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

Part 1 of 2

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The Journal of the Social Services Research Group

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Editorial

Welcome to this, the final issue of *Research, Policy and Planning* (RPP).

We decided to mark this occasion by inviting as many of our previous contributors who could be contacted to send us their further thoughts on topics they had previously written about, providing a historical perspective.

We invited them to reflect on their previous thoughts and, also, to look forward. It didn't escape our notice that 2020 marks 50 years since the Local Authority Social Services Act. This created the local authority Social Services Departments, within which research and planning activity was placed at least partly on a statutory basis. The Social Services Research Group (SSRG) was formed a few years later, with a national membership typically in the low hundreds, but with individuals from all social services sectors and many academics playing prominent roles. RPP was started in 1983 as a journal publishing substantive papers and other contributions. These were sought especially from people working in social services departments and the voluntary sector, alongside papers from those in academic positions or active as researchers. The RPP Editorial Board plans to try to ensure that the archive of these 33 volumes remains available, as at present, albeit not in a readily searchable form.

This trawl was productive, as we hope readers will agree. It also shed some light on the reasons why we can no longer publish RPP. Very few earlier contributors who were then based in local authorities could be contacted at their previous addresses, and evidently many had ceased to work for local authorities. A larger proportion of earlier contributors were from academia, and many have since retired or moved to other universities. Retirement as such does not denote a lack of engagement, as a glance at this issue's contributions shows. However, several of those who responded told us they had made a clean break, taken up new interests or were very engaged in caring activity! The general background is also the erosion of the membership base of SSRG by a change in the role of research and information within local authorities, who have had to make job cuts during the best part of a decade of austerity in local authority expenditure. As a result, SSRG merged with the Local Area Research and Intelligence Association (LARIA) in 2017. The aim is to maintain a stream of social care activity within LARIA, within which there was already a strong interest in social care.

It's pleasing that a wide range of contributors and historically informed contributions is reflected in the present issue, with a variety of topics and approaches.

Mabel Lie reports on her desk-based research on responses to migrants and health issues from the third sector in Newcastle-upon-Tyne, over a period of 20 years. She had limited sources of data ('grey literature') to draw on, despite her efforts to broaden these. Nevertheless, it is possible to see how responsive and adaptive the local organisations were in representing the interests of specific migrant and minority groups and in responding to government, local authority and NHS funding initiatives. Facilitators identified for health improvement for migrant groups were a culture of partnership working, built through local authority funded community workers. Barriers included cultural and organisational reluctance to address health issues, the economic downturn, immigration from Central and East European Countries (2004-2007), and the arrival of refugees and asylum seekers, which challenged the sustainability of services and existing knowledge about migrant communities.

As with all historical research, a segment of the available records tells only part of the story. Findings are indicative, not conclusive. Research on the recent past actions of statutory agencies in Newcastle or elsewhere would be equally difficult, but equally important to be undertaken for purposes of accountability, policy evaluation and an examination of human rights support in practice.

A related aspect of human rights appreciation and use in practice is proposed in the book on working with asylum seekers and refugees reviewed by **Heidi Holenweg**. In the background, and with information published since the review was prepared, in the year ending December 2019 Home Office statistics show that the UK 'offered protection in the form of grants of asylum, humanitarian protection, alternative forms of leave and resettlement to 20,703 people, up 30% compared with the previous year, to levels last seen in 2003'. Also, according to ONS, non-EU net migration has gradually increased since 2013 and is now at the highest level since 2004.[1] These figures indicate the wide and continuing impact on policies and frontline workers within UK health and human services, as these respond to international political turbulence.

Guiding practical assistance to help work with refugees, within the real-life world of sometimes reluctant organisations, is one of the core aims of the book. Citing the author, our reviewer points out there is not only a statutory duty to support refugees, but also it is important that every service user should get the appropriate help. This is argued as obligatory, regardless of immigration status, nationality etc., by focusing on a client-based service (responding to the acuteness of need). In some ways this seems a traditional social work approach, using statutes creatively and forcefully, and acknowledging limits to expertise – but in a very contested area with growing demand. Social work has been noted[2] as relatively absent, and social work research poorly resourced in this area. Holenberg asks a pertinent question therefore about the competence profiles of frontline workers in this field.

Domestic political turbulence, at least in England, is at the core of a book reviewed by **Andy Pithouse**. The author, Ray Jones, does not pull punches in his critique of policies of privatisation in children's social care and child protection. He assembles evidence of the expensive failures of marketised initiatives, associated with under-evidenced promotional activities of some childcare consultants, such failures being coupled with austerity in local authorities, and with business malpractice. (Such was the inhibited culture in children's services that RPP was unable, a few years ago, to find a reviewer to examine the questionable claims of success made in a book about and by practitioners in the London Borough of Hackney.[3])

Children's social care became separate in 2006 from Social Services, at least legally; and from the Social Services Research Group perspective, this had a negative impact on the coherence, quality and visibility of research and planning activities in local authorities. Perhaps this consequence was an illustration of a broader cultural failure to critically appraise the consequences of policy. As Pithouse points out, regulations currently allow for the commercialisation of child protection and social work; as it were, nothing succeeds like failure.

Nuances in the application of research findings to day-to-day practice of occupational therapists appear strong in the paper by **Joy McLaggan**. She responded to our call for further thoughts on the topic she had previously written about, reviewing recent publications on equipment and adaptations for self-care. The apparently simple policy aim of maximising uptake and minimising abandonment throws up a constellation of issues where evidence is needed to inform judgement. For occupational therapists there are challenges, especially from austerity policies shifting assessment to simplistic check-box administration, and away from (ideally) co-produced and well-informed professional activity. Self-assessment might be feasible but is not always well informed – with even an absence of standardised measurement definitions. This has manifest practical consequences for the provision of suitable aids, not least in measuring bath height when this is self-assessed! Abandonment of aids itself has been defined differently in the different studies reviewed. In passing, McLaggan cites one piece of research which suggests, at least in the USA, there can be a time lag of at least a decade before research filters into routine practice. Assistive technology can promise an apparently quick fix, and it is

[1] ONS Migration Statistics Quarterly Report (February 2020)

[2] By Debra Hayes in '*Social Work with Refugees, Asylum Seekers and Migrants*', edited by Lauren Wroe, Rachel Larkin & Reima Ana Maglajlic (Jessica Kingsley, 2019)

[3] *Social Work Reclaimed: Innovative Frameworks for Child and Family Social Work Practice,* edited by Steve Goodman & Isabelle Trowler (JKP, 2012)

becoming more commonly used as a result of commercial and demographic pressures. Virtual reality techniques can also be of use but, as with outcome measures, day-to-day pressures on time and energy impose restrictions on professionals, even on the best-intentioned.

There is no shortage of good intentions and declarations in relation to adult social care policy, it seems, but little in the way of progress towards achieving specified aspirations. Three sets of contributors examine facets of national policy over the past two decades or so.

Martin Powell and Patrick Hall identify the key policy points, as indicated by official policy publications, Commissions, and Green and White Papers, including proposals to respond to acknowledged and rising pressures of demography. They detail why some necessary components for achieving wider change, derived from a theoretical 'Multiple Streams Approach', were absent or nullified by events. There is little evidence in the official publications over this period of any learning from recent experience, and minimal citation of earlier documents produced under different governments, but possibly written by the same civil servants. Specifically, proposals for serious change stumbled when faced with perceptions, Treasury traditions and political manoeuvring about costs – in one case, manoeuvring just by two members of an 11 member Royal Commission. There were windows of opportunity, but these were closed primarily on grounds of apparent cost and sometimes mendacious publicity about taxation. Ideas were 'on the agenda, but not seriously so'. Ringing declarations by politicians have not been followed up seriously when they or their successors have subsequently been faced with controversial policy recommendations.

In RPP Vol 25 (2-3) **Andrew Kerslake**, responding to the aspirations of a 2006 White Paper, published a cogent proposal for a rational approach, conceiving older people as consumers purchasing care services through an individual budget. Returning to his 2006 theme, he discerns disempowerment of consumers, with increased demand for care due to demographic pressures. This has been responded to by large scale purchasing of private care services, and a two-tier market. With financial austerity restricting local authorities, the prices paid for care are held down for local authority supported service users, while those funding their own care pay a premium for a similar service, and thereby keep traditional residential care afloat. In a way the latter are like late Soviet consumers, buying what there is rather than what they want. Economic austerity on a long-term basis is the background. A known imperative, simply from population and morbidity trends, is the continuing rising level of demand for health and social care services, and Kerslake suggests ways in which this can be reduced. These ways include undertaking serious analysis of, and commitment to the prevention of much demand, by making alternative interventions, and not concentrating on the supply of care. Such care is largely provided through the private sector, and through individuals, and in his view anyway needs to be incentivised.

He continues advocating an economically rational approach, involving a careful balance of public sector management of and engagement with independent sector organisations. The approach advocated is wide-ranging in aspiration but specific in detail, though one anchored within current and historically recent market-oriented thinking.

Colin Slasberg and Peter Beresford are similarly unsparing in their critique of a failure of personalisation policy, even on its own terms, and are sceptical about the evidence for claims of success with localised variants, as in Wigan's 'strengths-based practice'. In their view, the government, local government and the private sector's own actions have failed the test of delivering better outcomes for service users, and policy is in a vacuum; instead they call for the views of the users of services to be followed. Specifically, this is envisaged by means of independent living, achieved through a ('real') direct payment, to enable the person in need to meet their specific need through managing their own support. They argue that this is not possible in the present legal arrangement, where the possibility of meeting needs is circumvented by cost imperatives. Slasberg and Beresford argue instead for the assessment of needs for independent living to be a specific legal right, with the extent to which the resources

are available to meet them becoming a transparent political responsibility. A new independent living service, managed by central government but delivered locally, would be the vehicle for services.

Whether these turn out to be good ideas, or just further aspirations in a policy area not short of aspirations, will be for future commentators to assess on the basis of responses to the critique and suggestions offered.

In the meantime there is a duty, well justified by the evidence of past editions, to thank the current Editorial Board of RPP for their many and varied contributions: to Martin Stevens who has been the strongest possible link to SSRG over the years and a valuable contributor in his own right; and to thank our publishing editor Shelley Nix for her unassumingly diligent and professional work. The greatest thanks are to our two editors John Woolham and Guy Daly. They seem to have survived their years of editorial tenure with vigour, starting the period with papers on personal budgets by Peter Beresford and on historical amnesia by John Clarke. No chance of amnesia while the former contributor is still going strong!

