by labelling the Roma as 'criminals', 'black-marketeers', 'thieves' and 'murderers' (Helsinki Watch, 1991). Incidents in parts of Bulgaria such as Cherganova, Pleven, Malorad and Dolno Belotintsi during the mid-1990s left many Romanies either burnt out of their homes, badly hurt or even dead in some cases. For example, in the village of Podem (near Pleven) in May 1991, fifteen Romani houses were burnt to the ground leaving 150 people homeless (Hancock, 1993: p.12). In the capital, Sofia, similar incidents occur often with anti-Romani arson attacks being particularly common. Allegations of police brutality, ill-treatment and torture of Romanies in areas like Glushnik, Dubova and Stara Zagora have left the minority with little faith left in the democratic parliamentary structures and the legal system.

Non-governmental organisations (NGOs): the challenge [2]

As Deacon (1997: p.154) has written, the term 'non-governmental organisation' is "now widely used... in the sphere of social welfare, but it is rarely defined". He goes on to suggest that the term has quite different meanings in different parts of the world and often it is simply equated with the notion of 'associations of citizens'. For the purposes of this article, when we speak of 'non-governmental organisations' we are specifically discussing independent, non-profit making agencies which are formally registered in the main country of activity. There were in fact many hundreds of independent bodies set up in the wake of the collapse of communism in Bulgaria, but little formal regulation or control of this burgeoning sector existed then or, indeed, exists now. For example, initially some organisations were - allegedly - fronts for mafia-type enterprises and helped to discredit the notion of the establishment of independent 'foundations'. Our interest is refined to focus on those non-profit making organisations with an ostensible social policy remit; the reader should be wary about imposing Western notions about the distinctions between the 'state', 'market' and 'voluntary'

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2.   This section and the following one of the paper is largely informed by fieldwork undertaken in both Bulgaria and Romania by one of the authors (Titterton) during 1998-99.

sector activities upon the transitional countries of eastern Europe.

Non-governmental organisations in central and eastern Europe face a range of formidable problems. In most cases they involve individuals setting up something where there has been no or little prior history of voluntary effort in the society, where 70 years of 'actually existing socialism' has diminished individual initiative and fostered reliance on the state. Groups of individuals with an interest in reform in the 1970s and 1980s found it very difficult to establish independent organisations. Most often, activity would focus around a particular issue or perceived need: for example, in Bulgaria, families with autistic children had few specialist services or felt their particular educational and social needs were not being met by the state system. In the late 1980s families and sympathetic professionals formed an association, one of the first NGOs in Bulgaria, formally set up in 1988.

With the collapse of the Soviet Union and the communist system from 1989 to the early 1990s, the stresses and strains produced by the transition were significant. With the painful shift towards a market economy away from a command economy, there was massive insecurity about economic futures and the labour market, with rocketing prices and hyper-inflation. Many professionals and workers saw their pay packets fall to a quarter of what they were previously. This had an enormous impact in Bulgaria where there was a higher standard of living than some neighbouring countries such as Romania. There were increased demands for mental health services, for counselling, stress reduction and for community based forms of assistance. In addition, the hospitals had run out of money, with rapidly deteriorating conditions, with little food or blankets for inpatients. The professional associations, such as the Bulgarian Association of Psychiatrists, began to change with younger and more radical professionals pressing for change. The reform of psychiatry has been pressing ahead, if slowly, throughout eastern Europe. However in the sphere of voluntary associations, that is those organisations outwith the state and outwith professional associations, groups had been trying to form to bring about change from 'below'.

It is important to point out the difficulties faced by this developing independent sector. First, there are very few paid staff; most are run by volunteers, or unpaid staff which may be a better term. No funds are available from the government, either for core funding or specific project funding. All funds have to be raised from independent grant making bodies from international foundations which sometimes have a base in the country, such the Soros Open Foundation or based abroad or from a supranational body such the European Union. Thus they are in competition with every other organsiation pressing for funds. It is always difficult to raise funds for groups who are deemed 'less worthy' or undeserving, for example people with mental health problems or the Romani communities, compared to say children's welfare or care of the elderly.

Second, most are on a short term project basis, from six months to two years. The proliferation of projects is something shared by the British voluntary sector (Titterton et al., 1999), but it is far more pronounced in eastern Europe. This makes it very difficult to plan long term services or strategic approaches to reform and change. While again this is a problem of the West too, in the East because there are few stable NGOs and projects, with little in the way of government support, the problems are multiplied and more pronounced.

