

**PRIORITY AREAS FOR SOCIAL RESEARCH  
& INFRASTRUCTURE AND CAPACITY ISSUES**

**SOCIAL RESEARCH SCOPING GROUP**

**FINAL REPORT**

**JUNE 1<sup>ST</sup> 2005**

**Peter Huxley  
Nick Gould  
Jerry Tew**

## Executive Summary

- The UK Mental Health Research Network commissioned the authors to undertake a scoping exercise on social research priorities in mental health.
- The primary method used in the exercise was a survey developed from consultation exercises undertaken previously by the authors with various stakeholder groups. The questionnaire asked respondents to rank their research priorities and comment on capacity development issues.
- The questionnaire was disseminated electronically through key professional, academic and service user lists, with an invitation for list members to snowball it further through their own organisations. This elicited 315 usable returns from a wide range of practitioners, academics and service users; disciplinary backgrounds of respondents included academic social scientists, social workers, nurses, psychologists and doctors.
- **The clear overall priorities for research were:**
  - **Social inclusion/social capital/ social networks**
  - **Social factors that enable resilience and recovery.**
- Sub analysis of responses indicated little difference between respondents in terms of demographic characteristics, but health staff tended to give higher priority to risk and alternative treatments as significantly higher priorities, while other respondents put user and carer participation and stigma as higher priorities.
- Comparing health care workers with social care workers, the latter gave higher priority to research into compulsion, the health and social care interface, and social work interventions.
- Factor analysis of the responses suggested that health care workers on the whole endorsed clinical priorities above social issues, and the reverse for social care workers. The small number of responses from social scientists made it difficult to draw inferences on their views.
- Respondents, particularly academics, commented on a range of capacity issues, in particular the need to:
  - Develop service user involvement and research capacity, and to address payment and benefit traps for user researchers
  - Raise research mindedness among practitioners, particularly among social workers and care staff
  - Bridge gaps between academic institutions and service providers
  - Compete more effectively for research funding
  - Establish new sources for funding
  - Overcome obstacles in ethical and R and D approvals
  - Disseminate what already exists more effectively
  - Support local research cultures and infrastructures
  - Enhance access to fit for purpose IT.

## **Background**

The UK Mental Health Research Network commissioned this scoping exercise on social research priorities in mental health as part of a larger programme of work on the development of research groups. A small steering group comprising representatives of the MHRN, the Social Perspectives Network (SPN) and the NIMHE/ SCIE fellow for social care research was set up, all of whom had been involved in priority setting exercises in the past. The results of these exercises were used as the basis for a consultation exercise to refine the priority lists.

The previous exercises raised questions about research values and methodologies, and highlighted the need for infrastructure and capacity building in social research. Work on the former is being taken forward through a Position Paper that is being drafted jointly by the NIMHE / SCIE Social Care Research Forum and the Social Perspectives Network, and through establishing links with the Government Social Research Unit in the Cabinet Office. The latter topic was included in the consultation exercise and exploratory meetings have been held with the NCC for Capacity development, in Leeds, the Department of Health and the ESRC. A series of mental health and social science seminars have been planned, and a bid for a seminar series has been submitted to the ESRC. Group members have also been involved in the development of a collaboration for social research with the NIMHE Eastern Region Development Centre (NIMHE Eastern Consortium for Social Research: NECSR) and in the development of the NIMHE Social Inclusion Coalition.

## **Method**

The method used was to compile a questionnaire based on the results of previous consultation exercises, and circulate this via relevant stakeholder organisations and networks with an interest in the field. The main organisations were the Social Services Research Group; the hubs of the mental health research network and the associated development centres; the Social Perspectives Network; the interdisciplinary Mental Health in Higher Education Project; SURGE and other service user and carer research groups; and the Joint University Council – Social Work Education Committee. There is an unknown degree of overlap in these lists. Individuals on each list were also invited to 'snowball' the questionnaire on to other potentially interested parties, either within their organisations or via relevant mailing lists.

While the organisations are broadly representative of some of the interests in the field, the responses can only be taken as indicative and not representative. Due to the lack of established networks for carer researchers in mental health, it is recognised that this constituency may be significantly under-represented in the survey. We are exploring the possibility of a further carer consultation to remedy this lack in the survey.

In relation both to priorities and to developing research capacity, respondents were invited to add their own ideas as well as respond to what had emerged through previous exercises. There were 27 'given' topics from previous exercises, and 3 free responses.

