

A Profile of 15 Social Work Services with Deaf and Hard of Hearing People in England

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Abstract

This article presents data from 15 social services teams in England providing services to Deaf and hard of hearing adults. Data were collected by means of a postal questionnaire in early 2002. The profile gathered includes information on staffing, resourcing, population served, degree and kind of service user consultation, staff communication skills, accessibility of services, and self evaluation of services against the 'Best Practice Standards in Social Work with Deaf and Hard of Hearing People' (ADSS et al, 1999). Results are compared with the last published SSI report on services for Deaf and hard of hearing people (DoH, 1997) and in light of the requirements of Best Value reviews and performance assessment.

Key words: Deaf people, deaf social services, hard of hearing, specialist social workers.

Introduction

This paper profiles 15 social work teams working with Deaf and hard of hearing adults in England (1). The data reported were originally provided to assist in the selection of three teams to work on a three year development and research project concerned with the implementation of 'Best Practice Standards in adult social services with deaf and hard of hearing people' (ADSS et al, 1989). These Best Practice Standards are a document setting out nine areas of service delivery and associated quality indicators specifically relevant to social work with Deaf and hard of hearing adults. It was jointly written by the Association of Directors of Social Services, the Royal National Institute for Deaf People, the British Deaf Association and the Local Government Association in response to a damning SSI report in 1997 about the quality of social work with deaf people (DoH, 1997).

In the course of setting up the main project to study the implementation of these standards, 15 social work teams provided detailed information about their structures, funding and service delivery to assist in the selection of the three teams (and associated service user groups) who would ultimately work on the wider project. That larger project is not the focus of this paper. However, the information acquired from the 15 teams stands in its own right as a significant resource in a specialist field devoid of much normative and/or quantitative data. There is, for example, no specific social services performance indicator within the performance assessment framework (www.doh.

gov.uk/paf/) that relates to services to Deaf and hard of hearing people - they are usually subsumed under that related to 'physical disability' despite the fact, as this paper demonstrates, that is not organisationally where such services necessarily sit. Best Value and Joint Review initiatives can require a close and specific focus on Deaf/hard of hearing services, but there is little comparative or baseline data that assessors are able to use. The last published SSI inspection of services to Deaf and hard of hearing people took place in 1997 (DoH, 1997) and no follow up data have been published despite a range of practice initiatives that its publication prompted (e.g. DoH, 1999a).

In short, although our original intention had been simply to recruit three teams to work on a multi site development and research project, the data generated by the instrument designed to help in the selection of those sites, was deemed too valuable not to report in its own right. This is the purpose of what follows.

Critical issues in quality social services with Deaf and hard of hearing people

The consistent use of the phrase 'Deaf and hard of hearing people' within the title of the Best Practice Standards and in this article may seem rather cumbersome, but it makes a necessary and accurate point. The term 'Deaf', conventionally expressed using an upper case 'D' (Woodward 1972), refers to the population of people whose first or preferred language is British Sign Language (BSL). This is not a visual version of English, or a gestural semi language, but a fully grammatical, living language as complex and expressive as any other (Sutton-Spence and Woll, 1995). Its community of users form a distinct sociocultural group estimated at

between 60 and 100,000 in the UK (www.bda.org.uk). In May 2003, the British government finally recognised BSL as a language. How the associated rights and responsibilities this brings will be fulfilled remains to be seen. Social services, within the British context, has long recognised the validity of this alternative language use, sociocultural identity construction and the community structures of the population (OU, 1991). To be 'Deaf' is to have a cultural identity and the term refers to this ethnicity as much as the description of someone as 'Asian' or 'Native American' would - although clearly within such descriptors there is room for considerable diversity (Ladd, 2003).

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However, Deaf people are not the only constituency of users addressed by social services. The vast majority of people with some sort of hearing loss do not use BSL (Davis, 1995). Many are hearing aid users who have lost their hearing progressively through the ageing process. Some have become traumatically deaf through illness or accident. Some may have a hearing loss most of their lives but prefer to use speech and/or lip-reading. In the UK today, one in seven people have a hearing loss. Once over the age of 60, 55% of us will experience degrees of deafness (www.rnid.org.uk). Approximately one child per thousand is born with a 'permanent childhood hearing impairment' with the same proportion again acquiring a hearing loss before the age of 14 (Fortnum et al, 2002). This larger group of people who are not Deaf in the culturo-linguistic sense are variously referred to as hearing impaired, deafened, partially hearing, hard of hearing and 'deaf' with a small 'd'. [In this article we will follow the terminology of the Best Practice Standards and refer to them using the generic term 'hard of hearing' except in cases where the teams involved in this study themselves use a different terminology]. In addition to such diversity amongst Deaf and hard of hearing people, social services also provides services to Deafblind people, and to those Deaf and hard of hearing people with physical and/or learning disabilities (DoH, 1999a).

In other words, the fundamental diversity of the populations served and the crucial differences between the needs and approach of Deaf people who use sign language and those who do not, are central to any understanding of quality provision,

service user satisfaction, and approach to practice.