Third, the sheer lack of infrastructure is a crucial barrier to NGO activity. Many organisations have no offices, no computers, no meeting rooms, no transport, and no paid staff. They operate out of apartments. Occasionally a building will be used to house a number of NGOs who will share facilities, as in the Centre at Dimitri Nesterov Street in Sofia, where the National Network of NGOs operates from.

Fourth, the lack of trained staff and lack of trainers and educational and learning structures to support staff and users forms a major problem. The training needs are extensive for new NGOs; these includes topics such as financial management, organisational development, equal opportunities, volunteer development and others. There are also needs at many levels however; training unskilled workers, awareness raising, working with the media, campaigning and the like. There is a kind of cycle to be noted where the demands are intensive to start with, then tail off, then pick up as the NGOs projects increase. Eventually they reach a point where they have the competence and ability to pass on what they have learnt to other, newly emerging NGOs. However this is affected

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by funding and assistance from abroad. Some funders are now preferring to fund projects which promote East-East links, as opposed to West-East links. In truth though, both types of links are needed; it is unlikely that the reliance on the West can be broken, at least in the immediate future.

The fifth challenge facing these NGOs concerns their relationship with Western-based international NGOs and the formation of appropriate East-West partnerships. The growth of Western NGO involvement in East European countries has been notable in recent years and merits careful scrutiny. The modalities of intervention vary widely and few have been subject to rigorous evaluation. Some organisations such as Help Age International and the Hamlet Trust tend to focus on the development of regional networks. Others, such as InterMinds (formerly Penumbra International), seek to work in directly empowering ways with national and local NGOs, through the provision of organisational development and the transfer of essential skills, involving both service users and professionals. However, some Western NGOs have adopted methods of working which must be open to question about whose interests are being served. One example is Save The Children which has recently established offices in Sofia in order to set up its own operation, ignoring local groups who had requested assistance to help them develop in their own right. This sort of approach leaves Western NGOs open to accusations of empire building, at the expense of Bulgarian community groups wishing to work with children, including those of Romani communities.

More empowering types of links between West and East are needed and the type of situation that Green (quoted in Deacon, 1997: p.155) discusses should be avoided at all costs:

> "in extreme cases (large NGO presence combined with weak government and civil society) they engender fragmentation, incapacitation, and client creation to a degree that generates major resentment, not least among the by-passed domestic social sector actors."

The Romani projects in Bulgaria: two examples of a changing environment

Demands for reform of the difficult conditions of many Romani communities emerged swiftly with the fall of communist regimes in Bulgaria. A number of the Romani projects started in 1990 out of an initiative called 'conflict mediation' for ethnic conflicts, organised with the help of the Foundation for Inter Ethnic Initiative for Human Rights and the New University of Bulgaria, which are both based in Sofia. A number of groups came together in a training conference based on experiential learning, including visits to several schools in Sofia based in Romani 'ghettoes'. They sought to work with representatives of the Romani population, such as the head of school in the Rhodope mountains. The intention was to try to set up a network of NGOs, along with a clinical social work programme. Visits were made to social work services in Romani areas. The 'Learning from Experience' conference saw a number of groups from Sofia and Sliven come together wanting to contribute in various areas, for example, working with single mothers; children on the streets; people with physical disabilities; isolated older people; young women prostitutes; and poor families. They developed programmes and sought funding from sources such as the Open Society in Bulgaria and the EU Phare programme. Most of the projects have a basic structure, with a chairperson, administrator and eight to ten people working in different areas; most of the cases involve helping individuals and families with contacting required services, preparing documents and going with them to hospital and other agencies; as well as also distributing donations. The use of volunteers is crucial to these projects. One project which is emerging involves attempts to create foster families in Plovdiv, bringing together school, police, abandoned children and social workers working in field to help families sustaining a foster role. Literacy is seen as important though this is a vexed issue; there is pressure on children to leave school early to become earners and staying on at school is perceived as increasing dependence on the community. Education is regarded as being critical for achieving independence and, in turn, independence is seen as important for helpers too. The thrust of the work is towards developing a 'self-help' ethos.

Two examples of Romani NGOs are now considered, illustrating the kind of organisations which are trying to bring about change in Romani and mixed ethnic group communities.