### **Research priorities: results from survey**

The overall response was 337, but 22 returns were unusable. Since respondents were allowed to select more than one of the membership categories describing themselves, the total in Table1 (511) exceeds the number of individual returns (315).

There was a good spread of responses between practitioners, academics and service users. In terms of disciplinary background, there were significant levels of response from social scientists and from the different professional groups of social work, nursing, psychology and medicine. The low response from social scientists is of particular concern, given the known capacity problems in social research in mental health (and more generally – see Huxley and Evans 2003, and Commission on the Social Sciences, 2003).

<b><i>Table 1: Respondent categories</i></b>		
<b>Respondent category (multiple choice allowed)</b>	<b>n</b>	<b>% (rounded up)</b>
Practitioners	97	19
Social Workers	85	17
Academics	77	15
Service users	60	12
Nurses	46	9
Social scientists	38	7
Psychologists	37	7
Medics	18	4
Voluntary sector workers	13	3
Service managers	13	3
Other health workers	12	2
OT	9	2
Social care workers	6	1
Total	511	101

### **E-mail responses**

Responses came in two types, hard copy (42%) or by e-mail (58%). There were no significant differences between the ratings made coming from the two sources, in terms of either SFC or WoO. E-mail sources were not always clearly identifiable, so the following figures are indicative only. Almost one

third (30%) came from NHS Trust sources, 22% from academic institutions, 17% from the voluntary sector and 10% from individual users and carers.

There were slightly more female respondents (153 women and 142 men), but a relatively low response from black and minority ethnic groups (5%), which may reflect the composition of the mailing lists, rather than the composition of mental health services.

The following tables present the results of the priority exercise in two ways:

1. Rank of opinion: reported as the frequency with which each item was ranked number 1. ('Simple First Choice')
2. 'Weight of opinion': reported as the (Weight of Opinion) overall sum of the scores from 1 to 10 for each item (ie 1 =10, 2=9, etc)

***Table 2 : the top ten using each method***

<b>Item</b>	<b>Simple first choice n</b>	<b>SFC rank</b>	<b>Weight of opinion score</b>	<b>WoO rank</b>
Social inclusion / social capital / social networks	39	1	1280	2
Social factors that enable resilience and recovery	32	2	1535	1
Employment / Welfare Benefits / financial issues	26	3	913	4
Social stress / vulnerability factors contributing to distress / breakdown	25	4	755	8=
Own priority 1	22	5	787	7
Participation and partnership with users and carers in service delivery	21	6	887	5
Housing and community support services	17	7	755	8=
Black or minority ethnic group issues	16	8	533	12
Stigma and impact on social identities	15	9	983	3
Whole systems and community interventions	13	10	841	6
Families and carers	8	13=	730	10

As may be seen, the two methods for ranking priorities produced similar lists (the same nine of the 27 'given' response items appear on both lists) but in different rank order. Black or minority ethnic group issues is ranked eighth by

the SFC method but 12<sup>th</sup> by the WoO method. Conversely, families and carers are ranked 13<sup>th</sup> by SFC and tenth by WoO. This indicates that not many people made carers their first choice, but many people put them somewhere lower in the list. (It must also be acknowledged that the relatively low ranking of this item may reflect the under-representation of this constituency within the survey itself).

However, despite the differences thrown up by the alternative methods of ranking priorities, a consistent result does emerge in terms of the top two priority areas for research:

- Social inclusion / social capital / social networks
- Social factors that enable resilience and recovery

## **Sub-analyses**

### **Sub analysis by age group**

There were hardly any differences by age group. Only two emerged in analysis of variance after Bonferroni adjustment. Those under 35 placed research at the system level as a higher priority than those over 35, and those over 35 placed research into the health and social care interface higher. Research into compulsion just failed to reach significance, older respondents placing it higher in the order of priority.

### **Sub analysis by gender**

There were also very few significant difference by gender. Only teaching and stigma produced different responses, women rated stigma research (mean 6.3 sd 2.5) higher than men did (mean 5.2 sd 2.9), and men rated research into teaching (mean 5.7 sd 2.5) higher than women did (mean 4.4 sd 2.9).

### **Sub analysis by data source**

First, using the e-mail data only, omitting the user and carer responses, and classifying the remaining respondents into health care sources and other non-health (largely social care) sources revealed interesting differences in relation to some of the priority categories. The results in Table 3 show that the weight of opinion among health staff puts risk and alternative treatments as significantly higher priorities than other respondents, and other respondents weight of opinion scores put user and carer participation and stigma as significantly higher priorities. (Mean priority scores of these variables are presented for ease of interpretation).