The SSI report 'A Service on the Edge' (DoH, 1997) as the name suggests, identified serious problems in the delivery of services to this diverse service user group. Assessments of Deaf and hard of hearing people's needs were often poorly developed or did not happen at all. Most service users were not aware whether they had been assessed or indeed why they should have been. Deaf people under 21 were described as receiving a 'minimal service' with none of the Social Services Departments inspected contributing effectively to the assessment of 14 year olds as required by the Disabled Persons Act 1986, Section 5. Hard of hearing people were unlikely to receive any help other than the provision of equipment. Criteria for the provision of environmental equipment varied considerably between authorities with key safety equipment such as flashing fire alarms not necessarily being considered standard.

In terms of inter team and inter agency working, specialist social workers were under considerable pressure to provide interpreting services for colleagues in other teams (eg working with people with learning disabilities who may also be D/deaf). The difficulties this created were not simply those of time or role compromise (specialist social workers always being seen as assistants rather than capable of carrying out complex tasks in their own right). It also set up a situation whereby from the service user's perspective different parts of social services were not independently accessible without social workers for D/deaf people providing that access. Indeed, in seven out of the eight areas there were inadequate interpreting arrangements to enable Deaf people who use BSL to access other services within social services not covered by the specialist D/deaf services teams/workers. Only 18 per cent of social workers themselves had what was regarded as a minimum level of BSL fluency to carry out their job effectively. Most were working in situations beyond their linguistic competence. In consequence a great deal of information about services and more significantly rights to service was not accessible to those who did not use English fluently.

The inspection 'did not find any effective consultation with Deaf and hard of hearing

people' (DoH, 1997, p.6) and almost no involvement in service planning despite statutory responsibilities to develop service plans on a basis of consultation. Overall strategic management was described as 'limited' and 'Most specialist teams were overwhelmed with work and were trying to do a wide range of tasks with little management direction' (DoH, 1997, p.4). Finally, in terms of approaches to service delivery, there was an underlying concern that a dependency model of service provision was still in some cases being pursued. This is particularly pertinent given social work with Deaf people largely grew out of a tradition of missionaries to Deaf people - originally religious people later more generally welfare workers - who operated for many years a strongly paternalistic model of welfare. Ample evidence now exists over the near total control that such missionaries exercised over the everyday lives and decisions of Deaf people and the difficulties the community faced in offering resistance (Ladd, 2003). In the Deaf community, there remains a strong suspicion of social workers and their dependency provoking attitudes - despite concerted efforts to the contrary, the sign for social worker is still largely synonymous with the sign for missionary.

The data we were able to derive from the 15 teams who participated in the postal questionnaire profiling their services gives us a snapshot of what has happened five years on from the original research and whether the significant concerns of the 1997 SSI report still endure.

Method

As previously noted, the original impetus from which the following data is derived was to recruit three teams to work on a larger development and research project concerning practice standards change implementation. As a means to such recruitment, the 150 specialist social work teams in England listed on the RNID national directory were contacted by letter about the project and in addition information was distributed via the ADSS Directors of Social Services mailing, the ADSS sensory special interest group, RNID and University web sites and personal contacts. Subsequently, the 27 teams who responded were provided with more detailed information about the

bigger project and a written questionnaire to fill in. The aim of this questionnaire had been to assist in the selection of three sites for the wider project that would be differentiated by: demography of populations served, organisational structure of services, size of resource, self assessment of delivery against Best Practice Standards, self assessment of degree and type of service user involvement. Of the 17 teams sent a questionnaire, 15 replied.

It should be noted that the Best Practice Standards concern only services to adults, not children. [There is a separate set of standards recently produced in parallel, (NDCS/RNID, 2002)]. In filling in the questionnaire respondents were asked specifically about services to adults only (2).

Results

Description of teams completing the questionnaire

The 15 teams were representative of the differing Local Authority organisational structures currently in existence. Two were London boroughs, six were county councils, four metropolitan authorities, two unitary authorities, and one a combination of unitary and county. Seven described themselves as 'sensory impairment teams' i.e. working with visually impaired service users as well as Deaf and hard of hearing; two were not constituted as independent teams but existed as personnel within another team structure (one in a physical disabilities team one within a generic team), five were described as a 'specific Deaf and hard of hearing team' and one a mixture of a Deaf/hard of hearing specific team and a sensory impairment team. Only one of the 15 teams had also been part of the 1997 Inspection. Ten out of the 15 teams contracted out part of their service. The most popular parts of the service to be met by external contract were the provision of equipment (6 teams) and the BSL/English interpreting service (5 teams). Other contracted out services mentioned included advocacy within the Deaf community and development work with deafblind service users.

The overall population (not just Deaf/hard of hearing population) of the areas covered varied considerably from under 200,000 people to well over one million, with the majority having a

population size of between 200 and 400,000.

Size of service user populations served

Teams were asked to ‘estimate the size of your adult service user population who are (a) Deaf sign language users; (b) hard of hearing; (c) Deafblind service users.’ The figures given are difficult to interpret because some teams specified that they had only counted those who were ‘registered’; some extrapolated from national figures of prevalence of hearing loss in the general population rather than actual numbers for specific populations in their area; two gave approximations based on local knowledge; six gave highly specific figures but did not explain on what basis they were known; one could not answer at all; one could not disaggregate numbers for children from numbers for adults given how the information was recorded; and one had problems deriving accurate figures after the merging of two authorities who used totally different criteria to keep records.