Union Spravedlivost 96 (Justice)
This NGO was set up in 1996 in the Roma suburb of Plovdiv, with funding from the Foundation for

Inter Ethnic Initiative for Human Rights. It started from a workshop on training skills for creating projects for people from this foundation and following discussions with the main Romani NGO, the Foundation for Local Development Roma. It was intended to be used by other NGOs and to promote client advocacy. The project got under way with the involvement of five volunteers in 1998. A training agenda was drawn up by local experts from social work agencies and the employment office and includes topics such as project creation, the municipality, social issues, and the health and welfare system. Feedback from the community on the work of the NGO is actively encouraged, being given vocally at meetings of the NGO and local people. A two-year programme, funded by PHARE, was used to develop fifteen social workers, who each trained for five months, and fifteen people act as volunteers. Over thirty people are now working for the organisation, with advice from the New Bulgarian University in Sofia. The group is very interested in learning skills and developing exchange visits; they also are in urgent need of office equipment such as photocopiers and computers. The project has recently set up in a house which was formerly a kindergarten, with funding from the United Dutch Foundation.

The key problems which users of the NGO bring to the social workers and volunteers have to do with unemployment, poverty, lack of clothes and food, ill-health, lack of medicines and a general shortage of money. The conditions of the suburb are extreme; there are burst mains, rubbish everywhere, gaping holes on buildings which somehow still stand up, a community (within a community) that has been largely forgotten about by the municipal authorities. Housing conditions in the Romani suburb are very bad; there is little in the way of basic amenities such as electricity and running water and there is no hot water. While some welfare services do exist, project workers contend that they face discrimination and prejudice from these services; doctors and teachers do not really want to work with the Romani community. Most children leave school very early; some girls become prostitutes from the age of 12, because they need clothes and food. Some children are neglected and uncontrolled, and there are drugs problems, like sniffing glue. Some families are overcrowded, with 3 or 4 families living in one apartment. Family problems such as divorce are prevalent, leading to mental health problems, and causing stress for children. There are also long

standing health needs such as diabetes. There are ten people with diabetic needs at the clinic but there is no service. The NGO would like to help the community create such a clinic and to create an organisation to help them. The aim would be to help people with diabetes to help each other.

Project workers say that what is required are educated social workers who can work with local communities, other professionals and already existing social services. The kinds of skills which social workers need are communication skills to enable workers to link with different levels and other agencies. In addition, good facilitation skills are necessary for making things happen on the ground and for encouraging people to help find their own solutions to their problems. The skills of people living within the community themselves, perhaps without formal education, are also essential to illustrate to various groups, such as isolated mothers, prostitutes, orphans, that life can be better and they do have a choice. The NGO has talked with the principal of the school about the need for a safe building, books and equipment, just for Roma children. Equal treatment is one of the primary goals, as is helping people out of helplessness, anxiety and depression. Deaths from overdoses of alcohol need to be prevented and the increasing numbers of street children need attention, clothing and care. If the building project is successful this will help the children by creating a 'safe shelter' for them to live until foster parents can be arranged.

Spravedlivost 96 provides community leadership whilst being based firmly within a Romani community and as such provides an encouraging example. It has a large and enthusiastic group of people under the guidance of a co-ordinator who himself is a Romani man living within the community.

NGO Roma

This NGO works with Bulgarian Romani and Turkish minorities in Targovishte, a town situated near the Black Sea. It provides a range of services, including language and cultural activities. It collaborates with other NGOs such as the Mental Health Society and the Library Club for Turkish speakers, founded in 1964. They operate a twenty four hour telephone system and there are groups for people without work who are organised into groups by currently unemployed teachers. There is a centre organised by two agencies, set up in April 1997, whose main task is to solve unemployment

problems which are very serious in Targovishte. The NGO works with unemployed people to help them solve their own problems and there is a club for unemployed persons where they can exchange information and ideas. Some of those who attend have their own ideas to solve problems, for example, starting up a business on a small scale. The centre also helps people to unite smaller clubs into larger single organisations such as the Association for Young Roma or the Ecology Association, with the dual intention of helping people to assist themselves and to help the town of Targovishte as a whole. Other clubs have explicitly social aims, such as assisting women at risk, lone mothers, pensioners and homeless children.

The philosophy is about teaching people to find their own solutions, taking appropriate steps to move on. However the project workers need some help with know how, with providing information and assistance and with technical expertise. They would like to develop further the idea of self-help groups and they are interested in training the trainers and other suitable training programmes. They see a pressing need to work with the system, while seeking to improve it and tackle wider structural injustices and discrimination. They are resolved to keep on campaigning for change, despite official indifference and inactivity.

