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## **International Principles of Social Impact Assessment: Lessons for Research?**

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## **Abstract**

The ability and importance of being able to demonstrate how research has benefited humankind has been a by-product of global exercises assessments and attracted only marginal interest. However, with the introduction of new indicators for ‘what counts’ in research, impact has now entered centre-stage. Nursing ought to have little problem with the concept of impact: we should be able to demonstrate the influence of nursing research on culture, health, society, policy (etc) in a way that might be more difficult for disciplines that are less applied.

Whilst the international principles of impact assessment are quite familiar to those working in the third sector and are encouraged by governments across the world, academic disciplines in general – and possibly nursing in particular – appear to lag behind in knowledge of these principles. Moreover, on examination nursing has much that is congruent with the principles, but so far has left these unstated. In this paper we explore potential lessons from the principles of social impact assessment for nursing research. We use illustrative examples from our own area of expertise - child protection - but the principles apply across all substantive topics.

Social impact assessment is underpinned by four principles which we explore first: the precautionary principle; then the principles of intergenerational equity; multisectoral integration; and subsidiarity. We go on to unpack the seven focus areas of impact assessment to demonstrate how these could be articulated within nursing research. Finally, we offer some pointers as to how nurse researchers might begin to assess and measure the social value of interventions and services through the framework of Social Return on Investment (SROI). Impact mapping can make useful delineation between outputs, outcomes and impact and as a framework, social impact assessment has much positive guidance to offer nursing research.

**Key Words:** social impact assessment (SIA); social return on investment (SROI); research assessment; impact statements; child protection.

## **International Principles of Social Impact Assessment: Lessons for Research?**

### **Introduction**

Impact statements are becoming *de rigueur* in the build up to another research assessment cycle in the UK. However, many countries, including Australia (Australian Government, 2010), the United States (Cozzens, 2005), Hong Kong (Harvey, 2009) and across mainland Europe (SPARC Europe, 2009) have begun to develop increasingly sophisticated methods of measuring the product of research. Unlike previous assessment exercises in the UK, impact is now vitally important: whereas being able to demonstrate how research has benefited humankind has been a by-product of previous exercises, impact has now entered centre-stage. It is anticipated that impact will be worth 25% of the overall assessment profile, hence:

Significant additional recognition will be given where high quality research has contributed to the economy, society, public policy, culture, the environment, international development or quality of life (Higher Education Funding Council for England, 2009).

Nursing ought to have little problem with this concept because, theoretically at least, we should be able to demonstrate impact in a way that might be more difficult for disciplines whose output is less directly or obviously relevant to practice or people. Whilst consultation and piloting is ongoing at the time of writing, it is understood that impact on a range of points will be assessed (Figure One), and that it will be gauged by ‘qualitative information informed by appropriate indicators’ (Higher Education Funding Council for England, 2010). These will take the form of a generic impact statement for the submitted unit as a whole, and a number of case studies.

*Insert figure one about here*

The impact statement must describe the breadth of interactions with research users and provide an overview of positive impacts during the assessment period. Both the impact

statement and the case studies need to demonstrate indicators of impact, which will be assessed against criteria of reach (how widely impacts have been felt) and significance (how transformative the impact). Whilst we have a few years yet to perfect the rules and techniques for these impact statements, the time will roll by with astonishing speed and it is worth being both proactive and prepared for when it is time to press the button on the next (high quality) nursing submission.

Reflecting on a recent job change made by one of us (JT) into the charity sector, the relevance of social impact, and particularly its assessment, has become extremely meaningful. In this paper we explore potential lessons from the principles of social impact assessment for nursing. Whilst it is not possible to slot every aspect of nursing research into these principles, we believe they have resonance with much of the essence of nursing care. As such, they have relevance in shaping aspects of our thinking towards that next research assessment submission. Our intention is to alert readers to the importance of social impact and avail them of a number of principles on which it can be conceptualised. We use examples from child protection given our own expertise in this field. However, these are illustrative only, as the principles should apply across all substantive topics.