There could also be a window of opportunity, looking beyond the depths of the COVID-19 pandemic. Social care has received public acknowledgement and support alongside the NHS. This is despite, or perhaps because of, political limitations in translating crisis policy advice into decisive and speedy action to protect lives in England at local level. So far so familiar to our specialist contributors in this issue of RPP. However, there can be an enforced opportunity in the next few months for serious research and analysis to contribute to a long-lasting resolution of a long-lasting failure of movement in adult social care policy. Alas, RPP will not be there to evaluate the possibilities and promises that emerge.

Paul Dolan

Reviews Editor, and Editor of RPP Vol 33 (3)

Improving migrant health in Newcastle upon Tyne (1997-2017): a grey literature review of third sector involvement

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Abstract
The aim of this paper is to provide an account of third sector attempts over 20 years to improve the health of migrant populations in Newcastle upon Tyne, so as to inform, encourage and enable services to be better equipped to improve migrant health and wellbeing in an increasingly uncertain future. Employing a qualitative content analysis of 'grey literature' source material, the findings are presented in terms of the facilitators and barriers to service improvement, as well as reporting examples of good practice through the years. Though the foundations of collaboration between the voluntary and community sector and health organisations were established mainly through government initiatives, continued partnership between the statutory and third sectors is vital to sustaining collaboration. Intermediary and advocacy roles in networking organisations are important in continuing the trust relationships that have been built up over the years. While the widespread increased competition for funding has led to communities resorting to their own resources, this paper highlights those historically documented community-led and partnership initiatives that are rarely described in published academic literature.

Keywords: literature review, third sector, migrant health

Background

A migrant can be defined broadly as a person who has undertaken 'movement from a usual place of residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons' (International Organization for Migration (IOM), 2019). More specific to the UK, migrants have been defined as all those who are born outside the UK, whether recent, temporary, settling, or settled for many years (Jayaweera, 2014). Out of the ten regions of England and Wales, the North East has the lowest population share of non-UK born residents. However, a 2011 Census Profile (Krausova & Vargas-Silva, 2013) identified Newcastle upon Tyne as the North East local authority with the highest number (37,579) and proportionate share (13%) of residents born in countries other than the UK. Historically, Newcastle, like Sheffield (Robinson *et al.*, 2007), is a city to which relatively small numbers of people from different countries migrated. The majority of such residents tended to settle in the West End of Newcastle (Foggie, 2014). Following central and eastern European (CEE) countries' accession to the European Union in 2004 and 2007, and associated migration to the UK (Fitzgerald & Smoczyński, 2017), Benwell, Elswick and Scotswood in the West End were identified in the 2011 Census as having the highest numbers of CEE migrants among Newcastle wards.

Although a national guide[1] has been developed, to assist inclusion of the needs of migrant populations in the production of Joint Strategic Needs Assessments as part of the commissioning process (Rose *et al.*, 2011), the topic of migrant health continues to be challenging (O'Reilly-de Brun *et al.*, 2015; Such *et al.*, 2017). Community engagement interventions are undertaken across a wide range of contexts and community-centred

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[1] This guide was produced in 2011 by the Health Inequalities and Local Improvement team at the Department of Health and was originally hosted on the Local Government Association website (http://www.idea.gov.uk/idk/aio/26070159). This page is no longer readily available and may have been archived.

approaches to health are being promoted by Public Health England and the NHS (South *et al.*, 2015). However, evidence of successful community engagement with migrant groups is scant (Bagnall *et al.*, 2015; Jayaweera, 2014). The policy-driven move to the private, independent or third sector for health and welfare service provision was heightened in the face of increased austerity, as a result of the economic challenges posed by the financial crisis of 2008. In Newcastle and Gateshead, the voluntary sector has a record of working with migrant groups over many years (Newcastle Council for Voluntary Service, 2018). But the challenges and risks for this sector to continue to deliver services are great (Curry *et al.*, 2011). The aim of the literature review described here is to provide an overview of third sector attempts (including partnership across sectors as appropriate), over a period of 20 years, to meet the health needs of migrant populations in Newcastle. This account of recent history could inform, encourage and enable services to be better equipped to improve migrant health and wellbeing in an increasingly uncertain future.

The review was funded by a Catherine Cookson Foundation grant based at Newcastle University, to which the author reported her findings. The review was to support a funding application for a public health intervention.

Aim

To document third sector involvement in improving migrant health in Newcastle upon Tyne.

Objectives of the literature review

1) To conduct a qualitative content analysis of grey literature that records work by third sector organisations seeking to improve the health and wellbeing of migrant communities in Newcastle upon Tyne.
2) To identify the barriers and facilitators in improving the health and wellbeing of migrant communities and individuals.
3) To identify and describe exemplar case studies of third sector involvement or initiatives aimed at improving migrant health.

Methods

Because of the regional specificity of the review, a narrative review rather than a full systematic review was conducted. The search plan involved consultation with content experts and snowball sampling of references in documents, followed by targeted hand searching of websites. Web searches accessed reports from Healthwatch Newcastle, the Angelou Centre (a Black-led women's centre), the Comfrey Project (improving refugees' and asylum seekers' health and wellbeing through allotment gardening, cooking and crafts) and online patient participation group reports from primary care providers. Search criteria are listed in **Table 1**.

The following local experts were given the aims and objectives of the literature review, and were requested to provide relevant documents, which were screened and selected according to the search terms above:

1) Vicki Harris (Network Coordinator) and Dr Ann McNulty (former CEO), Health and Race Equality Forum
2) Dan Duhrin (Involvement Coordinator), INVOLVE North East Resource Bank
3) Lucy Hall (Equality and Diversity Lead), Newcastle upon Tyne Hospitals Trust
4) Christine Irklis (Project and Finance Lead), Riverside Community Health Project
5) Andy Lie (Project Leader, 1993-1998), Elswick Asian Project, Diocese of Newcastle.

Table 1. Search criteria.

Inclusion criteria	Exclusion criteria
Published or unpublished document reporting on health-related activities in Newcastle upon Tyne, UK	Document reporting on health-related activities beyond Newcastle upon Tyne
Dated between 1997 and 2017	Undated or not dated between 1997 and 2017
Available in English	Unavailable in English
Most current version of the document	Document in draft version
Contains references to ethnic minority or migrant health	Does not contain references to ethnic minority or migrant health
Health communication from Newcastle City Council or NHS organisations or third sector organisations	Memorandums; texts from social media

The type and number of source materials eventually used for the study were: annual reports (7); third sector initiatives (8); initiatives to improve community engagement (8); conference reports (18); research/project reports or evaluations (21); community feedback or consultations (16); and partnership events and initiatives (33).

Scope of the literature review

The third sector operates extensively across health and social care, working flexibly to address health inequalities and unmet needs in a wide range of communities. While recognising the social determinants of health, such as employment and economic deprivation, the study focused on health-related initiatives. These cover health promotion, signposting, and advocacy, including preventive and wellness support, on which much of the sector is focused (Curry *et al.*, 2011). In order to gain a more comprehensive understanding of voluntary sector involvement in health improvement for migrant communities, the review expanded to include a range of literature reporting on those voluntary groups that worked independently or in partnership, rather than relying solely on reports from the groups themselves.

In making decisions about inclusion and exclusion criteria, reports on voluntary groups that did not have a specific remit of addressing the health and social care needs of migrant populations (see **Table 1**) were excluded from the literature review. This is not to negate the excellent work that some organisations, such as the former Age Concern or HealthWORKS, have carried out, welcoming people from these communities to their activities, or which had some separate provision for selected groups within their overall programmes. However, large umbrella organisations, with specific aims and programmes of work to reach migrant communities in general, are included. Special mention should be made of the Riverside Community Health Project (McNulty, 2018) which over 35 years became well respected for their work with local people in an economically disadvantaged area, including working with relatively high numbers

of migrants, many of whom have settled in the West End of the city. Riverside supports local people across communities, working with an approach that avoids the risk of being gender and ethnicity blind (McNulty, 2017). Their focus on women, children and families has included the development of work to meet specific needs, for example Bangladeshi family support, Arab-speaking women's group, and more recently migrant families from central and eastern Europe, many of whom are of Roma background.

Also significant is the terminology used by services that seeks to meet the health and social care needs of 'Black, Asian and Minority Ethnic' (henceforth 'BAME'[2] even though the acronym BME has often been used in the sector) communities (see the **Discussion** section of this paper for further thoughts arising from the review findings).

Hard copy documents were scanned and together with those in electronic formats, were uploaded to NVIVO qualitative data management software (NVivo, 2012) for indexing and retrieval, coding and analysis. Sections of relevant textual references within documents were coded according to themes or topics that were developed to address the objectives of the review. There was also an analysis of whole documents to counter the potential fragmentation of data, and a recognition that texts are social constructs of their authors, of the audience (mainly community stakeholders) to which they are directed, and of the contexts within which they were written. This review is based on the key themes emerging from the data.

Findings

The figure below describes the distribution of the source material over the 21 years (1997-2017).

Thematic analysis

The themes in **Table 2** emerged from the coding of the textual sources and were used as the framework for the qualitative interpretation of the data to address the objectives of the project. The themes are listed according to the number of documentary sources where references to the theme are found, and the number of references indicates the frequency of references within the sources.

Figure 1. Distribution of sources (1997-2017).
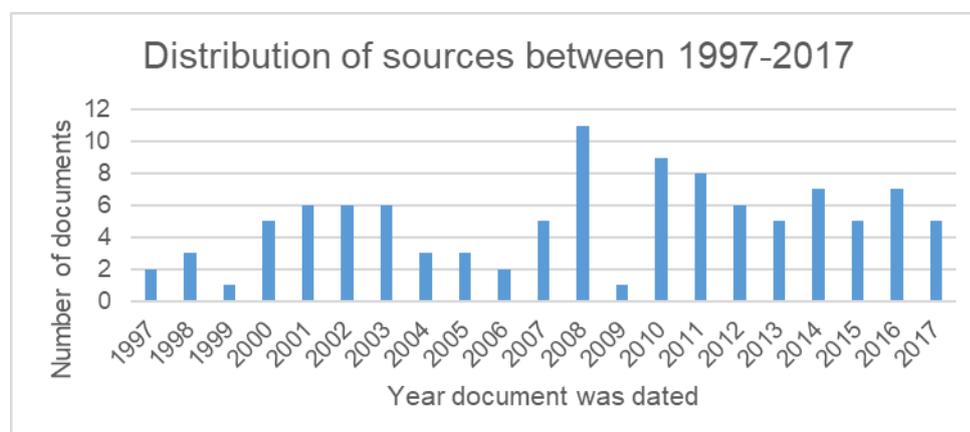
Table 2. Key themes emerging from the data.