Opportunities and constraints for the two NGOs: a critical commentary

The emphasis on self-help in both these NGOs is very interesting to note. This is an attempt to help people break from old forms of dependency on the state, but also to help people avoid building new types of dependency. It also helps to counter the commonly made assertion among the majority communities in Bulgaria that the Romanies are not prepared to help themselves in any way. The use of volunteers is also noteworthy; it is part of a developing voluntary ethic in central and eastern Europe, but also a reflection of the lack of resources and funding to pay people for their time. In addition, these NGOs and their projects involve tackling a broad range of social issues such as literacy, poverty, abandoned children, unemployment and health care. These projects also involve Romani communities in working with many different types of agencies and professions, such as schools, hospitals, the municipal authorities and so on. They can provide, moreover, new opportunities for Romani communities to

engage with civil authorities, and the majority population, in fresh and constructive ways.

The limitations of these projects, however, should be acknowledged. First, the people involved in such projects are seeking to bring about lasting reforms, attempting to redress structural inequalities with few of the right kind of tools at their disposal. The social exclusion of Romani communities is buttressed by profound inequalities of employment, education, health and wealth as discussed earlier in this paper; tackling these historical and deeply ingrained inequalities will require sustained national and international programmes of action. Second, they are trying to bring about cultural and attitudinal change in the face of massive government indifference. Without a determined and widespread campaign backed by respective governments, the European Union and the wider international community, the positive work of these sometimes fragile and local initiatives will be lost. Third, the need to form progressive alliances, both within Romani communities and between these communities and the majority population, is essential in order to bring about change. Such alliances are hard to foster and sustain in an atmosphere of overt discrimination and prejudice. Fourth, these NGO inspired projects are typically run on very limited funds and are mostly staffed by volunteers; without properly resourced staff, and without support from local social workers, there is little chance of continuity and development with a trained and experienced group of people.

Conclusion

"The only weapon with which I can defeat them
           is a flame-thrower;
I will exterminate all Gypsies, adults and
           children;
Although they can only be destroyed if we
           co-operate;
If we exterminate them successfully
We shall have a land free of Gypsies."
      (Lyrics to a song by the Hungarian group
      Mosoly, quoted in Hancock, 1985: p.15)

Despite the wishes of many non-Romanies in various parts of central and eastern Europe, this part of the world will never be 'free of Gypsies' as the song puts it. The history of the eastern part of Europe is inextricably bound up with the history of the Romanies who have been present in those lands since the 14th and 15th century. Having survived hundreds of years of slavery, persecution,

going to 'go away'. In this paper we have attempted to review the historical and contemporary situation of the Romani minority populations in Bulgaria and show how this complex and disturbing history has impacted on present day attempts of NGOs to work with socially excluded Romani communities in each country. We have explored some of the most pressing issues in working with socially, economically and politically excluded Romani communities in eastern Europe and a number of lessons appear to emerging. First and foremost, there are messages here for Western funders. The availability of independent sources of funds is crucial for helping NGOs develop new forms of civil society in eastern Europe. It is evident that a little (western) money goes a long way in these kinds of settings. Second, these initiatives are often delicate and require nourishing in a sometimes inhospitable climate. Realistic expectations are needed of projects which are sometimes only funded and in operation for six months or so. Third, successes so far are small but are encouraging. However, there are counter examples of mismanaged resources which need to be attended to. Appropriate training, with support from Western agencies, is essential, including working on key topics such as equal opportunities and financial management. Fourth, the availability of a body of volunteers, prepared to give some degree of commitment to a project, is critical. Ideally, the expansion of a trained and salaried cadre of professionals within the emerging voluntary sector must be the end goal to ensure some support to marginalised communities such as the Romani one discussed in this paper. However, without positive and enlightened engagement by the West, this aspiration will remain only an unfulfilled dream.

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Can participatory research be a route to empowerment? A case study of a disadvantaged Scottish community

Mike Titterton and Helen Smart

Abstract   The growth of participatory research in recent years has been notable. This paper considers its potential for empowering disadvantaged communities and providing a route for overcoming social exclusion. Problems of definition and key challenges for undertaking participatory research are reviewed based upon work undertaken in a deprived community in Scotland. Opportunities exist for researchers and community developers together to develop participatory approaches. A principal role for researchers is in bridging the gap between service users and policy makers, funders and other service providers by working with service users to demonstrate the impact of social exclusion. The authors conclude that participatory research merits close attention as long as its difficulties are acknowledged.

Introduction

The marked growth of participatory research in recent years has been commented on by numerous authors (Cornwall and Jewkes, 1995; Bennett and Roberts, 2004; Boothroyd, Fawcett and Foster-Fishman, 2004; Edgren *et al.*, 2005). Participatory research has been described as a collaborative venture, the outcome of which is the application of research findings into the process of community development (North American Primary Care Research Group, 2003). Applications include needs assessment, evaluation and sustaining projects beyond the life of external funding (North American Primary Care Research Group, 2003). There is now a growing interest in using participatory approaches in healthcare settings in order

to improve clinical practice (Meyer, 2000), in assessing the impact of health education initiatives in schools (Paulus and Boldt, 2002), in healthy heart campaigns (Naylor, Wharf Higgins and Blair, 2002) and in work with particular groups such as children and young people (Ducket and Perry, 2005), older persons (Ritchie, Bernard and Trede, 2003; Brearly *et al.*, 2005) and people in marginal groups (Power, 2002).