**Table 3: Differences in WoO scores by health and other sources (E-mail data only)**

	Health mean score (sd)	n	Other mean score (sd)	n	Mann-Whitney U	Z	(Sig) Asymp p
<b>Stigma</b>	5.02 (2.8)	44	6.4 (2.7)	54	857.0	-2.379	0.017
<b>User &amp; carer partnership</b>	4.5 (2.8)	41	5.7 (2.9)	55	838.0	-2.158	0.031
<b>Risk</b>	6.1 (2.2)	39	4.7(2.9)	33	475.5	-2.119	0.034
<b>Alternative treatments</b>	5.2 (2.6)	24	3.7 (2.2)	29	227.5	-2.178	0.029

The 'n' in Table 3 is low because the data is e-mail data only, excludes users and carers, and relates only to those health and other professionals who did rate these items as of some importance. No significant differences emerged in the simple first choice data.

**Sub analysis by professional group**

When the professional groups are divided into health care workers (doctors, nurses and psychologists) and social care workers, a number of understandable differences in priorities emerge. Sixty-five per cent of social care workers put research into compulsion as a top ten priority compared to only 36% of health workers ( $\chi^2=8.03$  df1,  $p=0.005$ ). The health and social care interface was a top ten priority for 36% of health workers but for 64% of social care workers ( $\chi^2=8.66$  df1,  $p=0.003$ ) and social work interventions was a top ten priority for 79% of social care workers but only 21% of health care workers ( $\chi^2= 26.85$  df1,  $p<0.001$ ).

Other priorities failed to show a significant difference, although a number were found to be in the expected direction, based on earlier results (above), and a number of trends were observed. For instance, health care workers more often rated research into personality disorders/self-harm/eating disorders in their top ten, than did social care workers (55% cf 44%;  $p=0.21$ ), and also research into hearing voices and other psychotic experiences (61% cf 39%,  $p=0.08$ ). Other current pre-occupations within mental health services also entered the health workers top ten more often; risk (59% cf 41%,  $p=0.07$ ) and crisis resolution (60% cf 40%,  $p=0.16$ ) among them.

## **Additional priority areas**

Table 4 shows the list of additional research topics suggested by respondents. Only faith communities really emerges as a separate topic not included in the 27 options we initially offered. Mental health promotion and forensic research were also mentioned five times and three related to in-patient settings (and each of these has their own research funding streams). It is interesting to note how few other specific illness conditions and health treatments are included here, perhaps a reflection of the instruction to consider social rather than medical priorities given in the instructions on the form.

The list shows that the range of possible areas is wide and the potential research agenda vast. We did not re-group these items into a reduced set, and respondents would probably not have appreciated any successful attempt to reduce them, as many put their single option as number one – leading to their first alternative choice emerging fifth in the SFC list, and seventh in the WoO list. In general terms we regard this as a positive situation, showing great potential interest and perhaps untapped capacity to engage in or to discover about research. In this sense this finding supports the argument that there is a major capacity problem in research in this area.

However, one can look at all the items in the original list and those added to it as three (possibly overlapping) groups. First there are those which reflect the influence of the social environment upon the prevention of the occurrence of disorder, on triggering symptomatic episodes of disorder, and relapses, and the maintenance of well-being over time. Second there is the organisation and effective delivery of social care services, either in partnership with health or as alternatives. Third, there are specifically health related issues, such as the effective treatment of specific conditions, or the organisation of specific treatment services.

**Table 4: Additional priority areas for social research**

Suggested area for research	Number of responses – one only unless otherwise indicated
advance directives	
Ageism	2
alternatives to medical model	
care coordination models and outcomes	
carer involvement in research	
carer services	
causes of personal isolation	
coherent social models of understanding	
comparison UK MH systems	
cultural competency	
direct payments	2
disabled patients perspective on services	
disfigurement and identity	
effectiveness non medical interventions	
factors effecting effectiveness psychological interventions	
faith communities & spiritual needs	11
further and higher education	
healthcare chaplains	
mental health promotion	5
impact of BME results on practice	
impact of parenting on adult common mental disorder	
in patient care 24 hour nursed care	
loss of friendships during illness and regaining them	
offenders with mental health problems	5
multi agency information systems	
nutrition and mental health	3
parenting	3
person centred planning	
physical activity	
preorientation to types of help avail	
prevention of PTSD	
professional allegiance and outcome	
promote engagement	
quality of life	2
residential care, therapeutic factors in	2
self help groups	
shared health and social care metrics & language	
social enterprises and social firms	3
social alternatives to inpatient care	
social model	
suicide prevention	
teamwork, new ways of working	
talking therapies, access to	
therapeutic in patient environment	
ward culture impact on illness	