Thematic codes	Sources	References
Cultural and community issues	65	256
Health promotion and information	60	152
Actions on behalf of BAME communities	58	208
Language issues and interpreting	57	202
Funding support and commissioning	55	137
Partnership working	50	102
Service providers – staff and training	45	131
Meetings and events	43	88
Community representation	40	62
BAME projects and services	35	80
Community engagement and support	35	66
Key leaders and workers	32	54
Community based research	31	62
Initiatives based on government agendas	31	58
Networking and shared learning	31	50
Racism, discrimination, crime and health	30	75
Fact finding about communities	25	43
Third sector organisations	19	26
Evaluations and reviews	17	32
Collective action	15	17
Primary Care and Hospital Trust initiatives	15	22
Health benefits from community participation	6	16

Findings from the review of the literature

Facilitators for improving the health and wellbeing of migrant communities and individuals

Voluntary and community sector (VCS) partnerships with health service providers and the local authority, in response to Government led public health initiatives, were often the main drivers and facilitators. Communication and consultation networks were established, particularly through the foundational work of Community Action on Health (CAH). Set up after a consultation with local people in 1997, this single-worker project was initially funded by the Health Authority and West Newcastle Primary Care Locality Group. It was not directly accountable to them, but to the community, supporting them to have a voice. The GP-trained community development worker's report 'Health and Race in Newcastle' (Crowley, 1997) explained how the CAH project put into practice the principles of community participation that appeared in the Government's Patient Partnership Strategy, and Green and White Papers at the time. CAH secured funding and adapted to the restructuring of the health service and demands of national policy initiatives, such as Health Action Zones (HAZs). These were established in 1998 (first wave) and 1999 (second wave), with a planned 7-year lifespan and clear priorities regarding the needs of BAME communities.

The Health and Race Equality Forum (HAREF) is a network of organisations and community groups working to reduce health inequalities related to ethnicity. Linking practitioners and BAME organisations and individuals since 2000, it grew out of and continued the work of the Newcastle HAZ Race Equality Area of Special Action (or ASA, part of the Tyne and Wear HAZ). The forum was initially one of the areas of work of the charity 'Newcastle Healthy City Project' (which started in 1994 as part of the World Health Organization's Healthy City Network). The project hosted the Race ASA, employed its coordinator, and supported the continuation of the HAREF network after HAZ funding ended[3].

The Newcastle Health Improvement Programme (HImP, programmes as first mentioned in *The New NHS*, 1997 (Department of Health, 1997)) aimed to reduce inequalities in health through local NHS services working with community groups, voluntary sector organisations, and the local authority. CAH played an important role in this by developing meetings in order to address the needs of populations in different parts of the city. Responding to the (national) Acheson report of 1998 (Acheson, 1998), Newcastle Primary Care Group's strategy was for the development of equitable and sustainable partnerships, with CAH funded by it and by the Health Authority to facilitate the process, together with a reference group of local BAME organisations and individuals.

The work of CAH, Newcastle HAZ Race Equality Area of Special Action, and HAREF resulted in links, for example, to the South Asian community, the Chinese community, Islamic Scholars Health Forum, African Community Advice North East, and the Regional Refugee Forum. They also served to facilitate the collection and dissemination of health information, based on relationships of trust built up over the years, including community-based research and consultation, especially more recently for commissioning purposes.

In an evaluation of the work of CAH (Green, 1999), the two major achievements reported to date were its appraisal for the Community Health Council of the unmet needs of black users of mental health services, and its involvement in the development of the Newcastle Interpreting Service, based on results from their community consultation activities. By 2005, successes reported had also identified agencies with common agendas working together, sharing time and resources to achieve targets together, with the 'interweaving' of services that captured joint working.

Results from these networks and interactions over the years were:

1) Considerable awareness-raising among service-providers and reminders about unmet health needs of migrant communities.
2) Greater liaison between health providers and VCS providing information about health policy developments and public health alerts, for example swine flu (2010).
3) Employment of community development workers and health professionals from migrant or minority ethnic communities.
4) Race equality training for all health and social care professionals, and
5) Training of people in BAME communities, for example bilingual Health Trainers in Mental Health First Aid training (2008).
6) Established community relationships of trust and credibility, for example awareness-raising about sex and relationship education among BAME parents and faith leaders (2007) and providing information about access to a male infant circumcision service (2008).
7) Established partnership working between primary care providers and voluntary agencies, in particular HAREF, raising the profile of BAME health needs for mainstream health agendas.

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[3] Information from personal communication with Dr Ann McNulty.

8) Research, development, and planning including consultation work in particular by HAREF, for example in plans for the transformation and integration of health and social care services through the Better Care Fund (2014).
9) The greater use of information technology for research, intelligence and communication services, including access to resources such as online training. For example, a checklist was produced to support staff in ensuring their services are culturally appropriate (2013).

Thus, a tradition of partnership working with migrant groups was built up through local authority funded community workers. Often instigated by government health policy agendas, as well as by committed health professionals with particular expertise (e.g. in relation to diabetes), this partnership was established, and evolved, adapting to societal demands and the digital information and communication age.

Barriers to improving the health and wellbeing of migrant communities and individuals

These include the lack of political will and action to address unmet need, lack of relevant concrete actions and outcomes based on available evidence, exacerbated by social conditions of economic deprivation, racism, and isolation faced by migrants, and their increasing numbers and diversity. Health professionals might well perceive work with migrant groups as time consuming and 'a distraction' from their main focus. For example, feedback in a CAH feasibility report included 'very time consuming to deal with the needs of non-English speakers'. There were reported tensions between providing targeted services and mainstreaming services, and services not being sufficiently equipped to meet need. With the increasing diversity of BAME communities, rarely were there specifically targeted projects, but greater attempts were made at directing attention to the needs of these communities within the generalised service provision for all. However, by 2002 the needs of asylum seekers and refugees were being represented in the Asylum Seekers and Refugees Working Group, which was a subgroup of the Newcastle Health Partnership[4]. A specific service for these migrants was supported by CAH West, in the form of a surgery attending to their immediate health needs when they first arrive in the city, before registration at other surgeries.

In mainstream services, the Newcastle Carers' Project identified in 2002:

- a need for a change in the culture of health and social services towards adapting existing ways of working and engagement to encompass cultural and religious differences,
- more understanding of community workers' roles, and their need for more support in their roles, made more complex and demanding by the financial climate and new funding regimes,
- greater understanding of, and trust in, what the VCS could offer.

The economic downturn, immigration from CEE (2004-2007), and the arrival of refugees and asylum seekers, challenged the sustainability of services and existing knowledge about migrant communities. Also, the restructuring of the health service i.e. the merger of the two Strategic Health Authorities and clustering of primary care trusts (2006-8), led to challenges and changes in relationships and established ways of working. 'Community engagement' was the catchphrase, but a 2008 report on *Delivering Race Equality in Mental Health* identified that this was not sufficiently balanced by 'clinical engagement' i.e. from health professionals. In public health, initiatives tended to be a result of a professional working with the community to identify need, for example Supari (betel nut) addiction identified by a HealthWORKS health trainer, and a support group being established for the Bangladeshi community.

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[4] A group of different organisations whose aim is to improve the health of the population of Newcastle upon Tyne through partnership work across the city

While there were many benefits from the networks of relationships between health providers and migrant communities, these were far from reaching the aspirations of the 2004 White Paper on health and social care, to involve the VCS in commissioning and providing health services. Advocating for community organisations, a CAH report of GPs' views of working with the VCS (Community Action on Health, 2012) highlighted that in the previous few years, VCS organisations had increasingly to provide evidence, costings, and benefit analyses to meet funding requirements if the services they offered were to be paid for. Comments in a report on the VCS in Newcastle (Young *et al.*, 2014) noted that '*NHS and social care staff worry about risks, safeguarding, sharing information, quality of services, and have a low understanding of the breadth and depth of the voluntary sector offer*' (p.17). But from another viewpoint, '*what is really needed is greater community development within neighbourhoods, to ensure that communities look after each other*' (pp.17-18).

Austerity and further restructuring took its toll. The Heath Improvement Service for Ethnic Minorities (HISEM, part of the Newcastle HImP in the late 90s), was decommissioned in 2017, leaving a gap in services for migrant communities. Following the closure of Newcastle's Healthy City Project in 2012, HAREF became an independent organisation with charitable status, before moving in 2017 because of lack of funding, to become part of Newcastle Council for Voluntary Services, with a remit that covered Gateshead as well as Newcastle[5]. Several charitable groups were closed, or their projects catering to migrants' needs ended, because of lack of funding. With the withdrawal of public funding and support, the need for communities to draw on their own resources increased.

Conferences and networking events

The organisation of city-wide conferences, to include the voices of disadvantaged communities, was a key strategy employed by CAH, which worked hard to encourage participation from marginalised groups. Notably, the 1998-99 CAH conference report made the point that every health issue was an issue for BAME communities, and the danger was that if these communities were treated separately, they could be marginalised. West Newcastle PCG in 2000 adopted a Race Equality Strategy based on this feedback, and as a response to the Government's agenda emphasising fair access to health services. CAH conferences were the vehicle for producing information and receiving feedback on topics (see **Table 2**) such as language issues and interpreting, cultural and community issues, the negative health impacts of racism and the city-wide 'Going for Growth' economic regeneration strategy.

The 2005, 2007, 2008 and 2010 HAREF conferences followed the pattern set by CAH earlier. This involved bringing together more than 200 people to include senior representatives from health care commissioning and provision, the local authority, local universities and VCS organisations. One example in a conference workshop was the use of 'stories' to exchange ways of understanding mental health between the African community and mental health professionals in primary and secondary care. Each workshop was informed by community feedback from previous CAH and HAREF conferences, as well as by local reports.

In response to the Health and Social Care Bill 2010, a consortium of GP practices serving West Newcastle (Newcastle Bridges Commissioning Consortium) held a conference 'Redesigning services to meet the needs of a multicultural community', with workshops attended by a range of organisations including from the VCS. Following the conference there were meetings organised between Bridges practice managers and local community development projects, networks and communities of identity and interest.

