

Research paper

Supporting the independence and well-being of adults through a universal service: diversity, difference and proportionate universalism

Alastair Roy BA (Hons) CQYW

Senior Lecturer (Research), Psychosocial Research Unit, School of Social Work, University of Central Lancashire, Preston, UK

Karen Newbigging MA (Hons) Dip Clin Psych MSc

Clinical Psychologist, Principal Lecturer and Senior Researcher, School of Health, University of Central Lancashire, Preston, UK

What is known on this subject

- Personalisation, choice and control are key components of current health and social care policies.
- Promoting well-being and preventative strategies are central policy objectives.
- The Marmot Review argues that the application of resources should be proportional to the degree of disadvantage experienced.

What this paper adds

- Reciprocal relationships and interdependence are at least as important as independence and autonomy in promoting health and well-being.
- Independence, dependence and autonomy are individually and culturally located.
- Universalism can paradoxically be socially exclusive, because it fails to address the differences in power between groups to the benefit of the already included.

ABSTRACT

This paper reports on the introduction of 'Help Direct', a new initiative in Lancashire, England. This is a universal service which aims to give people the right information or advice, individual guidance or practical help before a problem becomes a crisis. As part of the initial development of the model of delivery, the authors were commissioned to undertake research to investigate the views of relevant people who might use the service. The research had three overarching aims, namely to explore how potential users understand well-being, to explore the possible contribution of the service to maintaining independence and supporting well-being, and to identify factors that might facilitate and inhibit the use of such a service for different groups. Data collection took place between August and

December 2008. The findings reported here draw on the focus group data. A total of 11 focus groups ($n = 100$) were convened in collaboration with community organisations. The paper describes the ways in which different groups conceptualise well-being and help seeking, and moves on to examine the implications of delivering a universal service to heterogeneous communities in relation to the concept of proportionate universalism. Thus, although the study is based in one county of England, the themes are considered to be relevant to a wider audience.

Keywords: cultural competence, diversity, help seeking, self-management, social support, well-being

Introduction

Promoting well-being and instituting preventative strategies to address health inequalities are dominant themes in government policy in the UK (HM Government, 2007a,b). The Department of Health policy statement *Independence, Well-Being and Choice* (Department of Health, 2005) emphasised that services should enable people to maintain their independence by giving them greater choice and control over the way in which their needs are met. It further suggested that this approach should include all sections of the community and should place an emphasis on preventing problems and ensuring that health and social care services work collaboratively. The White Paper *Our Health, Our Care, Our Say* (Department of Health, 2006) outlined the fundamental elements of a reformed adult social care system in England. It proposed that this system should 'be able to respond to the demographic challenges presented by an ageing society and rising expectations of those who depend on social care for their quality of life and capacity to have full and purposeful lives' (Department of Health, 2006, p. 1). *Putting People First* (Department of Health, 2007) outlined the elements of a personalised adult social care system, which set out to maximise independence, choice and control. As one element of a system-wide transformation, a 'first stop shop' was suggested, that would offer a universal information, advice and advocacy service for individuals and their carers who need services, irrespective of their eligibility for public funding. Personalisation, prevention and partnership are all key components of the revised social care system set out in *A Vision for Adult Social Care: Capable Communities and Active Citizens* (Department of Health, 2010a). Since the change in government in 2010, the White Paper *Equity and Excellence: Liberating the NHS* has set out the long-term vision for the NHS, which includes a focus on improving aspects that are important to patients (Department of Health, 2010b).

The Marmot Review (Marmot Review Team, 2010; see Box 1) addressed the social determinants of health inequalities and was intended to provide a blueprint for transforming health and social care delivery. The report identified a social gradient in health inequalities across the UK, in which those who lived in the poorest areas died sooner and spent more of their shorter lives with a disability (p. 16). The review suggested that well-being should be a more important societal goal than simply more economic growth, a point which emphasises that material growth can, ironically, be negatively correlated with the quality of social relationships (Hoggett, 2000; Wilkinson and Pickett, 2009). Of relevance to the current paper, the social gradients of health are steeper in areas such as the north-west than, for example, in the south-west,

which suggests that gaps in health, well-being and life expectancy between the wealthiest and the poorest are more marked in these regions. The Marmot Review identified 'proportionate universalism' as a key component of strategies to reduce health inequalities. This concept has been used to suggest that although 'actions must be applied in some degree to all people, rather than solely to the most disadvantaged, that the application of resources must be proportionate to the degree of disadvantage experienced' (Lancet, 2010, p. 525). This has clear implications for the introduction of universal strategies to improve health and social outcomes.