## Factor analysis

We attempted exploratory factor analysis (principal components analysis) but found that the resulting 12 factor solution (accounting for 59% of the variance) could not be rotated and was difficult to interpret. We next used a two factor confirmatory factor analysis, on the assumption that our original items were broadly represented by two groups of items, the first 15 presented, and the second group of 12 which related specifically to 'what works' for users and carers. Then we made the assumption that there were actually three broad groups of items, representing, as indicated above, social factors and influences, the organisation of the delivery of services, and illness and treatment related factors.

The two factor solution using the raw rather than the weighted data accounted for a limited amount of variance (13%) (Table 5), and the three factor solution accounted for a little more (19%) (Table 6). Both solutions confirmed that our second set of questions, related to research priorities lying in interventions that 'work' for users, does constitute a group, Factor 1 in both cases.

	Factor 1		Factor 2	
	Item	Loadings	Item	Loadings
Two factor solution (variance 13%)	Personality disorder	0.622	BME	0.444
	Psychotic phenomena	0.537	Gender	0.415
	Addiction	0.534	Housing	0.389
	Risk	0.352	Welfare	0.392
	Inequality	-0.422	Alternative therapy	-0.501
	User carer participation	-0.407	User led day services	-0.416
* Principal components analysis, varimax rotation, loadings greater than 0.350				

**Table 6: Three factor solution\***

	Factor 1		Factor 2		Factor 3	
	Item	Loadings	Item	Loadings	Item	Loadings
Two factor solution (variance 19%)	Personality disorder	0.625	Housing	0.410	Abuse	0.368
	Psychotic phenomena	0.545	Gender	0.379	Recovery	0.361
	Addiction	0.493	BME	0.379	Teaching	-0.478
	Risk	0.372	Alternative therapy	-0.525	System level	-0.440
	Inequality	-0.437	User led day services	-0.422	Health social care interface	-0.402
	User carer participation	-0.396				

\* Principal components analysis, varimax rotation, loadings greater than 0.350

The items relating to health and illness are positively correlated with the first factor and the items relating to equality and participation are not; this could be interpreted as reflecting the clinical model of care. Social structural and environmental variables, such as housing, gender and ethnic status are positively correlated with factor two, and alternative therapies and user led day services and similar are negatively related. This factor therefore represents something of the struggle between supporting diversity and promoting diverse service responses, and more conservative elements in the social and service environment. Factor three has something of the same composition, but the health and social care interface and system level interventions (including the evaluation of educational initiatives and strategies for the dissemination of evidence) as research priorities are quite heavily but negatively loaded. The focus on these issues is countered by the opposite valence of abuse and recovery, which are individual priorities on one level, but also system wide in the sense that the recognition of abuse has become a service priority and recovery is becoming one. In this sense they are organisational priorities. There is therefore some support for the existence in these data of health related, social structure related and organisational/system factors.

As a final contribution we produced factor scores from the three factor solution and compared the scores on each factor in the professional groups and the service users. Doctors and psychologists did not differ from other professionals or users in terms of their scores on any of the three factors. Service users ( $t=-2.10$ , (301)  $p=0.036$ ) and social workers ( $t=-1.97$  (299)  $p=0.049$ ) differed in their scores on factor 2 (social model), and nurses differed in their scores on factor 1 (clinical model), from the other groups ( $t=-2.72$  (299)  $p=0.007$ ).

The obvious conclusion from these analyses is that health care workers, when called upon to make judgements about research priorities, on the whole endorse clinical model items and not social items, and the reverse is true of social care professionals. The number of social scientists in the sample was

disappointingly low, and those who took part did not seem to share the priorities of the social care workers, so far as one can tell. Further research into the research priorities of social scientists and others who are teaching social care workers about research and the evidence base of practice in the mental health field is needed. We must treat some of these results with caution, given the low numbers of participants, and the possibility that the findings in relation to the smaller size groups may not be robust.