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[5] https://www.informationnow.org.uk/organisation/connected-voice/
  https://www.connectedvoice.org.uk/gateshead/
  (Accessed: 16.12.2019)

Also, from the beginning of 2012, HAREF facilitated a regular quarterly Community Forum, for people in marginalised communities and protected characteristics groups[6] to be able to inform local commissioning. With no further funding to organise conferences, HAREF instead contributed to conferences organised by Clinical Commissioning Groups. From 2016, HAREF bi-annual Network Meetings took the place of conferences, and they included 'action logs' detailing lists of actions to be carried out by the members, where they could sign up to fulfil some of the goals decided by the Network.

In 2015, a regional conference on 'Dementia and Caring in the Chinese Community' was attended by over 200 people. It was organised by the Chinese Health Group 'Wah Hong', in partnership with statutory and other CVS organisations, with presentations in Cantonese and aiming to support people in the Chinese community across north east England to live well with dementia.

Initiatives involving the third sector (not including consultation or networking events and conferences)

A range of initiatives by local voluntary groups to improve migrant communities' health and wellbeing through the years has been identified. The review could establish their existence but not exactly how long each lasted.

In 1997 the Elswick Asian Project Drug Education Initiative was an arts-based initiative in a primary school in the West End of Newcastle, part of a wider Church of England funded project working to build bridges with the South Asian community. In 1998-99 the Black Counselling Project, and Black Mental Health Forum and User Group campaigned for the mental health needs of Black communities. In 1999, Dekh Baal Asian Carers Project was formed to support Asian carers in the community. In the same year, the Black Family Health Project, a city-wide voluntary organisation was formed, working with and for Black and Minority communities, mainly Asian elders, to promote healthy living.

In 2003, Bondhon (bonding) group for Asian mothers, developed out of a piece of research by Dr Sayed Noor on the maternal mental health of South Asian women in the Westgate area of Newcastle: a project initiated by SureStart Westgate and New Deal for Communities. In 2008 'Sahelian' Women's Wellbeing Project was established, and based at the Pakistan Cultural Society premises, while in 2011 'Angelou Carers' – a forum and support group for BAME carers – was established.

The Chinese community were notably active in seeking help to provide for their community needs. In 2002, Chinese Complementary Therapy was a 3-year pilot scheme of free complementary therapy available to residents in West Newcastle, initiated by Chinese community representatives. In early 2006, members of the Chinese community approached HealthWORKS to help them plan and host the 2007 National Chinese Mental Health Conference in Newcastle. A *Dementia Carers' Guidebook* in Chinese and English produced with the help of healthcare professionals was launched at the conference. In 2007, they drew up a governing constitution for a Newcastle Chinese 'Healthy Living Centre'. By 2014 the Wah Hong Project began, organising the regional dementia and caring conference in the same year. Registered as a charity in 2016, the project aimed to address health and wellbeing issues for the Chinese community, together with the Chinese Healthy Living Centre and the South Mountain Luncheon Club, which have continued in their activities.

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[6] The UK 2010 Equality Act protects people with the following characteristics from discrimination, i.e. age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity.

There were several initiatives that came from service providers working with communities. Reported in 2005, one of the successes of HAREF's partnership working was a case advocacy subgroup, dealing with health and social care issues. Between 2000-2005 it was based at the Newcastle Advocacy Centre, which included South Asian and Chinese communities, health and community professionals, interpreters, and community organisations. In 2005-6, a multi-agency initiative helped increase the uptake of the flu vaccine across communities. In order to do this, a working group looked specifically at BAME needs, and involved community groups in suggesting ways to achieve improvement on uptake. It was led by the Clinical Nurse Lead from the Asylum Seekers Health Team, Newcastle Primary Care Trust. From 2006-8, as part of the national Delivering Race Equality (DRE) initiative aimed at mainstreaming race equality in mental health, through screening, signposting, networking, training and awareness raising, a 'Message on a Mug' campaign was organised. BAME mental health issues were highlighted through mugs distributed among service providers, using messages developed with input from the community.

In 2008 HAREF worked with Islamic scholars and the Diabetes Centre consultant diabetologist to address the health needs during Ramadan fasting of Muslim people living with diabetes. This was the first of several years of producing the annual Ramadan calendar with appropriate and trusted messages about how to manage diabetes during periods of fasting. In 2012-13 there were records of further partnership work, 'Demystifying Diabetes', resulting in 'important messages about diabetes for South Asian taxi-drivers'. In 2014, there was a similar leaflet, developed by a partnership involving HAREF, Newcastle British Bangladeshi Taxi Association and Newcastle Diabetes Centre, and distributed to taxi-drivers.

There were also examples of work among refugees, asylum seekers and newer migrants. In 2002, the Comfrey Project started as a pilot and was established as a charity looking to provide facilities for refugees and asylum seekers, to improve their wellbeing mainly through horticultural activities. In 2008, the Refugee and Asylum Seekers Health Action Group was established. From 2015-18, the Riverside Migrant Support Team focused on support for people who had moved from central and eastern European countries, as part of the Riverside Community Mental Health Project's overall approach to reducing health inequalities.

Discussion

This literature review is limited in many ways, most of all in its ability to record the full picture of community initiatives on the ground, and mainly because of the paucity of written records of action taken through community groups to improve migrant health and wellbeing. In addition, there were often no clear lines of demarcation between health and wider social issues, such as poverty alleviation, social deprivation, alienation, homelessness and crime that many communities experienced and that they therefore developed support groups (such as the Iranian Centre, Jewish Community Services and African Community Advice North East) to counter.

It is quite characteristic of the third sector in general that on account of funding constraints, time-limited projects come and go, and often there is not a paper trail or much documentation that is associated with initiatives, including those to improve the health and wellbeing of migrant groups. It is highly likely that religious organisations and universities have undertaken projects, or initiatives, or have participated collaboratively with other organisations. Apparently, there were only three instances of this occurring, as cited from the literature that was examined. (One was a drug education initiative by a Church of England diocesan project in the West End, and two were research reviews of projects by Northumbria University.) This small number is possibly because of the specificity in the terms of reference of this study of BAME 'health and wellbeing'. The community of interest being identified as 'BAME' extends to include refugees and asylum seekers, and indeed in recent years the term 'BAMER' has been adopted in some community development practice. However, this latter term has been avoided here because of the lack of usage in the literature studied.

With respect to health, people came together for mutual support, health information, health promotion and advice. In some groups, keep-fit sessions and cookery classes were organised. These activities could be classed as 'strengthening communities' and 'volunteer and peer roles' in the family of 'community-centred approaches to health and wellbeing' (South *et al.*, 2015). But many groups lacked the necessary personnel or infrastructure to record their activities and store these records, or if they did, they were not easily available for study. Despite requests made for the purpose of this review, reports to funders were also not made available, so secondary sources, which made reference to their work, were used wherever possible. A decision was made not to include projects working to address domestic and sexual violence because of the sensitive and confidential nature of their work, and their focus also related more to the consequences of crime than to health.

Since the late 1990s there have been projects initiated from communities themselves, often supported by local authority community workers, to support health and wellbeing. There has also been voluntary action, led by ordinary British residents, to address need in migrant groups. Some of these projects were church based, but a case in point is the Comfrey Project, organised to meet the needs of asylum seekers and refugees. There are also examples of action arising from community research, for instance with Bangladeshi women.

But an issue arising from the reports is the sustainability of these voluntary activities, particularly where they have not been developed with statutory funding and support. CAH, the Race Equality ASA and HAREF, with support from the Healthy City Project, laid the foundations for collaboration and partnership working with health authorities and service providers; and other newer networking organisations, such as HealthWORKS, built on these. Government health agendas provided the stimulus over periods of time, which primary care providers and health authorities responded to as part of their statutory duty. But successive structural and financial changes took their toll on this arrangement.

The lesson from all of this is that partnership between the statutory and third sector is key to sustainability. The importance of partnership is not new, as the Labour Government in 1997 devised compacts to set out the terms of partnership between the state and the third sector, even though the 'independence' of third sector organisations became contested (Martin, 2011). Partnerships may be built, but ultimately power imbalances remain, with control in the hands of commissioners and service providers, who hold the means of implementing change. Nevertheless, this review has identified intermediary and advocacy roles for networking models such as CAH and HAREF, with evidence that networks of communication and trust (Windrum, 2014) built up over the years provided the oxygen for good working partnerships. Outcomes of this relationship include race equality and diversity training, which has to be updated and ongoing, BAME staff were employed and capacity maintained to continually build up knowledge of newer communities, and the employment and support of community workers on the ground. Partnership working improved the task of health promotion and literacy, and enhanced preventive services in the communities they supported, while mainstream services were regularly informed of health and wellbeing needs, so that targeted interventions could be co-produced with community representatives, though not necessarily co-governed or co-managed (Martin, 2011).

The examples cited point to a degree of positive co-production between patients and providers, recognised as helping to meet the demands of preventive health and the management of chronic disease. Co-production and partnership working also benefitted from 'competence differentiation' (Windrum, 2014), in this case in relation to migrant health, drawing on the specialist knowledge of communities and cultures that was available. The 'third sector', as defined by New Labour (Baggott & Jones, 2014) includes not only community and voluntary organisations, but not-for-profit social enterprises, mutuals and cooperatives. However, actions from these latter groups were not very evident from the literature in relation to initiatives to improve migrant health. In an increasingly business-oriented and risk-accountable environment, perhaps there could be greater partnership with these actors in the future. But there are barriers

to be overcome, such as the need for trust to be generated as a result of previous interactions between stakeholders (Windrum, 2014). In addition, there are tensions between mainstreaming or targeting services, providing for the majority rather than minority patient populations, with the rationale of 'good health for all' needing a greater profile in the face of institutional racism.

The impact of the digital age has led to more IT intelligence (data gathering, analysis and presentation) such as baseline measures of unmet need, and web communications used in practice, for example the Health Signpost directory[7] and the HAREF e-bulletin[8]. Digitalisation will be the shape of things to come (Pedersen & Wilkinson, 2018), with the possibilities of greater democracy as individuals from all communities become au fait with smart technology and social media, supported by organisations that are skilled and funded for the full benefits of digitalisation. Research in this area is lacking, and particularly as the widespread increased competition for funding has led to greater need for communities resorting to their own resources, this paper makes a contribution where 'community-led initiatives rarely make it into the literature' (South & Phillips, 2014).