In this paper, the authors examine the potential of participatory research for empowering communities and ask whether it provides a route for disadvantaged communities seeking to overcome social exclusion. In the first part, definitional issues and some of the challenges for community involvement are reviewed. In the second part, lessons from an example of participatory research in a disadvantaged community in Scotland are presented. Some concluding thoughts are presented on the opportunities offered by this approach, along with the main elements required for it to work successfully.

Community development and participatory research

The literature on participatory research has grown of late, testifying to the increasing popularity of this approach, especially in North America, Africa and Australia, as well as the UK; however, Cornwall and Jewkes (1995, p. 1667) suggest that participatory research is a 'source of considerable contention'. Conceptual difficulties beset the term, particularly in relation to what is meant by 'participation'. A range of labels have sprung up, such as participatory action research (Koch and Kralik, 2006); community-based participatory research is gaining ground as an appellation (O'Toole *et al.*, 2003; Jason *et al.*, 2004; Wallerstein and Duran, 2006). All sorts of studies are described as 'participatory research', but it is sometimes difficult to see to what extent they are participatory (Cornwall and Jewkes, 1995; Gray *et al.*, 2000); often, it tends to be not much more than consultation.

What is perhaps less clear is why participatory research is now becoming increasingly popular; some writers talk of the wave of consultation sweeping over the UK and other Western countries (Cornwall *et al.*, 2003; O' Donnell and Entwistle, 2004). Bennett and Roberts (2004) identify a range of influences on recent debates, including demands for user involvement and emancipatory research. In a discussion on lay perspectives, Entwistle *et al.* (1998) suggest that with a current emphasis on the role of the public as 'owners' of research, political, as well as academic, motives may influence the decision to involve service users. Another factor worth mentioning, however, is a perceived need by government authorities to better connect with communities, particularly those that have been excluded from political power and social goods. As Muir (2004) notes,

the frequently stated aspiration to place communities at the heart of policy by the Scottish Executive creates challenges for how to sustain this engagement. Moreover, the social inclusion agenda being pursued in relation to improving the health of disadvantaged communities (Scottish Office, 1999) implies a key role for styles of working that are more participatory than has been the case in the past.

As some authors have emphasized in the literature, participatory research is not a method but an approach (Minkler and Wallerstein, 2003; Minkler, 2004). Taylor *et al.* (2004, p. 4) note that participatory research is a 'broad term for a wide range of approaches to empowering community members to engage in research that increases citizen power and voice in communities'. Bennett and Roberts (2004, p. 5) provide a rather looser definition as 'ways of working which result in people with experience of poverty having more voice in discussions about poverty'. Khanlou and Peter (2005) identify exploited or oppressed groups as the appropriate target; the key objective is to identify and implement action as a result of the research (Cornwall and Jewkes, 1995). Drawing on Third World experiences, Brock (2002) contends that knowledge, action and consciousness, by which she means an increased awareness of the issues, have to form three interlinked components for participation.

For the purposes of this paper, community-based participatory research will be defined as the process and outcomes of the active participation of community members and which involves the mutual exchange of skills and knowledge between researchers and the community. Typically, this involves communities that are lacking in power, which can be enhanced by the research experience.

This definition allows for a range of different methods and techniques to be deployed. It also means different settings can be used for participatory research, including community, institutional and street contexts (e.g. in health promotion). In terms of community settings, it has been suggested that this approach may be most effective in 'catalysing longer-term change where it is combined with methodologies for community development and empowerment' (Cornwall *et al.*, 2003, p. 33). Community development nonetheless 'remains a long intensive slow process' (p. 43).

The research literature tends to be overly defensive, and there is often a justificatory note struck when discussing this approach. The latter is seen as dubious by many academics (Minkler and Wallerstein, 2003; Khanlou and Peter, 2005). The present authors would argue that the time has come to move from these early debates and accept that, as an approach, participatory research is becoming steadily well established. They are less sure, however, that it represents a 'new paradigm' (Minkler and Wallerstein, 2003; McAllister *et al.*, 2003; Wallerstein and Duran, 2006); it does,

nevertheless, represent a new approach to researching with communities, with potential to explore a range of issues raised by local people themselves. Communities become less like objects to be studied and more like active subjects influencing the direction and methods of the research. Part of the process should be a transfer of researchers' skills and knowledge to the community. An example of research with a disadvantaged community is presented below.