Location

Lancashire has an older population structure than the national average, which is more marked in some districts, such as Ribbles Valley. In common with the findings of the Marmot Review, social and economic diversity is reflected in the health experience of the population, with persistent health inequalities between different groups and in different areas of the county. To select one example, those in the most deprived areas are six times more likely to experience extreme anxiety and depression than those in the least deprived areas. The wider literature suggests that service access and uptake by some groups, including black and minority ethnic (BME) populations and people with disabilities, is influenced by perceptions about particular service providers and preferred models of support (Jacobs *et al*, 1999; Wanigaratne *et al*, 2003; Godfrey *et al*, 2004).

In 2007, Lancashire County Council (LCC), in partnership with a wide range of organisations, set out a framework for the delivery of a new service that aimed to reduce or delay the need for statutory intervention, to help people to maintain their independence, and to support the well-being of citizens in

Box 1 Key messages of the Marmot Review

- 1 There is a social gradient of health, such that the lower a person's social position, the worse their health is likely to be. Action should focus on reducing this gradient.
- 2 Health inequalities result from social inequalities.
- 3 Actions must be universal, but the degree of support must be proportional to the level of disadvantage.

Source: Marmot Review Team (2010).

diverse communities. LCC concluded, on the basis of a service mapping exercise, that the provision of a universal information and advice service offered a sensible strategy for responding to needs which did not meet the threshold for statutory service provision. They also identified considerable scope for improving the coordination of existing information services (Lancashire County Council, 2007). LCC concluded that it was necessary to create a structure in which people seeking information and advice were able to obtain all the information they needed from a single agency. They also identified that it should be possible to access information in frequently used locations, particularly GP surgeries, supermarkets and leisure centres.

LCC set up 'Help Direct' as a source of information and practice help in terms of:

- delivering information and advice on well-being in each district of Lancashire under its jurisdiction
- constantly updating and improving a directory of well-being information
- coordinating access to a wide range of practical support services and developing new services to meet identified needs
- providing outreach support and volunteers to identify and engage 'hard-to-reach' (*sic*) people through case finding and work with local communities
- supporting a network of first contact agencies (e.g. the police, the fire service, librarians) whose staff regularly encounter people with needs not in their service remit, to offer follow-up referral.

The service was seen as having a potentially significant role to play in increasing well-being and tackling health inequalities related to factors such as gender, level of deprivation and ethnicity (Association of Public Health Observatories, 2008). Data from the Joint Strategic Needs Assessment suggested that delivering a service such as Help Direct, aimed at all adults, was likely to present some challenges, given the heterogeneity of communities in Lancashire and the clustering of needs in certain districts. Lancashire's population is less ethnically diverse than the national average, although some districts contain large Pakistani and/or Indian populations, and some of these are clustered in areas of multiple deprivation. This paper critically explores the objectives of Help Direct, considering how a service with such a broad remit might also be tailored to the diverse ways in which the various communities in Lancashire understand well-being and people's preferred ways of accessing support and guidance.

Method

Recruitment, sample characteristics and process

The data referred to in this paper are part of a larger study that has been published elsewhere (Roy *et al*, 2009). The full study involved two separate study elements and two different samples. This paper focuses on the data emerging from 11 focus groups ($n = 100$). The research team selected a range of groups which local data sets indicated might be less likely to access the Help Direct service. These included disadvantaged white and BME communities, adults with learning disabilities, people with low-level mental health problems, adults with visual impairment, adults with a brain injury, and carers (see Table 1).

The focus group method was selected because it offered the opportunity to explore, in depth, a set of themes seen as relevant to the provision of a universal service with a number of people from the target groups (see Box 2; Roy *et al*, 2009). We wanted to explore how people's accounts were socially produced and how relevant issues were negotiated and contested, in order to increase our understanding of issues that might affect the delivery of Help Direct to diverse communities and more marginalised groups (Lee, 1993). However, participants were not viewed as representative, or as providing complete insight into the concerns of these communities and groups which are internally differentiated (Alam and Husband, 2006).