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[7] This directory was run by Involve Northeast but funding ended in 2016 and the information was taken over by Information NOW (https://www.informationnow.org.uk/) – accessed 16/12/2019 – information provided by personal communication with Dan Duhrin.
[8] https://www.connectedvoice.org.uk/content/40-services/haref/453-haref-bulletin

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Equipment and adaptations used for self-care activities: suggestions for good practice to maximise successful uptake

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Abstract
It has been five years since the publication of 'Decisions about equipment and adaptations used for bathing and showering' (McLaggan, 2015). That article explored the issues which influence whether people use or abandon the equipment and adaptations for bathing and showering prescribed or recommended to them, usually by a professional, such as an Occupational Therapist (OT). It drew on original research from 2010, and also explored other literature.

The need to better understand the experiences, preferences and needs of users of equipment and adaptations remains important, both for those involved in recommending and prescribing these items, and for commissioners of these services. Since 2015 the Care Act 2014 has been enacted, and its impact on practice is now better known. Alongside this there has been the emergence of new research which adds to knowledge, along with new insights and considerations for practice.

This present paper revisits the findings from the earlier paper (McLaggan, 2015) in the light of new published findings, and the implications for practice and for further research.

Keywords: bathing, showering, equipment, adaptations

Introduction

Equipment and/or adaptations to the home environment are often recommended by professionals, such as occupational therapists [OTs] (Johnston *et al.*, 2014) who work within social care reablement services (Beresford *et al.*, 2019). These enable individuals to perform tasks (activities of daily living [ADLs], such as having a bath or shower) that they would otherwise be unable to complete, or to increase the ease and safety with which the tasks can be performed in the light of illness, frailty or disability (The Voluntary Organisations Disability Group, 2013).

The need for equipment and/or adaptations is known to increase with age (Gitlin *et al.*, 2006) and research suggests that a third of those individuals aged over 85 struggle with five or more ADLs (Marmot *et al.*, 2017). Demand for equipment and adaptations will continue to grow as the UK population ages: the number of people aged 65 or over is expected to increase from 12.2 million in 2018 to 16.7 million in 2033 (Stafford *et al.*, 2018). At the same time, the number of people living with chronic conditions is also increasing; and it is predicted that by 2030 there will be 50 per cent more people living with arthritis, coronary heart disease or stroke, and 80 per cent more people living with dementia (Select Committee on Public Service and Demographic Change, 2013). Increasing life expectancy is associated with increases in numbers of people living with more complex health conditions, and having more complex needs (Kingston *et al.*, 2018).

The use and impact of equipment and/or adaptations varies between individuals, with evidence of physical, psychological and economic benefits being reported. Equipment and adaptations can reduce pain and the level of difficulty, promote energy conservation, comfort and safety and help to prevent falls (Koketsu, 2018; Sainty *et al.*, 2009; Hersh & Johnson, 2008; Petersson *et al.*, 2008). They can reduce the need for personal assistance in the bathroom (De-Rosende-

Celeiro *et al.*, 2019; Allen & Glasby, 2013; Zingmark & Bernspång, 2011). Timely provision has been shown to prevent deterioration in health and promote skin integrity, welfare and independence, leading to long-term cost savings for care providers (Royal College of Occupational Therapists [RCOT], 2019a; Allen & Glasby, 2013).

Those experiencing bathing difficulties have historically been seen as of low priority for attention by local authorities (Whitehead & Golding-Day, 2019; Atwal *et al.*, 2017; Sheehan, 2015; Ahluwalia *et al.*, 2010), though for individuals the impact of such problems is significant. Participants from Whitehead & Golding-Day (2019) reported how being unable to bathe made them feel dirty and unable to leave the house because of fear of smelling. Similarly, participants from McLaggan (2011) reported that equipment provides an easier and safer way to bathe, compared to having an all-over strip wash.

Despite bathing and showering being one of the first and most frequent areas of daily living people struggle with (Gill *et al.*, 2006), there is still a deficiency of high quality research into the effectiveness of equipment and adaptations in relation to these self-care activities (De-Rosende-Celeiro *et al.*, 2019; Whitehead *et al.*, 2016). Recent research continues to echo earlier findings that the factors which affect uptake of equipment and adaptations are multifaceted (Goodwin *et al.*, 2017). Research tends to focus on the positive impacts of equipment and adaptation use upon individuals, and less is known about negative outcomes, and what factors are associated with these kinds of outcome, either through poor uptake or abandonment, as explored in the earlier paper (McLaggan, *op cit.*).

In some areas of practice, discontinuance of equipment or adaptations is not a cause for concern, and instead can be a measure of success, particularly in rehabilitation or post-operative settings (Sugawara *et al.*, 2018). Lauer *et al.* (2001) defined these specific circumstances as *'positive discontinuance'*, where an individual's function increases so that they no longer require the equipment/adaptation. Also included within this definition are occasions where equipment is replaced with another similar item or enhanced version, or even a different solution entirely, which could include utilising support from a carer or ceasing to carry out the activity entirely.

The type of discontinuance which is of concern is when individuals abandon the equipment or adaptation after a few days, months, or years, despite the continuing need for its use (Khosravinasr, 2017). Abandonment of equipment or adaptations has financial costs for the health and social care system and for the individual, particularly as equipment and adaptations for bathing have been shown to reduce care needs and disability (Whitehead & Golding-Day, 2019), so as a result individual conditions may worsen (Federici & Borsci, 2016). Other costs include reduced independence and safety, potentially leading to accidents that result in injury and admission to hospital (Goodwin *et al.*, 2017), or unused equipment and adaptations not being returned to the equipment provider and recycled (Sugawara *et al.*, 2018; Federici & Borsci, 2016).

The true extent of the problem relating to this type of abandonment is not fully known, although a commonly reported rate of 30% is often misleadingly referred to, examples being by Federici & Borsci (2016) and Johnston *et al.* (2014). Research specific to this topic area has identified varied abandonment rates for bathing and showering equipment and adaptations.

These rates of abandonment need to be interpreted with caution, due to small sample sizes, and because the clinical setting was not always defined, and the type of equipment or adaptation was not clearly documented. This makes the ability to accurately compare results extremely difficult and potentially misleading (Federici *et al.*, 2016; McLaggan, 2015). There is also a lack of consensus about the definition of a threshold for distinguishing between use and non-use (Wessels *et al.*, 2003), particularly when the participants are self-reporting and unclear about the definitions or importance of accuracy. **Table 1** illustrates some of this ambiguity and examples of abandonment rates.

Table 1. Shower and bathing equipment and adaptation abandonment rates and definitions.

Equipment or adaptation type	Abandonment rate	Definition of abandonment	Study
Mobile shower chairs	13%	Non-use defined by the participants during face to face interview. Participants' open-ended responses categorised into personal factors e.g. health changed, intervention related factors e.g. the user did not know how to use it, product related factors e.g. being broken, and environmental factors e.g. feeling discriminated against.	Sugawara *et al.* (2018)
Bath boards	0% discontinued usage 7% non-use	Terms used in study: discontinued use (had been used, but no longer being used) and non-use (were never used). Use defined as being used either every day or every few days. Researchers gave pre-defined answers/ options in self-reporting questionnaire. Reasons for items not being used: • Needed short term • Never needed • Preferred human help • Did not fit • Did not feel safe • Difficult to use • Broken	Hoffman & McKenna (2004)
Bath and shower grab rails	2.5% discontinued usage and non-use		
Shower chairs	13% discontinued usage 39% non-use		
All bathing equipment	10%	Term used in study: non-use. Self-reported definition by participants in questionnaire, examples participants gave: • No longer needed it • Felt unsafe/ frightened to use it • Did not help • Too difficult to use • Equipment was broken/ damaged • Not comfortable • Did not like it • Replaced by better equipment • Lack of space	Sainty *et al.* (2009)

It is imperative to better understand users' experiences, preferences and needs regarding successful uptake of equipment and/or adaptations for bathing and showering, so that evidence-based strategies can be developed to promote their safe and effective use (De-Rosende-Celeiro *et al.*, 2019; Boland, 2015). If we can increase uptake and achieve a better user fit, supporting individuals within their home environment, this will in turn reduce pressures on our already stretched health and social care systems (Spiliotopoulou & Atwal, 2014).

Local authorities are required to make £700m in cost-savings during 2019-2020 (Association of Directors of Adult Social Services, 2019), so they need to streamline services and invest in areas where there is capacity to contribute towards these savings. Prescriptions for equipment and adaptations should be considered in relation to this, as they have a proven capacity to produce cost savings (Heywood *et al.*, 2005; Mann *et al.*, 1999).

This paper examines the available evidence about how services can boost the successful uptake of equipment and adaptations for those with eligible needs, and discusses the considerations, especially for OT practice. The organising themes are *self-assessment for equipment and adaptations*, *joint decision making* and *user perspective* and are ordered consecutively, as they have emerged from the recent literature in this area of practice.

Evidence on how services can boost uptake, with considerations for practice

Self-assessment for equipment and adaptations

The general concept of self-assessment was first introduced by personalisation policy, and the Care Act 2014 stipulates that local authorities must offer options for self-assessment of needs. Equipment and adaptations need to be included as a part of this (RCOT, 2017). For equipment and adaptation self-assessment many local authorities use online tools based on AskSARA (Disabled Living Foundation, 2019), or will offer assessments over the phone with trained call handlers. Phone assessments provide those with the simplest needs assessments by working through a decision-tree to identify the solution. In both cases, the quality of the outcome is based on the quality of the information (which includes measurements of the individual and environment) that the individual provides or inputs into the online or telephone assessment.

There are several benefits of self-assessment. It enables people to be empowered to choose equipment and adaptations that fit their own individual needs, thus offering the potential to reduce equipment abandonment (Spiliotopoulou & Atwal, 2014). It also achieves cost savings, as OTs' time is set free from involvement with these individuals, especially as the process of equipment and adaptation prescription by OTs is time consuming (Federici & Borsci, 2016; Boland, 2015). This is especially important as OTs in adult social services only make up 1.9% of the social care workforce (Local Authority Workforce Intelligence Group, 2007). Self-assessment puts individuals at the centre of the decision-making process, and evidence suggests that if they have some involvement and engagement then adherence increases, so the outcomes are likely to be more successful (The Health Foundation, 2012).

The main disadvantages of self-assessment are two-fold.

Firstly, the interactions and relationships between the individual, their environment and the proposed equipment or adaptation may not be fully considered in a holistic way, comparable to the processes that an OT uses, where the professional guides decisions within the context of a professional theoretical underpinning. Recommendations may be made in the absence of a conversational dialogue and co-production of solutions, based instead on responses to a scripted and fixed set of questions, reaching a decision simply based upon the answers provided. This could result in a recommendation for equipment or an adaptation which may not be as suitable as the user originally believed it would be, leading to a failure to take up the equipment or adaptation, or to abandonment after a short period of time.