Although it could be argued that the original question could have been more helpful if it had specified ‘registered’ service users, it is well accepted that numbers who are ‘registered’ does not necessary equate with numbers who use the

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service or indeed numbers who would be eligible for services (DoH, 1999a). Also the range of difficulties that teams had in answering the question and the solutions they applied is of itself indicative of the on going difficulty faced by many specialist D/deaf services teams in estimating the size and scope of the populations to whom they should be providing a service. It would seem the difficulties in knowing the size of service user population have changed little since 1997. Given these caveats, in what follows, the size of adult service user populations is compared with overall adult population in each area.

It is clear from this Table, that there is little or no correlation between the size of the BSL using service user population and the size of the overall population of a given team area. There are two possible explanations. On the one hand, some areas of England are known to have a disproportionately high population of BSL users because of location specific issues such as the existence of schools for Deaf/deaf children or D/deaf related research and higher education institutions locally. Certainly, the large population estimate represented by one of the teams in the 200-400,000 overall population size group can be explained in this way. On the other hand, the variation we observe in the above Table may also be reflective of inaccurate or differently calculated figures as discussed above.

If we express the number of BSL service users as a proportion of the number of adults in the population of each area, we find that in the majority of cases this is considerably less than the incidence figure usually quoted of one Deaf BSL user per 1,000 population (Gregory, 1996).

How should this effect be interpreted? On the one hand, the fact that so many teams were seeing fewer BSL users than the 1 per 1,000 within the population could be regarded simply as evidence that the population of Deaf adults who are service users is not coterminous with the population of adults for whom BSL is a first/preferred language. Indeed to be Deaf is no longer regarded as a sufficient reason to be in need of social services (Hynes, 1988). On the other hand, the low prevalence of Deaf service users per 1,000 adult population in many teams may be an indication of

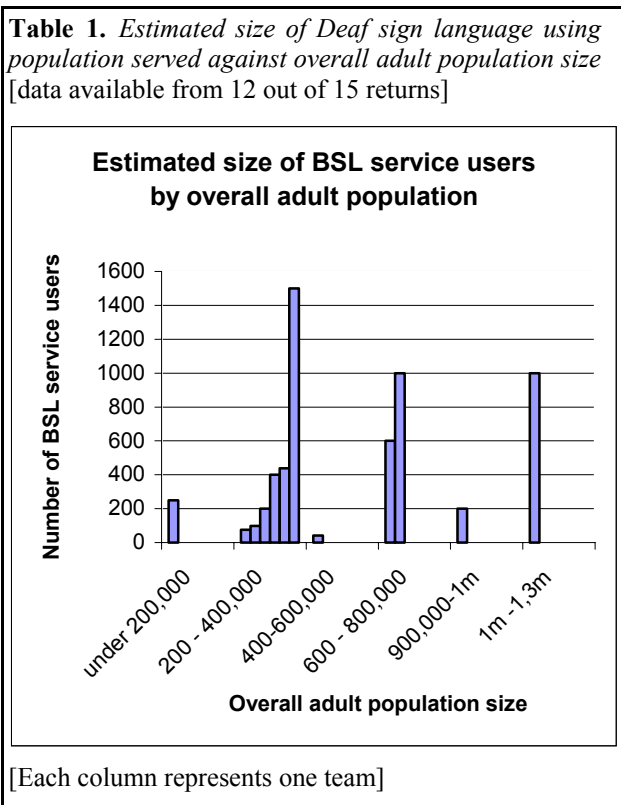


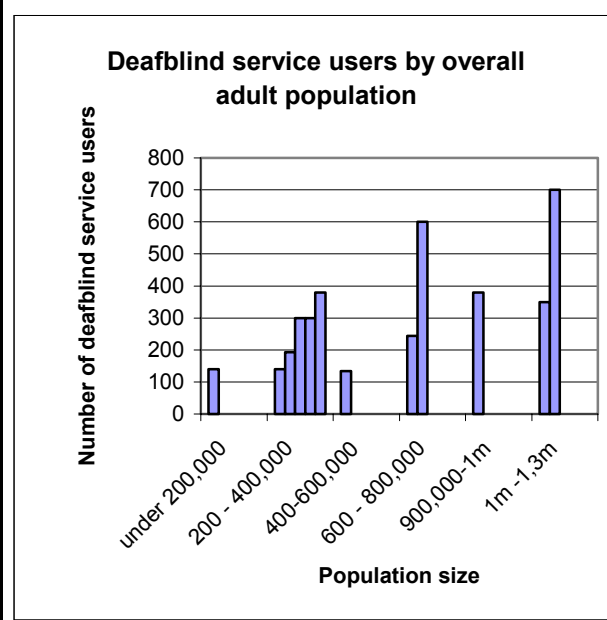
Figure 1: BSL Service Users

Team	Overall adult population	Estimated number of BSL service users	Incidence per 1,000 population
A	170,500	250	0.15
B	216,160	99	0.46
C	215,000	400	1.86
D	215,000	75	0.35
E	254,900	200	0.78
F	255,181	1,500	5.88
G	219,000	200	0.91
H	216,350	438	2.02
I	420,284	42	0.1
J	720,000	600	0.83
K	700,000	1,000	1.43
L	971,000	200	0.21
M	1,037,360	1,000	0.96
N	1,100,000	Figure not usable	N/A
O	1,300,000	Figure not given	N/A

social services failing to reach a significant proportion of the BSL using population or the fear of Deaf service users of being stigmatised by contact with social services. The data cannot provide a definitive answer to this question, but it should be remembered that social services' statutory responsibilities for the provision of eg equipment aids and adaptations is one potentially applicable to all Deaf and hard of hearing people and, therefore one potentially likely to result in contact with social services for most Deaf people.