We wanted to work in a way that would help to engender trust among marginalised and potentially mistrustful subjects (Bowser and Sieber, 1992). Participants were recruited in collaboration with community organisations. Working alongside community organisations was practically beneficial for two reasons. First, it facilitated access to relevant participants, and secondly, representatives from the community organisations co-facilitated the focus groups. This helped to build up trust and interest in the research, and certainly helped the 'communicative facility' of the process (Singer, 1992; Alam and Husband, 2006, p. 22). The research team met with the co-facilitators in advance of the focus groups to agree on the process. These meetings also provided an opportunity for the research team to develop a working relationship with the co-facilitators, and to develop the researchers' understanding of the community and the co-facilitators' understanding of the project.

One of the focus groups was conducted in Punjabi and Urdu with materials translated in advance. One member of the research team spoke both of these languages.

Table 1 Details of the focus groups and participants

Organisation	<i>n</i> (female:male ratio)	Description of participants
Age Concern	14 (10:4)	Aged 50–90 years, all identified as British and born in the UK, with 85.7% ascribing to Christianity. One person was receiving DLA for a physical disability
Headway	8 (4:4)	Aged 40–70 years, all identified as British, born in the UK and ascribing to Christianity. Two people were receiving DLA, with 50% describing themselves as disabled (two with a physical disability, one with a learning disability and one with a mental health problem)
Nguza Saba	4 (2:2)	Aged 30–60 years, mainly Caribbean (75%), and one person of mixed white and Caribbean heritage. In total, 50% were born in the UK and with British citizenship. None were receiving DLA or described themselves as having a disability
Preston Muslim Forum (1)	8 (2:6)	Majority aged 40–60 years, and one person aged 18–29 years. All described themselves as being of Indian ethnic origin, 75% being non-UK born and all having British citizenship. All ascribed to Islam. In total, 25% were receiving DLA and 12.5% were receiving Attendance Allowance. Two people described themselves as disabled (one with a physical disability and one with a mental health problem)
Preston Muslim Forum (2)	8 (8:0)	South Asian women attended this group, which was conducted in Punjabi and English
Ingol and Tanterton Action Group	10 (7:3)	Aged 18–80 years. The majority (90%) described their ethnicity as British, with one person identifying as Caribbean. The majority (90%) were born in the UK, and the one person not born in the UK had lived there for more than 11 years. All were British citizens, and 80% subscribed to Christianity. None were receiving DLA or Attendance Allowance or described themselves as disabled
Together	4 (3:1)	Aged 18–49 years. All described their ethnicity as white British, were born in the UK and were British citizens. Two described their religion as Christianity, one as none, and one did not answer this question. Three people were receiving DLA and one was receiving Attendance Allowance. All of them had mental health problems
Awaaz	15 (15:0)	A total of 15 South Asian women attended this focus group, which was conducted in Urdu and English. Six of the women identified themselves as carers
West Lancashire Carers Centre	10 (6:4)	A group of carers from West Lancashire
Galloways	14 (7:7)	People with a visual impairment attended this focus group. There was a broad spectrum of visual challenges and ages included in the group
REACT	5 (1:4)	Young adults with a learning disability attended this focus group discussion. The REACT coordinator also attended
Total	100 (65:35)	

Box 2 Themes used by the topic guide as prompts for the focus group discussion

- Personal understanding of the term 'well-being'
- Issues that positively or negatively affect personal well-being
- Views about the Help Direct service
- Describing Help Direct in your own words

The research plans and methods for this project were reviewed and approved by the Faculty of Health Ethics Committee at the University of Central Lancashire. All potential participants were provided with written information about the Help Direct service, the focus of the study, confidentiality and data protection a few days before the focus groups. Written consent was obtained. In one case this information was translated into Urdu. At the beginning of the focus groups the participants were given a verbal explanation of the same material by the research team. Additional explanation, and in one case translation, was provided by the co-facilitators, followed by a question-and-answer session.

In all of the groups, contemporaneous notes were taken and the main themes were agreed with the participants at the end of the discussion. After the discussion the research team met with the co-facilitators to discuss the process and to identify the main themes and issues.