Secondly, measurements taken by individuals or their carers to inform the assessment may not be correct; and OTs often do not trust the reliability of such information (Spiliotopoulou & Atwal, 2014). Atwal *et al.* (2017) and Hamm *et al.* (2017) found no national validated guidance to assist individuals or professionals in how to correctly measure the bath for equipment during the self-assessment or prescription process. As a result, Atwal *et al.* (2017) developed a tool, the *'Brunel University home furniture measurement'* (Brunel University, 2016), to support more accurate and standardised measurement for use by those professionals involved with the prescription of equipment and adaptations, which could also be used by individuals, their family and carers. The reliability and accuracy of the measurement tool has been tested (Spiliotopoulou *et al.*, 2018) and it was found that 80.55% of the measurements taken were within acceptable margins of variation, so would not compromise safety and functionality. The study found that *'bath height'* was one of the more difficult measurements to record accurately, as this was one of the measurements that exceeded acceptable margins of variation. This is a

key measurement to help ascertain whether an individual may be able to lift their legs up high enough to step over the side of the bath, or whether they could sit or stand from a bath or shower board fixed across their bath. Without use of the tool only 80% of participants were able to take the *'bath height'* measurement: however, this increased to 100% when using the measurement tool.

Joint decision making

Person-centred practice is a core skill which has traditionally underpinned OT, alongside enabling users to make informed decisions (RCOT, 2019a) and following this approach has been shown to reduce abandonment rates (Federici & Borsci, 2016). As clinicians, OTs recognise that individuals are experts in their own experience, and they should try to treat them as equal partners in the planning of their care and support (Social Care Institute for Excellence, 2019).

The importance of the therapeutic relationship in determining the best approach for equipment and adaptation use is well documented (Squires *et al.*, 2019), as is equipment and adaptation engagement being influenced by this relationship (Boland, 2015). However, it is commonplace that how the individual perceives their needs can be different from the professional's viewpoint (Johnston *et al.*, 2014), and this still results in individuals being sent unwanted equipment, rather than their preferred option (Squires *et al.*, 2019). Obviously, local equipment suppliers have eligibility criteria and guidelines which govern what can be prescribed. OTs would normally start by considering provision of simpler and less costly items first: for example, bath boards, bath seats or shower stools, before the more costly and disruptive option of removal of the bath and replacement with an accessible shower. Adapting to equipment and adaptation use by the individual is often entangled in the broader experience of responding to illness or impairment, including a decline in physical and/or cognitive functioning, alterations in self-concept, changes in body image, emotional distress, disruptions to valued goals, roles and activities, and changes in lifestyle and/or occupation (Desmond *et al.*, 2018). So simply providing equipment or adaptations, to an individual who may be uninterested in trying to use them, will not lead to their use (McLaggan, 2015).

As mentioned above, if users participate in the process outcomes tend to be better. This is true in relation to equipment and adaptations, where users need to be central to the decision-making process (Desmond *et al.*, 2018; Gramstad *et al.*, 2014; Johnston *et al.*, 2014). In particular, it has been demonstrated that satisfaction with long-term use increases when users are properly informed and involved in the issuing process (Borg *et al.*, 2012; Martin *et al.*, 2011), allowing individuals to ensure an appropriate fit based on their own priorities.

Part of working together with individuals to make an informed choice is about giving them the information in a meaningful and useful way. Use of visual aids, such as pictures or videos, within the process of equipment and adaptation prescription, is not widely evidenced (Atwal *et al.*, 2014). Nevertheless, visual aids are used in practice to illustrate what equipment or adaptions look like or how they work. Virtual reality (VR) interior design applications take this a step further, to allow individuals to design or redesign their homes virtually (to include equipment and adaptations) prior to making changes in reality. This allows for improved collaboration, enhanced understanding and communication of design options, as well as facilitating active participation for all involved, along with aiding the process of achieving agreement (Threapleton *et al.*, 2017).

Atwal *et al.* (2012) identified no existing 3D tools designed to support the collaborative process, which should occur between individuals and OTs, to visualise, negotiate and make decisions about how the individual's own environment may be altered or adapted to meet their needs, where equipment or adaptations are required to support ADLs within the home environment. Modifications to existing software (SweetHome 3D) were subsequently made, to include the addition of equipment and adaptations, which include some bathing and showering items. The

software tool was then trialled with OTs to determine its possible usefulness and clinical utility in practice (Atwal *et al.*, 2013; Atwal *et al.*, 2014).

Participants felt the tool would be helpful in aiding joint decision making, and enabling the individual to have more awareness and influence regarding decisions about adaptations, so they could agree what they would look like and understand what to expect (Atwal *et al.*, 2012). This was because ideas were put into a visual context that was personalised and intuitive (Atwal *et al.*, 2014). This may also allow individuals to identify for themselves what equipment or adaptations they may require in order to overcome problems or hazards within the home (Threapleton *et al.*, 2017).

Use of this type of 3D software could reduce the numbers of items of equipment or adaptations that are rejected before use is attempted, as individuals are made aware of what they are receiving and what impact these may have on the home, especially in terms of installation, space requirements and storage (Threapleton *et al.*, 2017). This software may be particularly useful for those with cognitive impairments or learning disabilities, where visually focused communication tools can be more easily understood.

Atwal *et al.* (2014) only tested and gathered feedback from OTs regarding the 3D software, so assumptions were made that the OTs' positive views would mirror those of the prospective equipment or adaptation user. Obviously, there is also clear value in establishing how easy such software is to use, as this can indicate what potential there is to apply it in practice. However, there needs to be a clear benefit for service users. Further research should be conducted to validate these assumptions for this specific client group.

Understanding the user perspective

A relatively new means of data collection in health and social care research is the use of photography (Wilson *et al.*, 2019; Bukhave & Huniche, 2016) to capture information regarding individuals' home environments and the ADLs which are needed. As these activities are often mundane in nature and occur without much conscious thought, data gathering through interviews alone may not elicit the full contextual experience. Combining interviews and photographs allows for reflection on these taken-for-granted behaviours (Wilson *et al.*, 2019) to enhance professional understanding of the user perspective.

Wilson *et al.* (2019) used innovative wearable cameras to explore the lived experiences of six older adults who had received an adaptation in the previous two years. Participants wore cameras situated around the chest area for one day at home, and still images were captured by the camera every 30 seconds. For privacy reasons, participants removed the cameras or paused them whilst carrying out personal activities such as using the toilet or showering. The information gathered from this research in relation to bathing and showering activities is therefore limited, but this research has uncovered the fact that equipment may not be useful all the time. For example, one of the captured images is of a wall-mounted folding shower seat. When asked about its use, the participant mentioned using it only on 'bad' days, but there was reassurance knowing it was there to be used if required. Another image alluded to a bath board not being used frequently, as there was clutter within the bath and it was covered with items, making it inaccessible for use. Upon questioning the participant about this, it was discovered that the equipment was only used when the individual was feeling well enough, so when not in use it provided a space for drying sheets, and for storing towels and toiletry supplies.

It is common for individuals to have to adapt their routines and behaviours when utilising equipment and adaptations (McLaggan, 2011). However, if there is a mismatch between the equipment or adaptation provided and the user's needs, or the environment in which it is used, this may lead to abandoning the equipment / adaptation, or to possible modifications to the way the equipment or adaptation is used, to intermittent use or use in unintended ways (Wilson *et al.*, 2019). When prescribing, OTs need to consider whether users will use equipment or

adaptations in the way that was intended (Boland *et al.*, 2017). Carefully considering the user's needs and opinions holistically and providing choice / options (where possible, in cases where provision is publicly funded) diminishes the possibility that individuals will make their own modifications to the equipment, which in some cases could be potentially dangerous (Wilson *et al.*, 2019). Although discouraged, not all modifications are unfavourable, and physical modifications carried out properly can make some equipment or adaptations more suitable, for instance those made by REMAP (a charity which custom-makes or modifies equipment). In the field of telecare other examples can be found whereby the needs of individuals are met by altering the way in which devices are used or protocols implemented (Procter *et al.*, 2016). Discussion in the even wider field of Assistive Living Technologies (ALTs) has led to the concept of 'bricolage' being proposed: 'pragmatic customisation', combining new with legacy devices, by informal carers, such as family members, in enabling ALTs to be personalised to individual needs. Bricolage allows users and family members to take the initiative in 'co-producing' ALTs, (emphasising) that making assisted living work relies on collaboration, involving not only formal carers, but also informal ones' (Procter *et al.*, 2013).

Virtual reality (VR) technology

As VR technology becomes more readily available a number of possible opportunities exist, although they have not been evaluated in literature to date. Firstly, VR can be used to simulate experiences to show others what it is like to live with a disability, an example being *'A walk through dementia'*, developed by Alzheimer's Research UK (2016). Wearable VR headsets offer this opportunity, with the purpose of education, by enabling people to experience what it is like to live with the condition and what difficulties are faced attempting different ADLs in various settings, including the home environment. If this type of VR experience becomes more widely used in training with OTs it could contribute to increasing understanding and appreciation of the user's perspective. If assistive equipment and adaptations were available in these virtual environments, they could lead to a better appreciation of the issues which surround their use for individuals with these challenges.

Secondly, a growing area in VR development is its therapeutic use. Not only can VR enable those with disabilities to simulate normally out of reach activities such as climbing a mountain or skateboarding, there is evidence to suggest that VR devices could be used as effective tools to motivate patients during rehabilitation sessions, to improve spatial orientation and attention in daily life activities to improve pain relief scores and improve depression resulting from a change in a person's functional ability (Massetti *et al.*, 2018). VR apps have already been useful in enabling users to practise new tasks and learn new skills e.g. using powered wheelchairs (Bigras *et al.*, 2019). Could VR apps be developed to offer experiences of other activities, such as self-care activities, where users and their carers could practise virtually with equipment or adaptations prior to their actual use in reality? The development of such a programme could be generally advantageous for people with a wide range of conditions, including those with mild cognitive difficulties, along with carers. The opportunity to practise in a safe environment first could build confidence and improve safety, giving the opportunity to learn how to use the items, how to adapt the tasks and incorporate them into routines prior to these items being supplied or adaptations being made. Subject to full evaluation, something like these VR apps could influence uptake and abandonment levels of equipment and adaptations.