### **Social Impact**

Measuring the real impact of what can be achieved, rather than just what can be easily measured, has a growing role in service delivery, in commissioning, and for grant givers and policy makers (Leighton & Wood, 2010). Both the previous UK Labour and current coalition governments have emphasised the need to ensure value for money, not just for economic efficiency, but for social efficiency as well. At the same time, other European countries are beginning to embrace the Stiglitz Commission on the measurement of Economic Performance and Social Progress (Stiglitz *et al.*, 2009), which looks at more than Gross Domestic Product (GDP) to measure progress, encouraging measures that incorporate sustainability and community well-being. The measurement and communication of such social ‘added’ value are at the heart of social impact assessment (Leighton & Wood, 2010).

The social value or impact of a programme refers to what might be regarded as ‘soft’ outcomes that include (for example) social capital and the environment. Social value can be distinguished from a wider public value or a narrow concept of individual value and represents delivery of the collective desired needs of individuals who share common expectations (NHS Northwest, 2009). Nursing, with its emphasis on care more than cure, likewise battles sometimes to demonstrate the effects of prioritisation and decision-making on the vulnerability of patients beyond their immediate physical needs (Niven & Scott, 2003). The aim of social impact assessment within healthcare is to develop a framework within which the social value of activity can be captured and articulated. This will allow the health service to show its true value across the public sector; embed the use of social value concepts which will allow commissioners to manage social value across a whole system and to work more effectively with their partners to deliver social value outcomes (Wood & Leighton, 2010). This means going beyond the traditional productivity measures usually used in healthcare settings, such as quality-adjusted life year and consider wider health and well-being indicators by taking account of social situations. We argue that impact statements for nursing research would be enhanced by reflecting the unique elements of nursing care, using the principles underpinning social impact assessment.

### **Social Impact Assessment**

Social impact assessment is an umbrella term that encompasses the assessment of the social impact of planned interventions. It includes:

the processes of analysing, monitoring and managing the intended and unintended social consequences, both positive and negative, of planned interventions (policies, programs, plans, projects) and any social change processes invoked by those interventions. Its primary purpose is to bring about a more sustainable and equitable biophysical and human environment (Vanclay, 2003).

Within international development agencies, non-government organisations, charities and other applied institutions, social impact assessment has gained widespread acceptance as a means of assessing the potential impact of planned interventions. The International Association for Impact Assessment (IAIA) has developed internationally agreed principles for social impact assessment, which can be applied across a wide range of interventions and settings (Vanclay, 2003).

### **The International Principles**

Since the original declaration of internationally agreed principles in 2003, there has been much more clarification, development and application and we follow that strand in a later section. However, there are four original principles that are absolutely key to the underlying philosophy of social impact assessment that we believe help illuminate the conceptual framework extremely well: the precautionary principle; intergenerational equity; multisectoral integration; and subsidiarity.

#### *The precautionary principle*

According to the precautionary principle, lack of certainty about threats or potential threats of an intervention should not be used as a reason for approving it. In other words, we should not engage in research activities as a means of determining whether their impact is harmful. This is particularly pertinent to healthcare research because although all research carries a degree of risk, this must be assessed against potential benefits (Johnson & Long, 2010). A general guideline is that advancement of knowledge should not take precedence over the well-being of human participants (Social Research Association, 2003; World Medical Association, 2008). The important point about the precautionary principle is that it may help guard against overclaiming – a hazard we discuss in the next section.

#### *The principle of intergenerational equity*

In a similar vein to the precautionary principle, intergenerational equity is also concerned with balancing benefits and risks. From this perspective, benefits from planned interventions should address the needs of all and social impacts should not fall

disproportionately on certain groups of the population. It recognises the particular vulnerability of children and women, disabled people and those who are socially excluded and marginalised (Vanclay, 2003) and thus has salience in a child protection milieu. Another important issue in relation to intergenerational equity is that the needs of the present generation should not be met at the expense of future generations. What is acceptable to society changes between generations and is different between cultures. Practices once considered 'normal' are no longer socially acceptable, or are even perceived as barbaric (for example we no longer send children aged under five up chimneys to clean them). Intergenerational equity encourages us to remain mindful of the best interest of the child whilst balancing this against cultural and historical norms (Taylor *et al.*, 2000).