### **Research infrastructure and capacity: results from survey**

The section on infrastructure and capacity produced responses from 73 people (23%) who made 129 responses altogether. However, as in the case of the priorities, some of the capacity issues they raised were already included in the given list. Only 26 (20%) of the responses were genuinely about additional infrastructure or capacity issues. Social care workers were more likely to respond to the question about capacity than health care workers (63% cf 37%;  $\chi^2=3.96$  df1,  $p<0.05$ ). There were no differences in response by age group or gender. Specific professional groups of social workers, nurses, psychologists and medics, and also service users, were not more likely than other respondents to answer the capacity question. Those who were more likely to provide an answer were, as one might expect, the academics (41% cf 19% of others;  $\chi^2=15.14$  df1,  $p<0.001$ ) and the social scientists (47% cf 21%;  $\chi^2=13.03$  df1,  $p<0.001$ ).

The previous priority setting exercises produced a list of capacity issues which formed the basis of the list in the consultation paper. Many of the responses added to our thinking about these issues.

User involvement in research – this is becoming better developed, and has the potential to compete for resources with other researchers. There is a capacity problem in the field because there are an insufficient number of user researchers to cope with demand.

Capacities of users as researchers – this is really for SURGE and others to take the lead, rather than, or in partnership with the social science community. A number of respondents thought this was a priority for capacity development.

Payment for services users involved in research – there are some developments on the benefit front in this regard, and local benefit offices have discretion to raise the statutory earning limits. This is not widely used or known since the local managers are reluctant to advertise the fact.

Research mindedness among practitioners – this is much less of a problem for some groups (eg medics and psychologists) for whom it forms a more substantial part of their training. This has been a long standing problem for

social workers and care workers, and it is not clear whether the new social work degree (or the possible social care degree) will help improve the situation. Some form of representation to the GSCC might need to be made. Post-qualifying education in social work has not tended to encourage research to be seen as an essential core activity. Among the suggestions made in this regard were:

- The development of senior research posts in organisations
- Linking those people with research experience with those without it
- Including research requirement in professional job descriptions

Bridge gaps between academic institutions and service providers – there is a history of joint appointments aimed to improve this situation, but social care and service agencies are not themselves research minded, which can present an obstacle for people in joint appointments. A real problem is the very separate funding arrangements, and the respective incentive schemes, ie there is no incentive in the academic performance world for applied research activity, or for funding obtained from service providers, and in the service world there continues to be a reluctance to spend scarce resources on research or evaluation. Jointly organised Fellowship or studentship schemes (like the ESRC CASE scheme) might help break down some of this resistance, and create better joint opportunities. A related issue is the general failure to get CASE into social care services settings, although this may improve in future because social work is now an ESRC recognised topic area.

Compete more effectively for research funding – this is related to current sources and their availability to social scientists. First of all opportunities are restricted in that there are far more funds available for other professional groups (the same applies to Fellowships). Second, there is a general feeling that social science methods are not well understood by funders, reviewers or ethics committees, and this reduces the 'effectiveness' ie the success rate of applications. Steps to widen the membership of review and funding bodies might help. The same point about the lack of representation of social scientists on ethics committees was made by some respondents. However, this is not likely to succeed if reviewers and others continue to favour health rather than social care priorities in their funding judgements.

New sources of funding – this is problematic, but some special Fellowships ought to be possible through existing funding sources, but there would need to be high level negotiation. One issue is who is to represent the field of social science in such negotiations with the funders. One option would be the government social research unit (GSRU). Some respondents suggested that there needs to be dedicated research funds for service user researchers, and others wished carers to be included as well.

Ethics committees as gatekeepers – this issue was mentioned earlier, and the changes to research governance in health have separated out the ethical issues from the peer review and other governance arrangements, which is a help. However, the social care research governance arrangements are being

put in place and it is hoped that these will facilitate rather than obstruct progress. As mentioned already there were many adverse comments about current procedures in ethical and R&D approvals. One respondent called for all the procedures to be simplified, partly because they have adverse consequences for user-researchers and academics in particular. Another pointed out that it is not only social science expertise that is lacking on ethics committees as they are currently constituted, but membership also lacks mental health experience.