Renewing OT processes

The development of an evidence base is a relatively new concept in OT (Bennett & Townsend, 2006), which has led to an observed dearth of research in the field of equipment and adaptations (McLaggan, 2011). In the past, the absence of research evidence meant that effectiveness and a quality of service was assumed (Mountain, 1997). Anecdotally, therefore, some OTs would observe a problem, provide equipment and then watch the result when the individual completed a task that was previously difficult or impossible to do. The extent to which effectiveness was appraised was to ask the individual if they liked the new equipment or

adaptation and whether they found it helpful (Edyburn & Smith, 2004). As attitudes towards the need for evidence have changed there has been the emergence of some relevant research in this field, focused on outcomes and including what was thought to be the first RCT of major housing adaptations, such as by Whitehead *et al.* (2016), Sainty *et al.* (2009), Häggblom-Kronlöf & Sonn (2007), Pain (2003) and Mann *et al.* (1999).

In ensuring that OT assessments are fit for purpose it is important to incorporate the evidence that the relationship between the individual and their home is multifaceted (Wilson *et al.*, 2019). OTs need to understand the perceptions of equipment and adaptations that may be held and observed, and to provide individuals with opportunities to share their concerns regarding perceived need, and their fears and concerns about stigma or embarrassment. These may all influence usage and possibly abandonment (Squires *et al.*, 2019). In ensuring there is a good evidence-informed understanding of these issues and the interplay between them, OTs must not forget the obvious questions to ask of the individual whether they are going to use each item of equipment or adaptation, understand the potential benefit of it, and intend to use it in the way that it is intended to be used (Boland *et al.*, 2017). Goodwin *et al.* (2017) developed a simple set of questions to act as prompts to aid clinical decision making, and these could apply to many different items of equipment and adaptations:

- Do you think this equipment will be helpful?
- Do you think you will use it?
- Do you understand how to use it?
- Do you have any concerns or anticipate any challenges using this equipment?
- Would you say you like, dislike or neither like nor dislike this equipment?

There are various models (shown in **Table 2**) which may support the OT in the assessment process, to help decision making regarding an individual's responses to questions on use of equipment and adaptations, so a better 'fit' can be achieved.

Models which explain or attempt to predict usage of equipment or adaptations are a new development (Boland, 2015), and despite their iterative development and use in research, theoretical models in this field have not gained traction in clinical practice (Tedesco Triccas *et al.*, 2019).

Table 2. Examples of existing models with relevance to equipment and adaptations.

Model	Author(s)
Assistive Technology Device Predisposition Assessment	Scherer & Cushman (2001)
Factors that influence equipment and/or adaptation use and satisfaction	McLaggan (2011)
Human Activity Assistive Technology Model	Cook & Hussey (2008)
Matching Person and Technology Model	Scherer & Craddock (2002)
Model of clinical reasoning for equipment prescription	Boland (2015)
Technology Acceptance Model	Venkatesh & Bala (2008)

Obviously the ideal would be to always assess people in their own homes; however, due to high demand, time constraints and pressures from hospitals to discharge people, this is not always possible, which could perhaps lead to unsuccessful provision of equipment or adaptations. In the absence of OTs seeing for themselves the home environment, ensuring that OTs use a tool (Brunel University, 2016) which simplifies assessment and the measurement process may contribute towards helping to reduce rates of abandonment, particularly when there is a self-assessment process. This tool on its own is nevertheless unlikely to fully resolve the problem, as a variety of reasons for abandonment have been identified (Lauer *et al.*, 2001). It is a relatively new tool, the only evidence-based one in existence, and would be useful in a variety of settings and of low cost to use. However, despite its apparent usefulness it is unlikely to be incorporated widely into practice within the next few years. Evidence suggests that it takes well over a decade for research to filter into routine practice (Juckett *et al.*, 2019).

Once equipment or adaptations have been prescribed, they should be reviewed by the OT to ensure the service users' outcomes have been achieved, and the items are being used as recommended. As mentioned previously, review needs to go beyond knowing the individual is utilising the equipment or adaptation. Ideally, an evidence-based outcome measure should be considered for this purpose, to supply credible and reliable justification for the interventions (equipment and adaptations) that have been delivered (RCOT, 2019b). Examples of existing outcome measures include the Quebec User Evaluation of Satisfaction with Assistive Technology (Demers *et al.*, 2002) and Psychosocial Impact of Assistive Devices Scale (Jutai & Day, 2002). Use of these in practice requires a commitment of time and resources from staff, so their uptake in practice is limited.

Overwhelming demands on frontline staff in social care often mean that reviewing bathing and showering equipment and adaptations, and completing outcome measures, does not routinely happen. There might typically be only a follow-up visit or phone call just after the equipment or adaptation has been supplied. Ideally, individuals require a period of using the equipment or adaptation, and incorporating it into their daily routines, in order to fully establish if it is suitable. Even if the prescription is initially correct and appropriate, there will continue to be occasions where an individual's condition declines or improves, which may result in the equipment or adaptation no longer being suitable, and subsequent abandonment (Wilson *et al.*, 2019). OTs are relying on service users and carers to be able to recognise if and when the equipment or adaptation is no longer effective, and to feel able to respond to this e.g. by contacting the person or organisation that initially provided them with the equipment or adaptation. OTs therefore need to ensure that they are accessible to such responses, and are open about the alternative options, so that if individuals experience problems, they feel they can make contact again and request alternative solutions.

Conclusions and implications for OT clinical practice

A number of ideas have been discussed within this paper which could have an impact on the quality of clinical practice and improve the uptake of and satisfaction with equipment and adaptations, particularly in relation to bathing and showering.

In summary OTs should consider:

- using clearer clinical guidelines, for measurement and around suitability / prescription of equipment and adaptations,
- using client-centred assessment processes with a sound theoretical underpinning of the issues that are relevant to the user,
- using tools to improve engagement with equipment and adaptations, such as enabling individuals to see and visualise how equipment or adaptations may look and function in their home, and
- using outcome measures to determine ultimate suitability.

Although this article has focused predominantly on current issues within the field of equipment and adaptations used for bathing and showering, many of the points raised extend beyond these, and would be applicable to other types of equipment and adaptations. This paper has attempted to respond to practice challenges by reflecting on opportunities to improve our understanding of service user needs and expectations by using technology, which in turn might lead to reductions in abandonment rates for sometimes expensive adaptations and equipment.

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Notes on Contributor

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Reviews

In Whose Interest? The Privatisation of Child Protection and Social Work Jones, R.
Bristol: Policy Press, 2019
ISBN: 978-1447351283 (pbk), £19.99, pp.387

Social work has had to wait a long time for a book like this. This is a lengthy, value-driven but forensic analysis of the evolution of children's services increasingly privatised by successive governments in England, most notably starting with Margaret Thatcher's rejection of the welfare compact of post-war Britain. It casts a bleak eye over the claims made for market disciplines in welfare and observes its real-world consequences. The book traces the tumultuous changes ushered in by Conservative administrations of the 1980s and 1990s, and to varying degrees continued by the Labour governments of Tony Blair and Gordon Brown, that experimented with all manner of outsourcing, franchising and commodification of care. More recently, the pace and direction in which England's privatisation agenda has moved towards the possible commercialisation of child protection and social work far outstrips that under any other UK administration. The book echoes the alarm of many in social work and beyond at how the human rights of children to be safeguarded, and parents' rights to a family life, are to be entrusted to unelected trusts, private sector corporations or other third party organisations such as the charitable offshoots of private companies, whose 'bottom-line' interests and accountabilities are profoundly dissimilar to those of the local state and the vulnerable citizens they serve.

The long post-war journey to England's contemporary children's social work is portrayed as created by a sequence of sceptical governments keen to control a profession they deem troublesome, and with a local government forever cast as inefficient. Children's social work in England has been subjected to the cherry-picking of corporate raiders, the carpet-bagging of management consultants, the collusive agenda of particular self-serving policy elites, a punitive regulatory system, and of course an antagonistic press, apart from the ever-faithful *Guardian*.

Such seems to me to be the overarching narrative of this 300-page critique, with its further 80 pages of dense notes, references and index. It is a sizeable and unrelenting exposure of some very dubious financial interests, questionable political motives, and muddied policy networks seemingly composed of the conflicted if not the downright morally suspect. Feelings are not spared in this sometimes muscular treatment of familiar politicians and 'key players' active in the policy world that Professor Jones holds up to his own test of probity. But the book is very much more than a 'knock-about' of the usual suspects, for there is conspicuous marshalling of evidence of the failure of marketized initiatives, as indicated by their own unmet criteria. In many ways this is a tour of the English social work world over the last 50 years, viewed from the prism of personal professional experience, considerable distaste for privatisation and a deep belief in the virtues of a properly funded local state.

For the already converted this will be a form of comfort reading, confirming that private is often bad; and public, wherever it can be delivered well, is usually better. But for those who find the world sometimes more contradictory than they might wish, there may be aspects of the Jones narrative that don't always square with alternative perceptions of market arrangements. Indeed, had the book contained more analysis of the mixed market and its key features, say in foster care and residential provision, we might have better explored the idea that good and fair-priced services can be commissioned from honourable businesses and third sector providers, and that not all are driven by greed. Any brief conversation with those running the independent fostering world will almost always include their insistence that their overheads are more transparent, and not dissimilar to a local authority's, were the latter to really identify their true costs. Of course, there are too many examples where a seller's market position is exploited shamelessly; and one has to ask why consortia of local authorities have not come together and got a grip on their regional commissioning, as those in some other services have.

That some local authorities have been complicit in their surrender to the corporate world, as described by Jones, is not in doubt. Too many authorities, of different political hues, after some major scandals and with stringent budget pressures, relinquished to Mammon their own children's homes and foster services. This was in return for holding fewer risks themselves, and in the guilty knowledge that those staff working in the private sector that they procured (subsequently more cheaply than they were when employed in-house) would often have employment terms and conditions inferior to those in local government. Indeed, many small private residential businesses do struggle to survive when local government's dominant impulse, predictably, is cost avoidance. It can be said, too, that carers in those small well-run foster agencies that pay decent fees and always respond promptly to calls for help are deeply loyal, and they would not easily transfer to what some have experienced as large, distant and unresponsive local authorities.