#### *The principle of multisectoral integration*

The principle of multisectoral integration states that social issues should be properly integrated into all projects, policies and planned activities (Vanclay, 2003). Child protection is an excellent example of multi-agency concern, bringing together social workers, a range of health care professionals (e.g. health visitors, paediatricians, psychologist, psychiatrists, family doctors, midwives), youth workers, police, criminal justice, housing and so forth. Child protection is everyone's business (Scottish Executive, 2002). Yet it is still not uncommon to find people perceiving of this area of work as the domain only of social workers. Indeed recently, a highly respected Medical Director at a social function made loud proclamations about what on earth nurses have to do with child protection and it certainly would not be of relevance or interest to the doctors in his organisation. This kind of anecdote reinforces the importance of multisectoral integration and moreover, for nursing to secure its position within such integration.

#### *The principle of subsidiarity*

According to the principle of subsidiarity, decision making power should be decentralised and taken as close to the people as possible (Vanclay, 2003). With this in mind, impact should be measured against the extent to which service-users have worked in partnership with researchers in the planning and development of research. An exemplar from child



protection can be found in Survivor Scotland - the Scottish national strategy for survivors of childhood sexual abuse (The Scottish Government, 2009). The strategy and the associated resource website were informed directly by individual survivors and those organisations that represent them. There are personal accounts and examples throughout that provide a clear demonstration of the impact of subsidiarity.

### **Social impact and nursing research – examples from child protection**

The original international principles developed by the International Association of Impact Assessment (Vanclay, 2003) have been widely developed and adapted by numerous organisations in diverse settings and countries. We use the adaptation of the UK Cabinet Office (2009) and others to unpack how they could be utilised within research assessment. The examples we use are drawn from our own substantive area – child protection – but we would urge readers to consider examples from their own cognate area.

#### *1: Stakeholder perspectives*

In this first principle, stakeholders should inform what gets measured and how it is valued (New Philanthropy Capital, 2010). Understanding and reflecting the views of users and carers and including them within the research design, data collection and analysis is now a key component of health services research, although it has not always been fully understood or reflected (Hanley *et al.*, 2004). Within child protection research, studies that include the voices of children are relatively uncommon, yet have enormous meaning for the findings. Researchers may sometimes be put off by the thought of getting necessary permissions from ethics committees, yet those that embrace the concept provide telling and meaningful data that would not be otherwise obtained. Research by Buckley *et al.* (2007) provides a compelling account of what it is like to be a child living with domestic abuse experience. Rather than a vicarious version through an adult or researcher lens, Buckley *et al.* collected the accounts *of* children, *from* children.

#### *2: Understand what changes*

In this principle, it is important to articulate how change has been created and evaluated through evidence, recognising both positive and negative changes as well as those intended and unintended (New Philanthropy Capital, 2010). We are not certain that as nurses we have always been very good at this. In child protection, we have only recently begun to recognise the damage that can be caused by removing children into foster care. However, it has been very difficult to differentiate the harm done to children prior to coming into care and the harm done by being in care. A recent study from the United States begins to shed light on the possibility that we are inflicting psychological harm on a large number of children by bringing them into care (Rubin *et al.*, 2007). The researchers followed 729 children for their first 18 months in foster care and found a high level of placement instability. This was strongly associated with a child's behavioural problems at 18 months, regardless of the level of behavioural problems on entering care. The risk of iatrogenic emotional abuse is thus very significant in placing children in foster care. Impact statements that illuminate the negative or unintended consequences of care or intervention are crucially important.

### *3: Value the things that matter*

For this principle, it is expected that we use financial proxies in order that the value of the outcomes can be recognised (New Philanthropy Capital, 2010). Whilst it may be relatively easy for health economists to cost the number of in-patient days saved by a new treatment, nurses are perhaps only beginning to project the kinds of costs that can be saved. In child protection, accuracy and verification of costs would require a high degree of accounting wizardry, but it is still possible to begin to account for financial proxies in assessing impact in this regard. To illustrate, in 34% of serious case reviews (where a child has died or suffered significant injury) in England, domestic abuse, mental health issues and alcohol and/or substance misuse are present (Office for Standards in Education Children's Services and Skills, 2010). The elements of this toxic trio are often interlinked and overlapping. Each can be caused by or be exacerbated by the other. In the last national prevalence study in the UK (Cawson *et al.*, 2000), nearly a third (26%) of children and young people reported physical violence during their childhood: 47% had experienced physical assaults and 13% of these had used object or weapon. Five per cent