If the same analysis is performed on estimates of the deafblind service user population in comparison with overall population of each area, we find once again very little correlation between size of area covered by team and size of deafblind population of service users reported.

Services to deafblind people have in recent years come under particular scrutiny with the issuing of specific guidance from the Department of Health (DOH, 2001). That document estimates that at least 40 people per 100,000 are deafblind. It places specific responsibilities on Local Authorities both

Table 2. Estimated size of deafblind population served against overall adult population size [date available from 12 out of 15 returns]

to keep an up to date register of deafblind people in their area and to take positive steps to identify deafblind people of which they may be hitherto unaware. If the figures supplied in the questionnaires are analysed in terms of incidence per 1,000 population, it is notable that in 7 out of the 12 usable returns, the incidence far exceeds the assumed national figure of 0.4 per 1,000, whilst two teams show figures far below that which would be expected.

It is hard to gauge the significance of these results. The Department of Health's (2001) own figure of 0.4 per 1,000 is qualified with the phrase 'at least'. However, it would appear that on the whole teams were reaching a significantly large number of deafblind people eligible for services in their area and that these returns question whether the official figures for this population are an underestimate.

Estimated size of hard of hearing population served against overall adult population size.

A similar analysis in relation to hard of hearing service users against size of overall population was not carried out, because it was clear from the figures quoted that there were huge discrepancies in how they had been arrived at and any results would be highly spurious. Whilst some respondents were clearly quoting specific figures

Figure 2: Deaf/Blind Service Users

Team	Overall adult population	Estimated number of Deafblind service users	Incidence per 1,000 population
A	170,500	140	0.82
B	216,160	Not known	N/A
C	215,000	140	0.65
D	215,000	193	0.9
E	254,900	10	0.04
F	255,181	300	1.18
G	219,000	300	1.37
H	216,350	380	1.76
I	420,284	134	0.32
J	720,000	244	0.34
K	700,000	600	0.86
L	971,000	380	0.39
M	1,037,360	700	0.67
N	1,100,000	Not usable	N/A
O	1,300,000	350	0.27

based on registration or known contact such as '442 service users', others were quoting theoretical proportions of the population given what is known about the prevalence of hearing loss eg numbers such as '138,000' which were clearly one seventh of the overall population in their area rather than a specific record of users of social services who were hard of hearing.

As these results demonstrate, there are enduring problems in teams being able to accurately specify who and how many are users of their services. There is also very little connection between the size of the service user populations served and the size of overall population in any given area. These findings, that reinforce those of the 1997 SSI report, demonstrate how in practice it continues to be extremely difficult to estimate likely service uptake, project shortfall in service delivery and plan for size of resource needed. Without such basic information being available to any given local authority how could services to Deaf and hard of hearing people actually improve whatever the will of any individual worker?

Social Services team size and constitution

Respondents were asked to define who constituted their team for purposes of this project i.e. those team members who worked with Deaf and hard of hearing adults (including deafblind people). This definition was important, because some teams were for example 'sensory impairment' teams where the whole team was also made up of specialist workers with visually impaired people. Also those who worked with Deaf and hard of hearing people may in reality be part of another team altogether such as a physical disability team. Respondents were asked to list job descriptions, titles and to give whole time equivalents for each post. For purposes of comparative analysis administrative posts listed by respondents have been excluded (not all teams gave this information) and interpreters are not included (not all teams had in house interpreters). Consequently, only social care staff and their team

Figure 3: Social Services Personnel

Size of overall adult population served	Team	Actual number of personnel	Whole time equivalents (wte)
Under 200,000	A	3	1.5
	B	6	6
	C	6	4.45
	D	7	5
	E	3	3
200 - 400,000	F	10 (+ 2 vacancies) = 12	8 (+ 1 vacancy) = 9
	G	7	6.2
	H	10	7.3
	I	3	2.8
	J	6	6
400 - 600,000	K	7 (=1 vacancy) = 8	7 (=1 vacancy) = 8
	L	31 (+2 vacancies) = 33	22 (+1.5 vacancy) = 24
	M	20 (+ 1 vacancy) = 21	16.6 (+ 1 vacancy) = 17.6
600 - 800,000	N	6	4.95
	O	6	[not specified]

management constitute the figures in the following tables. For comparative purposes, teams are also classified by overall adult population size in area served.

As the Figure 4 demonstrates, there was enormous variation in the size of the teams that could not simply be related to the size of the adult population in the area they served.

Teams working within similar sized adult populations could be two or three times the size of other teams working in similarly populated areas (see the 200 to 400,000 group). The teams working in the largest populated areas (1m to 1.3m) did not have the largest teams. In other words, it is quite clear that the factors affecting team size and the resourcing of personnel have in the vast majority of cases little to do with the size of the overall population in any given area.

If we consider proportion of qualified social workers (wte) to overall team (wte) we again find huge variations between the teams [range: 0.29 to 0.83; mean 0.52] (see below).