Data analysis

A systematic qualitative thematic analysis of the focus group data was undertaken in order to identify the key emergent concepts and the relationships between them (Ritchie *et al*, 2005). This approach made it possible to:

- 1 report on a wide range of experiences and perceptions
- 2 identify areas of consensus and divergence, especially differences between the data emerging from different focus groups
- 3 make recommendations on the way Help Direct might be altered to address the needs and perceptions of different communities and groups.

Findings

The findings are presented in terms of two key themes.

Conceptualising well-being

Many of the participants in different focus groups offered holistic concepts of well-being linked with other aspects of their lives. Concepts of *harmony*, *community life*, *equality of respect* and *peace of mind* were particularly important, and several South Asian participants referred to the more familiar notion of *sakoon* (harmony). Common themes identified as affecting personal well-being across different groups were the opportunity, or lack of it, to take part in social and cultural life in communities on an equal footing, and feeling safe and valued. Some South Asian respondents identified faith-based activity as particularly important.

Not everyone in each group shared the same concerns. Individual respondents identified a range of issues which they felt affected personal well-being, including *life stage*, *environment*, *stigma*, *social exclusion* and *significant life events* (e.g. bereavement). Health and fitness were also important concerns in relation to well-being, and were most commonly mentioned by older adults. At least one person in each focus group mentioned the opportunity to do something meaningful, which often reflected limited opportunities in their current lives. These individuals wanted learning and leisure activities or the opportunity to be involved in and to shape the community in which they lived.

Problems associated with low incomes or fixed pensions had serious knock-on effects on the overall well-being of older people. Practical consequences that were reported included being unable to pay bills, and being unable to afford to go out and see friends and family, to take a holiday or even in some cases to eat healthily. For some older people money had become a persistent and pervasive issue that was affecting many aspects of their life. These people regarded the availability of up-to-date and credible advice on benefits and social security entitlements, including how to understand and fill in forms, as fundamental requirements. Older people and those with physical disabilities also identified the need for regular and reliable subsidised public transport. For example, a group of older white people reported that there was no bus service operating in some towns during particular periods at weekends, which meant that people who relied on public transport became isolated. Young adults with physical disabilities described how elements of urban design excluded them from social and leisure opportunities, or even in some cases from something as simple as using the local shop.

Major life transitions could result in stress and isolation. Some older women cited bereavement as a life event that had severely impaired their own well-being, identifying an unmet need for support. Becoming a full-time carer was also cited as a potentially stressful and isolating experience. Some older women

who were caring for their husbands suggested that their spouse wanted only them to carry out caring tasks. This could lead to feelings of guilt if they chose to accept support services, or a feeling of endless pressure if they accepted full responsibility for caring for their partner.

Accessing information, advice and practical support through Help Direct

One clear message which has emerged from the study is that people's expectations about accessing statutory forms of support are located in their personal, social, environmental and cultural circumstances and, for some, in the expectations of other family and community members.

For many focus group respondents the idea behind Help Direct was new. The majority reported that they might use the service if they were confident that it provided something helpful and useful to them personally. The focus groups with BME populations all made reference to a history of problematic and inequitable welfare provision which had altered their views about and behaviours in accessing support. South Asian women in particular reflected on having had difficult and embarrassing experiences when accessing services in the past, which some of them suggested had left them 'feeling stupid.' Respondents from BME groups were more likely to state that they would test out the views and experiences of others in their personal networks when making decisions about using this service (Alexander *et al*, 2007; Roy, 2009).

A group of older South Asian men described a cultural expectation that they would be providers for their families, which meant that they would not approach a service that might be seen as altering others' perceptions of their fulfilment of this responsibility. In a focus group with black Caribbean respondents, the participants reported a preference for seeking advice, guidance and/or support from their family or community, and a reticence about using statutory provision, despite being aware of its availability.

Many BME respondents emphasised the need for real partnership work with community organisations in order to deliver advice and support successfully to specific communities. People described a history of superficial partnership working. Many community groups with which Help Direct needed to engage were small, informal and not necessarily known to LCC. Participants who had already established relationships with voluntary or community organisations also suggested that Help Direct ought to work in partnership with these organisations rather than duplicate what they already provided. These respondents highlighted the value of the expertise that existed in such

organisations and of staff who knew them personally and demonstrated a concern about them as individuals. The priority given to making a connection with the person providing the service was a common concern. Although some individuals described demographic characteristics that would facilitate this (e.g. age, ethnicity), most were more concerned about being treated as an individual human being, rather than as a faceless consumer with a set of problems and characteristics.