In short, there is a more contested and troubled history surrounding social services performance over recent decades, exacerbated deeply by austerity no doubt, but one which did not surface in the book as much or as often as might be expected. Likewise, the exposure of Morning Lane Associates (child care consultants), the Chief Social Worker for Children and Families, and a prominent professor of social work to what appear to be uncomfortable questions of association and motive did not seem to be accompanied by any record or comment (if there is such) of rebuttal or clarification by the relevant parties. More generally, the possibility of other more complicated stories other than the cash nexus, to account for sharp commercial conduct by those out with the local authority, did not always seem to accompany an otherwise trenchant and closely referenced critique of (often big) business malpractice in children's social care. Yet, in contrast, there are large numbers of adult self-funders who seem content with their private sector care, and all manner of social enterprise entities that collaborate with local authorities in good quality residential and day services for older people. Of course, children's services stand in some contrast to these more 'steady-state', albeit often stressed, services: but the point being suggested here is that the market can be made to operate responsibly, at least in some spheres; and doubtless this is true for some children's care. The mixed market is here and seems enduring, and it cannot simply be wished away. The big issue is how we rebalance commitment back to local authorities and away from an unhealthy over-reliance on some specific providers, without damage to children's lives. Such a discussion might have occupied more of the 43 pages of the concluding chapter of what is nevertheless a rattling good read.

Ray Jones is spot on with regard to his core contention and value position, in my opinion. Child protection and social work should never be outsourced to private or third sector entities. Vulnerable families need a 'wraparound' service that can, of course, buy in additional services from other providers: but the essential engagement must occur through an accountable and visible line between the local state, the family and child. The local authority can connect families to a range of provision that is simply not available to independent operators. Corporate parenting as a commitment has at its heart the collective authority of social services, health, education and their multiple links to legal services, housing, family courts, and other significant networks. This cannot be reproduced at scale by any single agency, private or voluntary. Worryingly, statutory regulation in England currently allows for the commercialisation of child protection and social work. Good sense, recent experience in some outsourced services, and international precedent would suggest, however, that interventions in family life that might entail the removal of children should only be conducted directly by the local state and licensed social workers. The case for both child protection and for social work, and for their approval and full support by government in England is made by Jones with passion and precision. Whether Prime Minister Johnson's new administration will take the same view is yet to be seen; but all good offices should be brought to bear upon that possibility.

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Working with Asylum Seekers and Refugees: What to Do, What Not to Do, and How to Help
Crowther, S., *London and Philadelphia: Jessica Kingsley Publishers, 2019*
ISBN: 978-1785923173 (pbk), £19.99, pp.269

Awareness of policy, expertise in asylum procedures, and knowledge of services and benefits which asylum seekers and refugees can receive under current legislation, requires not only professional handling and know-how by specialist lawyers. Increasingly, this requirement extends also to those working directly with asylum seekers and refugees (mainly in voluntary organisations), but also working in other social welfare fields like health, education and children's services.

There's an ongoing need, not only in the UK, for workers to help asylum seekers and refuges settle into their new homes, to find work and continue their lives as normal. But what do we, including workers and volunteers, actually know about refugees and asylum seekers, their day-to-day lives in the UK, living in shared accommodation, about job opportunities or the current legal situation? Can we even imagine what circumstances force people to leave their homes?

Working with asylum seekers and refugees therefore poses challenges for professionals and volunteers. This is due both to the technical complexity of the subject area of migration, refugee, asylum and human rights, and the often emotionally stressful fates of the people concerned. On home turf, it can be easy to forget to think about where these individuals are coming from, and the cultural, linguistic, and institutional differences that can create significant barriers and challenges for many refugees.

This new book is steeped in and benefits from the personal experience of the author, making it convincing and authoritative. Sarah Crowther is the Director of REAP (*Refugees in Effective and Active Partnership*), and a Founding Trustee of HEAR, London's Voluntary and Community Sector network of equality and human rights organisations. She explains that her professional background and the people she met over two decades have influenced the way she approached the task. The book draws equally on experience, material from REAP, and personal contributions by herself and others, including refugees themselves.

She mentions three intentions. First, to broaden awareness and provide information, sources of expertise and ideas to help practitioners and others (including volunteers), to respond effectively to working with refugees (p.17). Second, to give practical assistance to help work with refugees, within the real-life world of sometimes reluctant organisations (p.19), and finally, to do her bit, so we can make this society a more meaningful place of refuge for people who have lost so much (p.21).

The book is full of advice and encouragement. Examples show how hands-on workers and volunteers are forced into a contested space, where wider social tensions are played out. This pragmatic book will inform new hands-on workers and other professionals in consulting or advisory services. Or, if you are already in this field and want to improve, to be up to date or more confident in your expertise or know-how, the book will have an impact.

There are twelve chapters organised into two parts, including a list of acronyms, a glossary of specialist terms, appendices with lists of relevant organisations, sources and potential evidence documents, a list of references and a page-related index. Each chapter starts with an introduction and ends with a summary and/or conclusion, which makes it a great manual, as it can be read by chapter. Key points are repeated, such as the importance of workers not giving legal status immigration advice unless they are licensed to do so, despite this often being the most pressing issue for refugees they are working with.

Following an introductory chapter setting out the rationale behind the book and the central concept about who refugees are, Sarah Crowther explores not only the question why refugees should be supported, but also the differences between supporting refugees and supporting other service users.

Her explanation here draws attention above all to a value system. She recognises the equality of all people regardless of their nationality or migration status. This pushes towards the dismantling of discriminatory social conditions – as well as to direct work. Therefore, she points out, there is not only a statutory duty to support refugees, but also it is important that every service user should get the right help. She argues that this is obligatory, regardless of immigration status, nationality etc., by focusing on a client-based service (responding to the acuteness of need).

Working with asylum seekers and refugees requires the examination of and/or knowledge of a variety of legal bases, which have a significant influence on the advisory skill of workers and volunteers. These include, among other things, key legal processes and definitions, notably the Human Rights Act. Practitioners need to be well informed about current migration law and other relevant legislation, and they need to keep up to date. This links to two questions: who are asylum seekers and refugees?; and why do some service providers cut them off from services, by saying *"we do not do refugees"*? This is when not only are they obliged to treat people equally under UK law, but also when refugees have the same acute needs as other service users supported.

It is important to recognise that the people who are perceived as refugees are regarded primarily as refugees because we have labelled them so. Chapter 2 provides a good discussion. The author puts it in a nutshell: *'Refugees are migrants, but not all migrants are refugees'* (p.36). Choice or push factors of movement make the difference between a (voluntary) migrant or a refugee (forced migrant).

Both these chapters remind readers to bear in mind day-to-day work life. Sarah Crowther reminds us that supporting refugees isn't just an issue of need in the UK, or in the rest of the world. It is a contemporary and hotly debated social and political issue. The chapters successfully navigate through the complex policy and ethical terrain.

Chapter 3 covers three different types of definitions of refugees and practical entitlements. The first is a subjective definition based on people's experiences, followed by an official definition from the Home Office, and finally popular and political definitions. The chapter provides essential points on how to read and use the different definitions in day-to-day work, and on the key ethical and practical challenges faced when using different terms. As a reader of this book, I was curious to see if her definitions from the Home Office were literally from immigration law or were her own words, which should have been made clearer.

Working with asylum seekers and refugees involves a variety of cross-cutting tasks that cannot be accomplished without successful participation in functioning local networks. This requires dialogue with organisations that may be critical of the reception of refugees or even restrict their services for refugees. This dialogue should not be purely moralistic or instructive, but must aim at persuasion, which requires not only patience but also appropriate expertise.

Chapter 4 gives the reader ideas on how to use the Equality Act 2010 for this type of advocacy lobbying. It is mostly from a legal policy perspective, though well illustrated by examples. Anyone looking for material about how to convince organisations not to exclude refugees from their services needs to read Chapter 7, which covers who to network with in advocating for refugees. From my 'experiential' point of view, and from practice in this field, I can confirm that expertise is required, along with negotiation and communication skills, and a great deal of patience and persuasion. Supporting refugees directly means mainly giving various kinds of advice. This requires action guiding procedures and methods for taking steps in the advisory process.

In Chapter 5, the author goes on to practical work with refugees: how to access, how to engage and build a professionally based relationship. She describes this as being 'Friendly? Yes, but not friends.' Using plain language or professional interpreters, and not using other family members (e.g. children) to translate is an important point, which is discussed in the next chapter. In both chapters she explores the role, the nature of work with refugees, and has a specific focus on trying to maximise productive intervention.

By this stage I was hoping to get more information about the competence profile of a hands-on worker in the refugee field. Perhaps I'm not the only one to be curious as to what kind of formal basic qualification someone needs to work directly with refugees. The book does not clearly discuss this. Work directly with vulnerable people like refugees requires a range of professional competences (e.g. intercultural working, psychosocial skills) and personal skills (e.g. psychological resilience, competence in contact with "difficult" clients). With a clear competence profile, the reader could get an orientation and assessment, as the author strives to show in Box 1.3 (p.26) in which the reader him/herself can monitor their own learning.

The following four chapters concern practical topics in supporting refugees. Chapter 8 is about shelter and housing, money and providing money. Chapter 9 is about health, physical illness, mental and emotional health, and disability. Chapter 10 is again about language, at this point more about learning and educational possibilities, and training and employment. Chapter 11 focuses on refugee children and young people, with and without families. In summary, the author discusses topics which are faced in day-to-day work with asylum seekers and refugees. In each chapter the reader will find helpful information.

I make two concluding points.
First, the reader needs to have a good and up to date knowledge of the UK's social security and legal system, and about day-to-day life in the UK itself. Not then for most refugees themselves!
The second point is to acknowledge that the book doesn't explicitly claim to be a textbook, or structure it and use cited references in that direct way. References are in fact rare.
It seems that most of the book is the hard-won fruit of the author's experience, plus her strong commitment. 'You and the refugee have agency and can bring about change… by making services work better for refugees you make them work better for everyone' (p.236). On its own terms, this works as a generous guide to thinking and working in a fraught and somewhat stigmatised field.

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What are SSRG's objectives?

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

Who belongs?

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

How is it organised?

SSRG is run by an 'Executive Committee' (EC) which comprises elected and selected officers, elected members, co-opted members and representatives from SSRG Scotland, whose principal tasks are to promote the objectives of the group and to coordinate its activities.

What does it do?

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

Equal Opportunities Policy Aims

- To ensure that every SSRG member, user, job applicant, employee or any person working with, or in contact with, the organisation receives fair treatment irrespective of their age, colour, disability, gender, ethnic origin, marital status, nationality, race, religion, sexual orientation, responsibility for dependents, political affiliation or membership of a trade union.
- To ensure that the contribution of research, information, planning and evaluation work in social care and health is sensitive to this issue.
- To ensure that SSRG promotes the equalities agenda in all its activities.

Research, Policy and Planning is the Journal of SSRG