However, there are competing explanations for such an effect. On the one hand it could evidence difficulties in recruiting qualified social workers to posts (particularly given the usual requirement that they have some skills in British Sign Language). On the other hand, a low proportion of qualified social workers to team size could be viewed very positively as evidence of teams responding to the needs of service users through a diversity of roles and skill mixes, not all of which have to be encompassed by a 'qualified' social worker. Support service assistants, equipment officers; assessment officers, homecare workers, welfare benefits advisors and advocacy officers were all titles of staff identified in the questionnaire returns. Also, many 'care managers' were not qualified social workers. In relation, particularly to the Deaf community, the breaking of an automatic assumption that Deaf people need 'social workers' to meet their requirements has been discussed as vital in breaking a cycle of dependency creating services where need that is linked to linguistic access is not appropriately separated from social work service (Hynes, 1988; Open University, 1991).

Figure 4: Team Composition

Size of overall adult population served	Team	Wte of qualified social workers	Total wte of team	Proportion of wte of qualified social workers to total wte of team
Under 200,000	A	1	1.5	0.66
200 - 400,000	B	5	6	0.83
	C	1.75	4.45	0.39
	D	3	5	0.6
	E	1	3	0.33
	F	3.5	9	0.39
400 - 600,000	G	2.7	6.2	0.44
	H	3	7.3	0.41
	I	2	2.8	0.71
	J	4	6	0.66
600 - 800,000	K	5	8	0.63
	L	7	24	0.29
800,000 - 1 m	M	5.6	17.6	0.32
	N	3.2	4.95	0.65
	O	4	Not specified	Unable to calculate

It is interesting to note that 5 out of the 15 teams had qualified social work posts that were designated to a particular specialism within the Deaf/hard of hearing services specialism. Two had clearly designated qualified social work posts that were for 'social workers with hard of hearing'; one had a 'specialist deaf children's social worker'; one a 'mental health social worker' and one an 'ethnic minorities social worker' and one a 'Deafblind care manager'. In relation to hard of hearing, ethnic minorities and deafblind services, such specified posts are relatively non contentious in that they represent a division of responsibilities within the differing populations of Deaf and hard of hearing people served. They show some degree of inward investment and strategic planning of appropriate service delivery. However posts that are specialisms within a specialism such as those linked to mental health and child care re-open a difficult debate. That is to say the extent to which social workers in Deaf/hard of hearing services

should seek to be dually qualified specialists and the extent to which close co-working relationships with other teams should be developed (Kennedy, 1990). In this data there is only very limited evidence of a trend towards dual specialism and no data was collected on co-working. These issues however are crucial when we know that deaf children face a greatly increased risk of child abuse than their hearing counterparts (Ridgeway, 1993) and that the incidence of mental illness and mental distress in both deaf children and adults is significantly higher than in the hearing population (Hindley, 1997).

In summary, as the previous SSI inspection had concluded also, this study found there was no governing rationale that seemed to determine team size/constitution in comparison with size of population served. However, perhaps this is not a problem. As the recent Fair Access to Care Services guidance (www.doh.gov.uk/scg/facs/) makes clear, it is complexity of need and eligibility for service that are the more appropriate determinant of services to be met rather than simply the number of people seeking a service. On the other hand, the variations between teams in terms of size/constitution in comparison with actual service users were enormous. These variations are not easily dismissible by suggesting number of service users is not a good yardstick for considering adequacy of resource.

Budget/Financial Resources

Teams were asked to identify the financial resources committed by Local Authorities to Deaf and hard of hearing services in their area. Although most teams tried to supply meaningful figures, it proved impossible to compare resources across teams and by service user or population size. The difficulty is partly a result of the variation in organisational position of teams. Not all teams have their own identifiable budget. Many have access to a part of other budgets and in one case the team technically had no budget at all, but sought resources as required from 17 other teams within the county to which the Deaf/hard of hearing services team supplied a specialist service. As many teams were 'sensory impairment teams' separating out budget used for Deaf/hard of hearing services from that used for visually impaired services, was not necessarily easy. Local Authority reorganisation that had created new team

boundaries also did not help. It was also not clear from responses whether teams had included central recharges in their figures or whether team budgets were indeed disaggregated. Two teams quite straightforwardly explained that it was simply impossible for them to provide figures that could be regarded as even an accurate estimate.

This paucity of accurate and available financial resource information is rather disturbing in light of the Government's initiative on Best Value (DETR, 1999). If Local Authorities find it difficult to collect and submit information on resources being used by Deaf and hard of hearing services, it will remain difficult, if not impossible for teams to benchmark themselves as required or compare themselves with other similar services as a part of Best Value review. The lack of separate budgets can also make it difficult to argue for the priority of Deaf and hard of hearing services despite the distinctness of the population served. In particular the distinctive to Deaf people seen as a socio-cultural group rather than seen as disabled people is easily lost and dismissed when services are subsumed under a more general budget.

Qualifications in British Sign Language

The 1997 SSI report had been greatly concerned about the adequacy of staff's ability to communicate in BSL in relation to the complexity of the duties they carried out with Deaf people. They presented figures for the eight teams they studied differentiated by percentage of staff at different levels of operational responsibility possessing the different levels of CACDP [Council for the Advancement of Communication with Deaf People] BSL qualifications. For comparison purposes this framework is replicated for this sample of 15 teams. It should be noted in the following that 'Stage One' refers to the most basic level of communication and 'Stage 3' is generally regarded as the minimum level of fluency desirable for carrying out the complex and sensitive communication tasks such as those associated with social work (DoH, 1997, p.5). The term 'or equivalent' has been added next to each examination level to reflect the fact that these examinations are changing with some becoming NVQs (www.cacdp.org.uk) and also to reflect the fact that Deaf staff will in many cases have native levels of fluency rather than pieces of paper as such.