Discussion

Issues that affect well-being

'Well-being' is a term that is currently widely used in health and social care, but its precise meaning and usage are often far from clear. The findings of this study indicate that people's perceptions of well-being are strongly related to the availability of meaningful roles and relationships. In this sample, positive and negative perceptions of personal well-being reflected opportunities or the lack of them, and a capacity to maintain culturally relevant, valued lifestyles, roles, occupations and, in particular, positive and reciprocal relationships. Those individuals who identified long-term problems in relation to well-being were more likely to identify social structures that had inhibited their life and the attendant opportunities to participate in work, education, leisure or community life. Those who reflected on more recent negative changes in personal well-being often cited life changes or events which had led them to lose a sense of themselves because they were not able to continue with previous roles, activities or relationships. Some described having to put certain elements of their life or relationships on hold in response to a life event. For example, in the focus group of people with head injuries, some individuals described how friends had struggled to come to terms with their accident, and had quietly lost touch with them. This experience had often contributed to their own difficulties in coming to terms with a new reality. As Hoggett (2000, p. 6) suggests, 'Well-being, then, is equivalent to being well with others. It draws our attention to the quality of human relationships in which we are immersed. Just as good social relations are indispensable to our well-being, so being well is indispensable to our agency in life.'

What Hoggett emphasises is that well-being is strongly related to the ongoing availability of meaningful social relationships. The participants reported a range of issues which indicated ways in which their personal well-being had been compromised. For example, in the focus group that we conducted with young adults with a learning disability, it was clear that

perceptions of well-being were inextricably linked to historical and ongoing experiences of stigma and marginalisation, which often limited their social circles, and related to a struggle for full citizenship. People with head injuries provided another similar example. For both of these groups, getting out and about and being able to make use of normal everyday facilities were central to feelings of well-being and to limiting the perceptions of stigma and dependence which undermined personal well-being (Newbigging *et al*, 2008).

Perhaps unsurprisingly, respondents of different ages and from different communities and groups gave priority to different issues. However, it should be noted that many of the issues identified as affecting well-being were not common to all those in any particular focus group. This was because many of the situations that people described were complex, multi-faceted, and reflected multiple aspects of individual identities. However, what many respondents agreed on was that dealing with life changes was a process that involved adaptation and optimising opportunities (Godfrey *et al*, 2004). Of course adaptation is a process that can rely on personal, social and/or cultural perceptions of one's own autonomy, choice and agency. Respondents often suggested that what they valued when addressing issues that had negatively influenced their personal well-being were forms of support, information and/or guidance that provided an opportunity to rebuild old networks, or to develop and sustain new ones.

Help Direct is in line with recent policy initiatives that emphasise the need for services which help people to maintain independence by giving them greater choice and control. The findings presented here support the idea that many people wish to avoid being viewed as traditional service users. They also suggest that reciprocal relationships and interdependence are at least as important in promoting well-being as independence and autonomy. Therefore a central concern for a service such as Help Direct should be to assess and attempt to improve the quality of social relationships available to individuals, for it is this factor above all others that binds people together and facilitates feelings of agency, autonomy and well-being (Hoggett, 2000). As Godfrey *et al* (2004, p. 1) have stated, people want to be 'part of a community where people care about and look out for each other' and place an 'emphasis on mutual help and reciprocal relationships.' What is required when addressing such issues within a universal service is a form of proportionate universalism which recognises that those who experience multiple forms of disadvantage will require greater support and input to develop personally relevant and sustainable networks of support. The next section will assess the potential of Help Direct to deliver on this aim.

Delivering Help Direct to diverse and different communities

The task of delivering a universal service such as Help Direct is complicated by the fact that there are many different kinds of community and group, and people seldom fit comfortably within a single one of these. The definition and selection of groups for this research may have been somewhat crude, and was in part driven by methodological convenience (Taylor, 2010, p. 377). The limitations and crude nature of the groups were highlighted by the fact that, throughout the research, people described further personal networks and communities that were based on factors such as kinship, friendship, neighbourhood, religion, political affiliation, work relationships and hobbies. The broad range of personal groupings clearly demonstrated that cultures and communities are complex, multifaceted, and both internally and externally differentiated. Although this was clearly an issue for the research, it is also highly significant for those who commission and deliver services such as Help Direct.