The participatory research approach is not without its difficulties. In the first place, definitional issues can arise. 'Community' as a concept itself needs to be treated with care; assumptions tend to be made that distinctive communities exist as homogenous entities (Cornwall and Jewkes, 1995; see also O'Toole *et al.*, 2003). 'Community development' as a term also needs to be defined: it 'involves people who share a common place or experience working together to bring about community improvements that matter to them' (Boothroyd, Fawcett and Foster-Fishman, 2004, p. 37). It has been described as offering 'tremendous opportunities for integrating multiple sources of evidence to generate a knowledge base that helps to advance the field' (Boothroyd, Fawcett and Foster-Fishman, 2004, p. 48).

Participatory research is usually linked to attempts to assist local groups in having a greater say over decision-making, involving a shift in the balance of power. However, the very notion of empowerment can raise difficulties; as Laverack (2005) notes, it is a contested term. Bridgen (2004) contends that not only is there conceptual ambiguity inherent in the term 'community empowerment', but it also has consequences for evaluative research into the latter. Empowerment involving communities may be defined, for the sake of the study contained here, as the process by which socially excluded or marginalized groups are given a greater voice in matters that affect their lives.

The challenges of undertaking participatory research can be under-estimated by those wishing to embark on it. The skepticism of local people and a reluctance to take part will affect the degree to which the community participate (Cornwall and Jewkes, 1995). There is a problem of researchers exciting a community's interest and raising expectations of improved services and greater participation. It can be a disempowering experience if nothing happens. There has to be a shared willingness to negotiate open and realistic agendas from the outset of the research process. As Khanlou and Peter (2005) assert, researchers must consider in advance whether research protocols have the potential to be emancipatory, and permit this negotiation. Allowance has to be made for the amount of time required for this and for trust to be established (Mosavel *et al.*, 2005).

Edgren *et al.* (2005) rightly note that much has been written about forming initial collaborative partnerships, rather than how the research is

implemented using a partnership approach. Using the knowledge of community members can assist implementation, enhance the research process and can increase local ownership. A tricky question to address is how to continually involve community members; one solution is through the use of community lay workers, who in turn can have their skills and capacity increased. Examples of community-based participatory research initiatives that involve lay health advisors include the East Side Village Health Partnership in east Detroit (Schulz *et al.*, 2002) and the Messengers for Health Project in the Apsaalooke Reservation (Christopher, Burhansstipanov and Knows His Gun-McCormick, 2005). The need for cultural sensitivity when undertaking research is highlighted by these illustrations; for example, researchers have to be aware of the issues posed by going into a community that may be very different from their own background in terms of social class and ethnicity.

Participatory research has a number of strengths as an approach. Involving people in this sort of study can help them engage with local health problems and let them see the links between local and broader issues. Local people can be brought in as partners in plans for change. Local knowledge, expertise and resources can contribute significantly to the success of research. Collaborative partnerships may be mutually beneficial in relation to education and the acquisition of skills. The results of participatory research are applicable beyond the community being studied (Macaulay *et al.*, 1999).

Its weaknesses are that it may be perceived as a token gesture. A consultation fatigue can set in; communities can get tired of being 'over researched'. It can raise expectations for change that are not met. Local communities may 'buy in' to a process that incorporates them into existing power structures. Community members may be open to exploitation and may be simply used as a cheap form of research labour. Communities may well feel 'sandwiched' between political agendas being pursued from above and from below, and may consequently be reluctant to invest trust in exercises intended to increase participation.

On balance, the advantages of participatory research outweigh its disadvantages, providing researchers are prepared for the challenges. The key factors for a successful outcome include inclusive planning and willingness to negotiate the agenda with local communities and to allow time for this. Participatory research is valuable for those working in health promotion because it can involve people at their own level and allow them to raise their own issues and to develop their own solutions. As Cornwall *et al.* (2003) note, a key emphasis is placed on lay or local knowledge in participatory research, on taking account of local voices.

The voluntary health sector provides an arena that is substantially larger, more varied and more flexible in responding to these voices than has so far

been appreciated by statutory authorities (Titterton *et al.*, 2000). Community health projects are, however, notoriously underfunded, a factor that constrains their capacity to fully develop links with policy and planning mechanisms and other health providers such as primary care (Smart, 1999). They nonetheless have a role in assisting communities in overcoming their social exclusion, through developing inclusive ways of working with local people to reduce the effects of health inequalities and to promote better health. This includes identifying local interests and working these up into a health agenda that is owned by the community. It can also involve enabling access to resources that otherwise would not be made available. In the next part, some lessons from a participatory evaluation of a community health project based in a disadvantaged area of south Edinburgh are discussed.