Figure 5: Organisational Responsibility

Level of operational responsibility	BSL stage Three or above (or equivalent)*		BSL Stage Two (or equivalent)		BSL Stage One (or equivalent)		No BSL qualifications	
	1997	2002	1997	2002	1997	2002	1997	2002
Team managers 1997, n=7 2002, n=20	28%	30%	14%	5%	14%	5%	42%	60%
Social Workers and Care Managers 1997, n=18 2002, n=58	18%	29.31%	41%	41.38%	22%	18.97%	11%	10.34%
SW assistants/ technicians/ equipment officers etc 1997, n=10 2002, n=51	NIL	13.73%	20%	49.02%	20%	13.72%	60%	23.53%

* Where a team member is recorded as a 'native BSL user', stage three or above level of proficiency is presumed.

From the above comparison, it is clear that the greatest change in the past five years in qualifications in BSL has occurred amongst members of staff who are not social workers or care managers i.e. social work assistants, technical officers, equipment officers, day care workers and so forth. A far higher percentage have Stage 3/ Stage 2 or equivalent than was the case in 1997. Some of this change could perhaps be explained by the increase in the numbers of native Deaf BSL users who are successfully securing posts within social services departments, though not necessarily as qualified social workers (DoH, 1999). It may also be explained by the increase in popularity of BSL courses amongst hearing people in the past 5 years and the ease with which professional teaching can be found. Whilst a greater number of social workers and care managers have the Stage 3 qualification in the 2002 sample, the increase in levels of qualifications overall is relatively slight. This should be regarded as a major cause for concern if staff cannot actually communicate with the population they are serving and by corollary service users are unlikely to seek a service from those they know are unable to communicate with them. At the level of team management, it remains clear that with some notable exceptions, specialist Deaf/hard of hearing services teams remain largely managed by staff without fluent BSL. The issue here is not simply not being able to communicate with the population of service users (or indeed any staff that might be managed who are themselves

Deaf), but rather the lack of other relevant knowledge that goes with becoming a fluent signer for example, cultural understanding and sensitivity as well as heightened awareness of one's own outsider standpoints (if hearing).

Team self-evaluations against 'Best Practice Standards'

Teams were asked to evaluate their degree of development of service in line with each of the nine Best Practice Standards for adult services (ADSS et al, 1999). They did so on a five point scale (well developed = 4; developed = 3; developing = 2; under developed = 1; undeveloped = 0). A maximum score of 'well developed' across all nine standards would thus yield a cumulative score of '36'.

The average score was 19.26. Only two teams fell within the top third possible score.

Whilst clearly it could be argued that subjective evaluations only present a perception of performance from one point of view it is nonetheless, of significance that the overwhelming majority of teams regarded themselves as ones with considerable scope for improvement. Why this should be the case, is in essence what the rest of the research and development project will be able to explore with the three participant sites and associated service user groups.

Table 3: Team self evaluation against Best Practice Standards

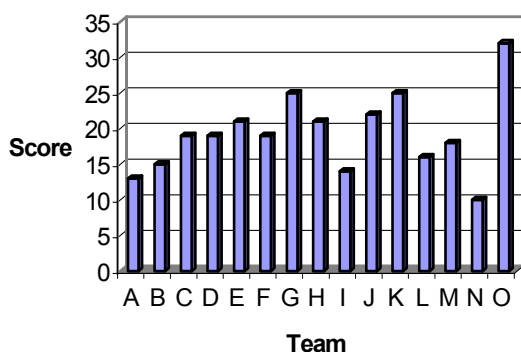
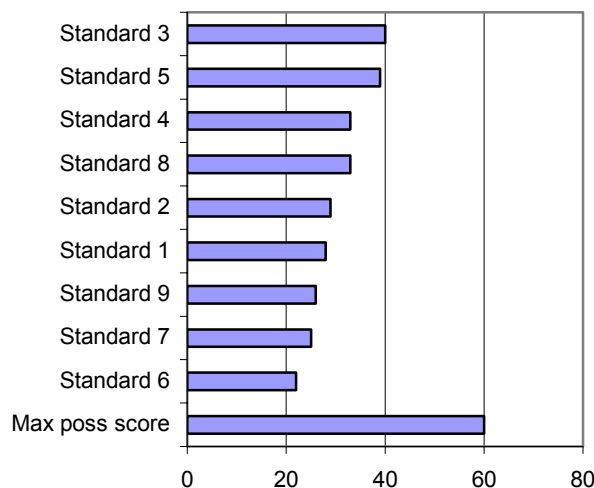


Table 4: Teams' cumulative self evaluation score by each standard



LEGEND

<u>Standard 1:</u> Information	<u>Standard 2:</u> Access to services	<u>Standard 3:</u> Communication services
<u>Standard 4:</u> Assessing and identifying appropriate services	<u>Standard 5:</u> Equipment services	<u>Standard 6:</u> Accessible services at home/outside
<u>Standard 7:</u> Planning	<u>Standard 8:</u> Service procedures	<u>Standard 9:</u> Procedures for joint working

Some standards, however, were ones that were more readily perceived as having been met than others. Using the same rating scale as described above, individual standards were rated cumulatively across teams. [NB maximum score for each standard if every team had awarded it a 'well developed' would be 60].