The data did provide an insight into the views, opinions and experiences of some individuals with limited social and financial resources. A large proportion of the focus group participants expressed some confusion and concerns about using a service such as Help Direct. For example, many of them described a process of deciding whether the service was intended for them, and identified potential barriers which included issues related to trust of mainstream services, understanding the service offered, and personal and community attitudes to help seeking. Participants were concerned about whether they would be understood or listened to, especially over the telephone, about the make-up of staff teams (in particular in terms of age and ethnicity), and about the skills of staff, especially in terms of language and understanding issues for different groups.

Participants from the BME focus groups were particularly concerned about knowledge and trust of statutory sources of information, advice and support, and some suggested that the way in which support is described and discussed may be vitally important in determining the level of uptake among some individuals. For example, in a focus group with older South Asian men and a focus group with older black Caribbean people, several participants expressed concern about how others in their community might perceive or interpret a decision to access support. These findings demonstrate that individuals will not necessarily use a service unless it is perceived as acceptable within their own personal, social and cultural context.

With regard to approaching universal services such as Help Direct, almost all of the respondents agreed that they would want to speak to someone who

demonstrated an interest in their individual situation and who considered their own perspective. It is therefore vital that staff demonstrate an appreciation of the way that independence, dependence and autonomy are individually and culturally located. This raises questions about the degree of agency and rationality that is being assumed in the model of service delivery. For Hoggett (2000, p. 172), one problem with 'rationalist models of agency' is that they 'simply cannot comprehend how the subject gets stuck, fixed or fixes itself, how it procrastinates' and 'flees from decisions.' The notion of 'being directed' mentioned by some participants, and also perhaps implied by the name 'Help Direct', suggests a different view of agency and rationality from that of 'signposting.' This seems to be at the heart of, and is arguably the most difficult aspect of, this policy initiative. Thus one potential problem for a service such as Help Direct is that it may appeal more to those who feel autonomous and well connected than to those who feel stuck, hopeless, and on the margins of social and community life.

Overall, the findings from the focus groups highlighted the fact that people's individual and group experiences of difference had contributed to perceptions of the accessibility of specific service structures. Thus one means by which Help Direct might address heterogeneous needs within its universal service structure is through an *associationist* model of delivery (Hoggett, 2000). This would focus on building a partnership of community organisations which would help to establish and maintain links with particular communities and groups. This approach has the advantage of building on and extending existing and, it might perhaps be argued, naturally occurring forms of social network and community reciprocity, rather than unnecessarily designing and building artificial new ones. The data suggest that community organisations that are sometimes very small and not necessarily known by officialdom, but which individuals know, trust and, importantly, already use might operate as Help Direct outposts to successfully deliver elements of advice and support to specific communities and groups.

Participants from different communities and groups made it quite clear that their own affiliation to certain groupings means that they are calling for Help Direct to demonstrate respect for and engagement with these group identifications as part of the way that it organises the delivery of its service. However, participants were also very clear that, when they accessed the service, they wanted to be engaged as individuals with their own experiences, preferences, needs and strengths. Therefore staff must be able to challenge their own assumptions, for example, about the possible needs of a South Asian woman who is experiencing domestic abuse, and to develop an understanding of the different layers of culture and subculture with which they

are dealing when meeting the needs of individual people who are seeking help (Clegg, 2003).

Methodological limitations

The project has several limitations. The award of tenders for the provision of Help Direct occurred as the research was under way, which led a number of focus group participants to express a degree of scepticism about the timing of the research in relation to the implementation of the wider programme. The timescale for completing the project was challenging, with the summer holiday period, Ramadan and Black History Month creating logistical challenges.

There were limits to the range of communities and groups covered and the numbers within particular groups. This limitation was imposed by the financial resources available for the work. As a result, we cannot be confident that the data captured the full range of issues, views and opinions that might exist in a particular community or group. In addition, recruiting target groups on the basis of a single characteristic, such as adults with a head injury, can tend to access 'crude communities' (Taylor, 2010) that may be more imagined than real (Alexander *et al*, 2007). We tried to be careful to avoid making assumptions about the views and experiences of people within these groups, and we have endeavoured to be cautious about our claims. Although we have in some cases described the issues emerging from a specific focus group, we do not anticipate that these will be seen as having any wider claim in relation to larger populations of which participants were members but not representatives (Alam and Husband, 2006).