Lessons from participatory research in a disadvantaged community

An illustration of participatory research comes from the authors' experience of a study conducted in a deprived community in a Scottish city. This consisted of an evaluation of a community development project, Be Well (formerly Craigmillar Health Project), which operates in the Niddrie House area of Craigmillar, Edinburgh. The area has been identified many times as one of the most deprived areas in the City of Edinburgh (Lothian Health, 2005).

Be well as an organization is involved in the social inclusion and health inequalities agenda by working with local people to identify and meet their health needs and make these needs known at strategic policy and planning levels. The researchers sought to ascertain the extent to which the Project was meeting these objectives and to assess the impact of the project on the lives of service users. The Project offers a variety of activities and services. These include a thrice-weekly drop-in, counselling, support groups and access to a range of complementary therapies, short courses and workshops (e.g. food, craft work) as well as health promotional events. In addition, members of project staff are actively involved in a wide range of local partnerships.

Method

The research study was participatory from the outset. A Working Group had, prior to engaging the services of the researchers, devised a methodology and prepared a preliminary draft of the research instrument. This was in keeping with the ethos of the community project, in line with the principles of community development, to involve service users in all

aspects of Project activities. The intention was to engage users and to discover their own experiences of health and to use lay people as researchers. A meeting was held at the start of the process with members of the Working Group to plan the research and establish criteria and aims. Involvement was sustained through regular dialogue and feedback and assisted by an open discussion about what could realistically be achieved by the research. Questionnaires were finalized in close consultation with the Working Group.

Lay researchers were employed to conduct the community interviews. It was decided to use local community members as interviewers for two reasons. First, it was considered more likely that local people would respond to someone else, who lived locally. Second, by involving users in evaluation, a sense of ownership would be fostered and it provided the opportunity for people to develop new skills. Community members were more than just lay interviewers; they were involved from start to finish, for example, in designing the research questions. In addition, the incorporation of lay perspectives has been shown to improve the quality of research (Entwistle *et al.*, 1998; Macauley *et al.*, 1999). This group also received training prior to conducting the survey. All of the interviewers were paid a fee. The research was conducted over a four-month period.

Face-to-face structured interviews were conducted with 100 residents of Craigmillar: fifty service users and a quota sample of fifty members of the population.

Key findings
The following findings of the study are of particular significance. First, those who had used the project had developed a greater range of coping strategies for dealing with stress, compared to other members of the community. They were, for example, able to get access to complementary therapies and relaxation techniques. The links between stress and coping are important to consider for better managing welfare strategies in order to avoid adverse outcomes for personal health (Titterton, 1992). Second, by providing volunteering opportunities the project enabled individuals to develop specific skills and to contribute to the life of both project and community thereby promoting self-esteem and a sense of self-worth. Third, social contact through attendance at the project was highly valued, suggesting a significant role in developing a sense of neighbourhood cohesion. Access to good quality food had also contributed to a healthier diet and improved eating habits on the part of service users. Finally, project staff were active in developing links outwith the project and beyond the immediate community through representation to a range of networks and planning groups.

Discussion

The research model deployed in this example involved using members of the community in developing and carrying out key aspects of the research. This approach proved beneficial both for participants and for the quality of the research. It was empowering in the sense that it taught participants skills and involved local people at all stages of the research, from design through to execution. These skills included communication, interviewing, group discussion, confidence building, reflection and so on. A greater interest on behalf of the local community and policy makers, in the results of the research was thereby generated. Community members enjoyed participating and taking advantage of an opportunity to influence the provision of health promoting services appropriate to their needs. Benefits of participating included gaining greater knowledge about health issues and the role of research and its potential to influence decisions. Practical benefits for local people were a sense of involvement and inclusion, a chance to have a say about health problems, an opportunity to contribute to the health inequalities agenda, and strengthening the case for participatory forms of health provision and promotion. While the study did not include an examination of benefits conferred beyond the research, informal feedback indicated that the sense of confidence gained by participants was carried over into subsequent meetings with local authority and health service officials.

With respect to this particular example, methodological problems in relation to sample selection, representation and quality control are considered below. These considerations notwithstanding, sufficient evidence was gathered to assess the impact of contact with the Project on the lives of service users and to draw some conclusions on the role of community health projects in tackling social exclusion and health inequalities.