of children had experienced frequent violence. The cost to the taxpayer is hard to calculate, given the long term damage, but the cost of violence to women alone (not accounting for the damage to children) has been estimated at £23 billion (England and Wales) in immediate costs to the economy of £6 billion, with human and emotional costs totalling £17 billion (Walby & Allen, 2004). Further, sexual offences have been estimated at a cost to society at £8.5 billion, with each rape costing over £76,000 (Home Office, 2007). But overall, the costs in terms of lost work, mental health and physical health services, subsequent substance misuse, homelessness or suicide; to the criminal justice, welfare and health sectors is considerable. The impact of research that addresses these issues can begin however to map out where those financial proxies may be found.

#### *4: Only include what is material*

Departments and individuals responsible for producing research assessment submissions will be familiar with this principle: determine the information and evidence that should be included to give a true and fair picture, such that reasonable conclusions concerning impact can be drawn (New Philanthropy Capital, 2010). Making those judicious decisions regarding what should and should not be included within the prescribed word limits can be difficult. But getting it right in research can be even more difficult. There is often a tendency to underplay the impact, or to have the design make it impossible to extrapolate the results in a meaningful way. A recent systematic review that focused on how children who are neglected come to the attention of professionals (and how these professionals then respond) was unable to gain potentially useful insights from a whole tranche of methodologically sound research papers (Daniel *et al.*, 2009). This was simply because in numerous child protection studies neglect and different forms of abuse are assembled under a single heading of ‘child maltreatment’, making it impossible to extrapolate data about children who were neglected as opposed to any other category of abuse. Knowing that neglect often only comes to attention because other abuses are noticed first, swathes of potentially crucial material were lost – as indeed was their impact.

#### *5: Do not overclaim*

Organisations should only claim the value that they are responsible for creating (New Philanthropy Capital, 2010). This is one principle we see broken over and over again. The individual *curriculum vitae* that overclaims is one thing. The organisational one is another. Given that impact statements are allowed to consider longevity (Higher Education Funding Council for England, 2010), this can certainly be a useful in assessing impact over time. However, it can also make disentangling the roots and branches quite a complex undertaking. The whole hearted support for parenting programmes as a fix for all manner of poor outcomes for children (compromised self-esteem; inadequate school performance; maltreatment; delinquency; cognitive and behavioural problems; mental health difficulties etc) is a good example. Whilst the apparent evidence-base for many of these programmes appears quite substantial, it can be difficult to track their origins, the consistent application, and most importantly, the outcomes for families and children of such programmes. Within one health board region there can be three or four different programmes running, for example Triple-P (Sanders *et al.*, 2003), Webster-Stratton (Hughes & Gottlieb, 2004) and Incredible Years (Letarte *et al.*, 2010). But Cochrane systematic reviews and further follow-up (Barlow & Coren, 2004; Barlow *et al.*, 2007; Barlow & Parson, 2004) have cast some doubt on the efficacy of parenting programmes, apart from the Family Nurse Partnership programme based on the work of David Olds and his team in the United States of America. Olds has shown, through randomised controlled trials and longitudinal follow-up over many years, the effectiveness of the programme on both maternal and child outcomes (see for example Olds, 2005; Olds *et al.*, 1997; Olds *et al.*, 1995; Olds *et al.*, 1998; Olds *et al.*, 1988; Olds *et al.*, 2005). This is not to say that other parenting programmes do not work, but that the evidence-base is less substantial. The claims made for parenting programmes however (and especially the lesser known ones not mentioned here) can be quite extreme.

#### *6: Transparency*

Principle number six exhorts us to demonstrate the basis on which the analysis may be considered accurate and honest and show that it will be reported to and discussed with stakeholders (New Philanthropy Capital, 2010). Impact statements that demonstrate such transparency in research are to be welcomed. Following a difficult history in the UK of a

failure of frontline services to protect children from extreme harm, the Right Honourable Michael Gove MP, Secretary of State wrote recently to Professor Eileen Munro, tasking her to conduct an independent review of child protection (Gove, 2010). The Munro Review, whilst focused primarily at social work systems, is clear that it concerns all professionals who make judgements about the best interests of children, including in particular health visitors. The terms of the Review are very clearly about transparency and must include:

- consultation with a wide range of professionals who work with children;
- consideration of other ongoing parallel reviews;
- information from the strongest systems in other countries (Loughton, 2010).