In future work on this subject it may be better to construct some focus groups of individuals across different subsample groups. This would allow the testing of similarities and differences within discussions, and may reduce the potential for a normalising tendency within some groups, which might have led to perceptions of greater agreement than actually existed on particular issues.

Conclusion

This project sought to explore people's views and perceptions of a new universal service. Help Direct aims to deliver information, advice and guidance on well-being, as well as practical support, to *all* adults across Lancashire. The service prioritises those individuals who require support to maintain their independence, but whose needs would not meet the threshold for statutory support.

In this research, the participants' positive and negative concepts of well-being reflected perceived opportunities and capacity to maintain culturally relevant and personally valued lifestyles, roles, occupations and, in particular, relationships. Many of those who described long-term health-related problems and poor well-being reflected on structural issues that prevented the possibility of change. Those who reported more recent negative changes to their well-being often reflected on life changes or events that had led to them losing a sense of themselves because they had not found it possible to continue with previous roles, activities or relationships.

Perhaps the most problematic aspect of this policy initiative is the degree of individual agency that is being assumed in the way in which it is delivered: "The concepts of "reflexivity" and "choice" are highly contentious in the lives of many of those with limited resources. To construe citizens as rational free agents ... is to deny the structural realities that constrain "choice" (Stenner *et al*, 2008, p. 423).

The Marmot Review suggested that proportionate universalism is the best strategy for tackling health inequalities, arguing that support delivered should be proportional to the level of disadvantage experienced (Marmot Review Team, 2010). Although the limited case finding and first contact components of Help Direct may provide some means to balance the differences in people's need across the social gradient, the fundamental model of provision is weighted towards an open-access formula which may simply prove to be most popular with those who feel autonomous, have good social capital and are fairly healthy. Thus the model may have engaged with the diversity of the population, but perhaps not with the reality that 'universalism can, paradoxically' be 'socially exclusive', because it fails to address the differences in power between groups to the benefit of the already included (Ellison, 1999, p. 59; Lewis, 2005). If these criticisms are true they suggest that, despite good intentions, Help Direct may manifest as a form of disproportionate universalism.

Another challenge for any universal service is to meet diverse needs without either inferiorising or essentialising people's differences (Williams, 2000). These findings suggest that there is a reticence about or in some cases resistance to using statutory forms of support, and some groups cite difficult and/or embarrassing experiences when accessing and using statutory services which will not easily be forgiven or forgotten. Our view is that a service such as this will be most successful if it places an emphasis on an associationist model which focuses on creating a partnership of communities and organisations (Hoggett, 2000). This partnership of organisations might act as trusted messengers, supporting the service in engaging

and consulting with relevant communities and in signposting individuals to support.

The research has a number of limitations. The sample is limited in scope and the numbers recruited to reflect the views of different communities or groups are small. Future work in this area should diversify the range of respondents and aim to understand the dense complexities of social and personal relationships that affect individuals' preparedness to engage with services such as this.

ACKNOWLEDGEMENTS

The authors would like to thank Professor Christopher Heginbotham for his contribution to the original research and his comments on earlier drafts of this paper. They also wish to thank Lancashire County Council, which funded the research project and allowed the publication of this paper, and are particularly grateful to Don Rowbottom, Sarah McTigue and Janet Beadle for support and assistance with the original project.

REFERENCES

- Alam MY and Husband C (2006) *British-Pakistani Men from Bradford: linking narratives to policy*. York: Joseph Rowntree Foundation.
- Alexander C, Edwards R and Temple B (2007) Contesting cultural communities: language, ethnicity and citizenship in Britain. *Journal of Ethnic and Migration Studies* 33:783–800.
- Association of Public Health Observatories (2008) *Health Profile 2008: Lancashire*. www.apho.org.uk/resource/item.aspx?RID=50247
- Bowser BP and Sieber JE (1992) AIDS prevention research: old problems and new solutions. In: Renzetti CM and Lee RM (eds) *Researching Sensitive Topics*. Thousand Oaks, CA: Sage Publications.
- Clegg A (2003) Older South Asian patient and carer perceptions of culturally sensitive care in a community hospital setting. *Journal of Clinical Nursing* 12:283–90.
- Department of Health (2005) *Independence, Well-Being and Choice: our vision for the future of social care for adults in England*. London: Department of Health.
- Department of Health (2006). *Our Health, Our Care, Our Say*. London: Department of Health.
- Department of Health (2007) *Putting People First: a shared vision and commitment to the transformation of adult social care*. London: Department of Health.
- Department of Health (2010a) *A Vision for Adult Social Care: capable communities and active citizens*. London: Department of Health.
- Department of Health (2010b) *Equity and Excellence: liberating the NHS*. London: Department of Health.
- Ellison N (1999) Beyond universalism and particularism: rethinking contemporary welfare theory. *Critical Social Policy* 19:57–85.