Overall it is noticeable that communication services (which includes the appropriate provision of BSL interpreters) and equipment provision (vital for all of the varied Deaf/hard of hearing populations served by the teams) were perceived to be the most developed of services. Why this should be the case is difficult to know with any certainty. However, traditionally it is interpreting and the provision of equipment that have been seen as the core business of social services with Deaf/hard of hearing people and therefore, perhaps the most readily graspable targets for change and improvement.

It is of particular concern that the provision of information (Standard 1) and access to services (Standard 3) are ones that score so low overall in teams' self-evaluations. These are essential gateways for service users to become aware both of their rights to services and to engage with those services in the first place - a principle enshrined in the modernisation agenda (DoH, 1998b). The poor scores given to procedures for joint working (Standard 9), accessible services at home/outside the home (Standard 6) and planning (Standard 7) continues to reinforce some of the key concerns of

the original SSI report (DoH, 1997). In other words, despite the great step forward of Best Practice Standards actually being defined following the poor SSI report, such definition has seemingly not lead to high standards of practice (by that yardstick). Although obviously it should be pointed out that a snapshot questionnaire such as the one used cannot measure improvement or decline in individual teams' service delivery as it does not take into consideration start point.

Team self-evaluation of service user involvement

As previously discussed one of the central criticisms in the original SSI report (DoH, 1997) was that service users, be they from the Deaf community, or other hard of hearing or deafblind groups, were very rarely if at all consulted and not effectively part of service planning. Results from these 15 teams continue to paint a picture of very poorly developed consultation with service users despite the practical guidance for the development of service user involvement provided in 'Stepping away from the edge' (DoH, 1999) and

contemporary research projects such as 'Visible Voices' (Hawcroft et al, 1996).

At strategic, operational and individual levels, we asked teams to rate on the same five point scale used previously, how well developed Deaf and hard of hearing service user involvement was. Specific examples of what was meant by each level of involvement were given. The maximum score possible for each team was 12 (equivalent to a 'well developed' rating on all three levels of involvement). One team (Team O) did indeed give themselves this maximum score. As to the rest, however, none achieved a rating over 6, and four teams scored 2 or less. It is to the teams' credit that they have been prepared to be so candid in their assessment of this lack of development.

If we take the three potential levels of service user involvement and compare the cumulative scores of all the teams for each level, then the degree of service user involvement at an operational level is slightly more developed (scoring 27) in comparison with strategic and individual level involvement each scoring only 21. It should be remembered however, that these scores are out of a maximum possible of 60 for each level. Of the 15 teams, only five were able to supply a name and address of a service user group co-ordinator with whom the team had had contact in relation to their interest in returning the questionnaire and applying to be part of the wider project.

It would appear overall, therefore, that whilst clearly some action had been taken to engage service users in the wake of the 1997 Inspection report there was still a lot of work to be done. In the wider project, the close working with the three sites over the next two years will enable the processes involved in moving toward more effective consultation to be charted in detail. Written into this project is a requirement that at least three service users groups (a minimum of one per chosen site) should take an active role in shaping (and/or directing) the projects that are undertaken by each social services team and that the research and development team work directly with service users to this effect.

Discussion

It would be right to question the extent to which the 15 teams in this study could be regarded as representative of specialist social work services for Deaf and hard of hearing people in England and, therefore, the extent to which the key findings can be regarded as generalisable. However, it is possible to be confident that the diversity of teams in the sample *does* reflect the diversity of provision and organisational arrangements previously documented (DoH, 1997; DoH, 1999). Also, information gleaned from a written questionnaire return and that is completed for another purpose must be treated with caution. However, as previously discussed, a sample of information from 15 separate social services teams working with Deaf and hard of hearing people cannot be ignored in a field where normative and quantifiable data is sparse. Indeed all 15 teams (even though 12 are not actually participating in the bigger project) have expressed a desire for the data to be collated and published. Many saw it as a means to further service evaluation and development through access to comparable information about other teams on a national basis. However, what does this profile of 15 teams actually tell us? There are in essence, six key messages.

Firstly, in social services with Deaf and hard of hearing people there is no governing or normative rationale to explain the distribution of resource, size of team or range of activity actually undertaken in relation to the population served. Consequently for service users, where one lives still remains a major factor in determining the kind of service available. It could of course be argued that such a lack of correlation between resource, population and team is of little consequence because it is the complexity of need and eligibility for services that should be the central determinants of the size, organisation and resource of the service on offer. However, as this data has shown, the sheer scale of variation we found between services challenges such an explanation, particularly when it is also clear that at a fundamental level the majority of teams did not actually know how many actual or potential service users they responded to.

Secondly, for Local Authorities seeking to meet modernisation aspirations (DoH, 1999b), core

problems still exist, for many, in benchmarking their services within the Best Value framework because fundamental information about resource, population, and finance remains hard to disaggregate and interpret. This lack of the most basic information is a key obstacle in seeking to improve and plan for better quality social services for Deaf and hard of hearing people.