Reflections on the participatory process

Reflection on the experience of conducting this study raises a number of issues. There were some clear benefits in using a participatory approach for the research. The research was largely instigated and constructed by users of the project, facilitated by the researchers. This engendered a sense of ownership and greatly contributed to the ease with which the study was implemented. Evaluation research that is truly participatory, where local people are involved from the outset, benefits from local knowledge and experiences (Parry, Gnich and Platt, 2001). Local knowledge was invaluable in this instance, in determining access to the community and in achieving the target sample of fifty community interviews. The close involvement of services users with all aspects of project management and the

obvious value they placed on the project as a resource also contributed to achieving the target of fifty service users. Their enthusiasm for the research helped to sustain community involvement throughout. Having a realistic time frame and clear outcomes for the work were additional facilitating factors. Remuneration for the work of community members also reflected the value placed on their contribution. Difficulties of access to research participants in disadvantaged communities have been documented (see e.g. Smart and Titterton, 2002), and it is probable that greater efforts would have to have been expended in eliciting the cooperation of participants had a more traditional research approach been employed. Issues of trust are crucial in research at community level and with vulnerable populations: getting a 'true' picture is more likely if a relationship with the community has been established (Hanna, 2000). Given the short-term nature of the study, members of the community were more likely to have established a position of trust than an outsider.

Methodological problems, however, should not be ignored. Traditional research methods such as the use of interviews and questionnaires can be used, if it is remembered that participatory research is not a method per se but an approach, as indicated earlier. More innovative methods can also be deployed; one such example is the use of Facilitated Discussion Groups, which is designed to draw on the practical and strategic experiences of participants and to develop collective wisdom by encouraging an exchange of views (Titterton *et al.*, 2000). Information sharing, both between participants and by the group facilitator, is encouraged. The method also permits agenda setting, identification of priorities and exploration of solutions. Although not used in this study, as local residents were keen to use survey-type methods, Facilitated Discussion Groups offer potentially fruitful rewards for participatory research, particularly where a consensus on key priorities needs to be fashioned. A general discussion of facilitation in the context of action research can be found in Koch and Kralik (2006).

In terms of quality assurance, training was provided for the lay researchers; within the limited budget for the study, it was not possible to conduct quality checks throughout the course of the interviews. There may also have been problems of bias in using local residents. Within this study, no efforts were made to stratify the sample in terms of age or gender: lay researchers approached people at random which may have resulted in the over-representation of particular age groups or an imbalance between men and women. Additional problems can also arise in terms of confidentiality: there may have been a reluctance among some people to disclose certain aspects of their lifestyle to people who may be known to them, however, distantly. In this instance,

efforts were made to ensure that confidentiality was respected and to inform participants of their rights to refuse to answer questions which they felt were sensitive; anonymity was assured throughout the process. Allowance should be made for such issues when using local people as researchers. Finally, participatory research is not necessarily a cheap option; sufficient time and resources need to be committed to ensure a robust design and reliable outcome. This will particularly be the case where local people require additional support, following an expression of interest in taking part in the writing up and presenting the results of the study. Issues to do with the ownership of the data and results may come to the fore and require further negotiation and open discussion [see, for example, the case study of a community action group in Lockerbie by Smart and Titterton (1994)].

Conclusion

In this article, the authors have explored the potential of participatory research as a route to empowerment in the context of community development. An illustration of individual and community empowerment in a disadvantaged setting in a Scottish city was provided. This was facilitated in three ways: through the transfer of knowledge and skills; by enhancing the self-worth and self-esteem of participants; and by giving the latter a voice in improving local services.

The ingredients for participatory research to work effectively are genuine involvement of community members from start to finish within a realistic time frame, early discussion and inclusive planning, regular consultation and feedback, open and shared agendas, training to facilitate the transfer of knowledge and skills and a willingness to take on board community perceptions and to rethink initial preconceptions about a community and its concerns.

The authors have argued that this approach offers a valuable route to involving communities, as well as socially excluded, marginalized and disadvantaged groups, in research. A key role for researchers is in bridging the gap between service users on the one hand, and funders, policy makers and other health care providers on the other, by working with service users to demonstrate the reality of social exclusion.

There are opportunities for researchers and community developers to work closely with each other to develop participatory approaches. The example presented here shows how this can be done in relation to the social inclusion agenda. Such an approach has challenges, including sustaining involvement and developing an open and honest dialogue with community members. Provided these are taken into account, participatory

research remains an approach that deserves further exploration and support by researchers and community developers alike.

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