- Godfrey M, Townsend J and Denby TJ (2004) *Building a Good Life for Older People in Local Communities*. York: Joseph Rowntree Foundation.
- HM Government (2007a) *Opportunity Age: meeting the challenges of ageing in the 21st century*. London: Department for Work and Pensions.
- HM Government (2007b) *Putting People First: a shared vision and commitment to the transformation of adult social care*. London: HM Government.
- Hoggett P (2000) *Emotional Life and Politics of Welfare*. Basingstoke: Macmillan.
- Jacobs RJ, Rasmussen LA and Hohman MM (1999) The social support needs of older lesbians, gay men and bisexuals. *Journal of Gay and Lesbian Social Services* 9:1–30.
- Lancashire County Council (2007) *Getting That Little Bit of Extra Help Needed to Stay Independent: working together to deliver local services to meet lower level needs in Lancashire*. Preston: Lancashire County Council.
- Lancet (2010) Health equity – an election manifesto? *Lancet* 375:525.
- Lee R (1993) *Doing Research on Sensitive Topics*. London: Sage Publications.
- Lewis G (2005) Difference and social policy. In: Ellison N and Pierson C (eds) *Developments in British Social Policy 2*. Basingstoke: Palgrave Macmillan.
- Marmot Review Team (2010) *Fair Society, Healthy Lives: strategic review of health inequalities in England post-2010 (The Marmot Review)*. London: Global Health Equity Group, Department of Epidemiology and Public Health, University College London.
- Newbigging K, Bola M and Shah A (2008) *Scoping Exercise with Black and Minority Ethnic Groups on Perceptions of Mental Wellbeing in Scotland*. Glasgow: NHS Scotland. www.healthscotland.com/uploads/documents/7977-RE026FinalReport0708.pdf (accessed 16 March 2011).
- Ritchie J, Spencer L and O'Connor (2005) Carrying out qualitative analysis. In: Ritchie J (ed.) *Qualitative Research Practice*. London: Sage Publications.
- Roy A (2009) *Evaluation of Manchester Drugs and Race Unit's 'Reaching Out' Programme*. Manchester: Black Health Agency.
- Roy A, Heginbotham C, Ahmed N *et al* (2009) *An Evaluation of Help Direct Gateways Across Lancashire. Part 1*. Lancashire: Lancashire County Council.
- Singer M (1992) AIDS and US ethnic minorities: the crisis and alternative anthropological responses. *Human Organization* 51:89–95.
- Stenner P, Barnes M and Taylor D (2008) Psychosocial welfare: contributions to an emerging field. *Critical Social Policy* 28:411–37.
- Taylor G (2010) Empowerment, identity and participatory research: using social action research to challenge isolation for deaf and hard of hearing people from minority ethnic communities. *Disability and Society* 14:369–84.
- Wanigaratne S, Dar K, Abdulrahim D *et al* (2003) Ethnicity and drug use: exploring the nature of particular relationships amongst diverse populations in the United Kingdom. *Drugs: Education, Prevention and Policy* 10:39–55.
- Wilkinson R and Pickett K (2009) *The Spirit Level: why more equal societies almost always do better*. London: Allen Lane.
- Williams F (2000) *New Principles for Welfare*. Cambridge: Polity Press.

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Alastair Roy, Senior Lecturer (Research), Psychosocial Research Unit, School of Social Work, University of Central Lancashire, Harrington Building, Preston PR1 2HE, UK. Tel: +44 (0)1772 895127; email: anroy@uclan.ac.uk

Received 6 September 2010

Accepted 31 January 2011