Thirdly, although there has been some improvement in the percentage of social workers with the minimum accepted level of fluency in BSL and a considerable rise in the fluency of staff fulfilling non social work roles, the picture of qualification still suggests that many social workers are likely to find themselves working in complex situations with Deaf people beyond their level of linguistic competence. Furthermore, specialist Deaf and hard of hearing teams remain largely managed by personnel who cannot sign. These results should be a major cause for concern. In effect what are demonstrating is that Deaf BSL users remain at considerable risk of receiving a service that they cannot understand or access on their own terms, despite what are now acknowledged rights to use that preferred language in Britain today. Clearly, teams may well argue that BSL users are not their total or indeed majority service user population. However that does not alter the fact that overall standards of sign fluency remain very low and have improved little amongst the level of staff likely to be dealing with the most complex issues.

Fourthly, although there clearly is a high awareness of the need for effective service user consultation and some teams have prioritised the development of such, the overall picture remains rather bleak with little evidence of well developed or effective means of consultation. This result is perhaps particularly worrying given the fact that considerable emphasis and practice guidance on such consultation followed the 1997 Inspection report and yet it seems that very little has changed. The time is clearly ripe to examine in far more detail exactly what the barriers are to establishing such effective consultation and why from the perspective of service users this has not occurred.

Fifthly, whilst enthusiasm for the development of better quality services in line with Best Practice

Standards remains high, teams by their own admission, perceive there to be a long way to go in emulating those Standards. Having such Standards defined has not been enough to guarantee quality services in line with them. For such a situation to change, research is required to understand what it is that drives and what is that potentially hinders the implementation of these Standards particularly given the huge variability in service provision arrangements we find nationally.

Finally, and particularly worryingly, it is the gateways to services that remain, with rare exceptions, poorly developed. The standards pertaining to information and the accessibility of services are ones that still present real challenges for teams. In many cases the improvement of information and accessibility will require close working with other sectors within the Local Authority not directly within the control of the specialist teams. This result therefore, perhaps reflects a wider organisational failure to take on the implications of the Standards rather than any deficit in the specialist teams themselves.

Conclusion

As previously discussed we cannot claim that this self selecting and self reporting sample is absolutely representative of the national picture. However it is possible to be confident that the sample does reflect well the diversity of provision and organisation arrangements for social services to Deaf and hard of hearing people previously documented and is, therefore, likely to be indicative of the central problems faced by these services. Although it should be emphasised that we have not in this research collected examples of good practice and have only taken a snapshot that cannot reveal the nature of development (or decline), the most depressing message is that very little has changed since the 1997 Inspectorate report. The inevitable question is: where do go from here?

At a policy level there are many new initiatives that potentially offer opportunities to promote improved services through the identification of local targets and quality indicators that are nonetheless set within a national evaluative context. For example, Best Value is placing Deaf and hard of hearing

services under the spotlight although somewhat ironically it is this article that is likely to provide an important resource to those undertaking such reviews. Over the next two years the Performance Assessment Framework is being reviewed which may give rise to more specific and appropriate indicators for sensory services (there currently are not any independent of physical disability). Participants in the advisory group of this development and research project are providing consultation to that process.

In terms of the wider project from which data in this article is derived, that project seeks to address some of the key underlying problems in the improvement of services. Over two years into it, the three chosen social services teams are each implementing new local projects to improve practice in priority areas they have defined. The research team is supporting these projects and simultaneously studying the dynamics of the change process - what is it that is proving facilitative or obstructive at organisational, policy, and practice levels and what generalisable lessons can be drawn from these experiences? Simultaneously the project is working with three service user groups (one in each site) who themselves are directing and/or co-operating with social services teams to achieve the specific targets for improvement. The research team is supporting the development of these groups through training and resourcing and simultaneously analysing the very different styles of engagement between the social services teams and the service user group evidenced in each site. Through such close analysis it will again be possible to understand better what the drivers and blockers are to successful user group involvement in the improvement and monitoring of service quality, and the extent to which the factors we identify are locally derived or more broadly applicable. The development of service user representatives as full partners in the research and development project advisory group is also under scrutiny.

In short, the wider project is not going to of itself ensure improved services. But it will go a considerable way to bridging the gap in understanding how to turn Best Practice Standards from paper to provision. It will provide critical models for addressing change processes and

service user involvement that have the potential to be applied in other local contexts. This article as a first step opens up the problem and clearly does away with any possible complacency about the quality of social work services with Deaf and hard of hearing people.

The broader project is due to report in May 2004 and details of the dissemination conference and published materials can be obtained from the contact author.

End Notes:

- (1) In this paper we have preserved the terminology used in the source document of the Best Practice Standards i.e. Deaf and 'hard of hearing', rather than 'hearing impaired'. That document uses hard of hearing to imply adults of all ages who in audiological terms have a hearing loss (of whatever degree and whatever age of onset) who are not sign language users and who would not self identify with the Deaf community. 'Hard of hearing' according to this usage does not simply refer to older people.
- (2) The responsibility for social service provision for deaf children does not always lie with specialist D/deaf or sensory teams who generally serve adults only. It more commonly lies with children and family teams or disability teams who often lack specialist knowledge of deafness - a circumstance that can create difficulties of appropriate service provision and joint working with other agencies c.f. Young et al, 2003.

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