Disseminate what already exists – this is a perennial problem, and many funders now require a clear and substantial dissemination strategy as part of the bid, and they look positively at the use of non-traditional methods, as well as feedback. The St Andrews University ESRC funded unit on innovation provides very useful materials on the dissemination of new ideas, and deserves to be more widely known e.g, the report it recently produced for SCIE (Walter et al, 2004) on research utilisation in social care. A related issue, which exercises the GSRU is the need to make better use of what is already available, and the GSRU will not engage in research which has not had a systematic review of existing work undertaken. Further problems which arise in this connection are the problems of access to grey literature and the limitations of existing search engines, both of which are receiving increasing attention in a number of quarters. Respondents argued that while dissemination is important, it is actually the translation of findings into practice that is the real problem. One respondent suggested that some guidelines about how to do this might be helpful.

Local research cultures and infrastructures – paradoxically the former is easier to address than the latter, but the latter is essential to make the former sustainable. There is no doubt that local issues generate more interest and attention, and so this is one way to help to develop a local culture. A number of services do 'buy in' local evaluation, and this may help to enhance the academic – service links mentioned earlier, and in some cases, the local evaluation is used to help the service sustain its funding. A number of respondents wanted the creation of local networks, linking the more experienced researchers with the less experienced, and others wanted help in bid preparation. No-one mentioned the availability of regional support units within the NHS, and although one cannot be certain this is probably because they are unaware of their existence.

IT infrastructure – is another problem! Despite the widespread availability and increasing sophistication of IT, practitioners do not often have access to it, and when they do it proves to be unfit for purpose. Not many respondents suggested that IT was a capacity problem. This probably suggests that not many of them have encountered the IT problems yet, because they have not attempted to use them. If research activity was greater then the reported problems might go up the priority list. One interesting suggestion was a call for the clarification of service responsibility for data collection. This was possibly in respect of the difficulty one researcher experienced in data

collection, but it does raise the issue of a professional responsibility to engage in research, to do so to a high professional standard, and of the need for routinely collected data for the purposes of service evaluation to be treated in the same way as other data collection.

Table 7 summarises the infrastructure and capacity issues not mentioned in the call for responses.

<b><i>Table 7: Additional infrastructure and capacity issues</i></b>
Dedicated funds for small scale research
Development of senior research posts in organisations
Involvement of BME groups in research
Linking those with research track records with novices
Quantitative methods training
Basic research methods training
Service responsibility for routine data collection for research purposes
Turning findings into action ('implementation not just publication')
Evaluation of dissemination efforts
The capacity of small voluntary organisations to participate in research

### **A postscript on methodological issues**

As explained in the 'Background' section methodological issues are being addressed elsewhere and were explicitly not pursued in this exercise - indeed, respondents were asked in the covering letter not to raise them. Nevertheless, several respondents chose to ignore this instruction and 7 of the 'own priority' categories and one fifth of the capacity responses concerned methods. We take the view that concerns about methodological approaches are best addressed by making common cause with existing groups rather than setting up a new structure or interest group to consider the methods issues in this field. The combined Social Perspectives Network and NIMHE/SCIE research group, or the methods group of the Campbell Collaboration might be suitable vehicles for social care workers to express their views and engage in debate with their peers.

#### **Peter Huxley**

Professor of Social Work, King's College London.

#### **Nick Gould**

NIMHE/SCIE Fellow in Social Care, Professor of Social Work, University of Bath.

#### **Jerry Tew**

Senior Lecturer, University of Central England, Birmingham, and research lead for Social Perspectives Network.

## References

Commission on the Social Sciences (2003). *Great Expectations: The Social Sciences in Britain*. London, Academy of the Learned Societies for the Social Sciences. <http://www.the-academy.org.uk>

Huxley P. & Evans S. (2003) Social science and mental health *Journal of Mental Health* (Editorial) Vol 12(6) pp 543 – 550

Walter, I., Nutley, S., Percy-Smith, J., McNeish, D. and Frost, S. (2004) *Knowledge Review 7: Improving the Use of Research in Social Care Practice*, London: Social Care Institute for Excellence.

## Abbreviations

BME	Black and minority ethnic groups
ESRC	Economic and Social Research Council
GSRU	Government Social Research Unit
IT	Information Technology
JUC-SWEC	Joint University Council – Social Work Education Committee
MHRN	Mental Health Research Network
NCCRC	National Coordinating Centre for Research Capacity Development
NIMHE	National Institute for Mental Health England
NECSR	NIMHE Eastern Consortium for Social Research
OT	Occupational Therapist
PTSD	Post traumatic stress disorder
R and D	Research and Development
SFC	Single First Choice
SCIE	Social Care Institute for Excellence
SPN	Social Perspectives Network
SSRG	Social Services Research Group
SURGE	Service User Research Group England
WoO	Weight of opinion