The key factor in the Munro Review is to advise on how transparent systems of child protection can be established that command public confidence and protect the privacy and welfare of vulnerable children and their families (Gove, 2010). Due to report in 2011 it is too early (at time of writing) to say to what extent it has been achieved. But the Munro Review has thus far been very clear about its intentions and wide-ranging consultation with a variety of stakeholders. There is much to be learned from this approach in application to impact.

### *7: Verification*

The final principle of social impact is to ensure appropriate independent verification of the account (New Philanthropy Capital, 2010). Researchers should be very familiar with this concept, which equates to principles of validity and rigour. Independent verification can be sought from different sources, but primarily through participant feedback and peer review. Participant feedback is a widely used, yet somewhat contentious strategy employed by many researchers (Bradbury-Jones *et al.*, 2010). It is a final validating step that involves returning to participants for verification of the findings. Unlike the stakeholder perspective detailed under Principle No 1, participant feedback is likely to be a one-off event. The benefit is that it provides study participants opportunity to correct, challenge, assess and confirm the interpretations of the information they provided (Lincoln & Guba, 1985). This may be particularly important in child protection research

because of the sensitive subject area and the potential for participants to hold multiple and changing perspectives. Peer review provides another avenue through which independent verification can occur. This is not an activity confined to the latter stages of research, such as during the publication process. Increasingly researchers are called upon to consider the impact of their research at grant application stage. This focuses attention on impact from the genesis of a research study. However, it may be worth considering how the evidence from the collective research of a unit can be verified, as opposed to that of individual projects. Adherence to and evidence of the other six principles will, in this view, verify the impact.

So far in the paper we have explored the concept of social impact assessment and the principles that underpin it. However, it could justifiably be asked: how do we actually *do* social impact assessment? In this latter part of the paper we attempt to address that question.

### **Assessing impact**

Measuring the social value of interventions and services is a developing science and there are a number of proposed frameworks. One of the most common is that of Social Return on Investment (SROI). Originally pioneered in the USA, it has been adapted and developed in the UK. Using financial accounting principles, SROI produces an index of social return. An index of 2:1 shows that for every £1 invested, £2 worth of social value is returned (Social Economy Scotland, 2010). SROI holds appeal because it speaks the language of finance and provides a way of proving that investment into social enterprises is ‘worth it’ (Social Economy Scotland, 2010). We have already discussed the principle of valuing things that matter. In the context of this paper that means the impact of research in the area of child protection.

Despite its general appeal, SROI is not without critics. Firstly, a recent analysis by the think-tank Demos shows that whilst the principles behind SROI are sound, there is yet some way to go before the sophisticated techniques used in SROI are achievable and sustainable across the sector (Leighton & Wood, 2010). Secondly, the ‘language of

finance’ is not one that is embraced by all. SROI is often viewed (mistakenly) as being all about financial ratio, that is, the social value created per £1 invested. According to New Philanthropy Capital (2010), this attracts some scepticism regarding the approach. It is important to recognise however, that SROI is about value, rather than money. In healthcare this matters because every time the public sector spends money, it should be in a way that achieves as many of its objectives as possible (NHS Northwest, 2009). Despite these criticisms though, the development of tools that measure SROI are being embraced widely to demonstrate value for money.

In terms of actually *doing* impact assessment, the New Economics Foundation (2010) provides a step-wise approach to assessing impact. It guides the ‘assessor’ through five stages that begin with asking questions about the project (its context, purpose, and intended effects); a mapping and analysis of impact; through to deciding on future action. The mid-stage process of impact mapping is the most relevant to our discussion. It is possible to produce actual impact maps using: inputs; activities; outputs; outcomes and impacts (New Economics Foundation, 2010) (Table One).

*Insert Table One about here*

Because outputs, outcomes and impacts are often difficult to conceptualise and articulate, the impact mapping exercise is ideal for forcing clarity. At a basic level, inputs are the resources needed to manage a project, such as people, time and equipment and activities are the actions that constitute the project. Outputs are the direct results that may be in the form of publications or dissemination to stakeholders. Longer-term changes are captured in the form of outcomes and may for example relate to behaviour change or improved health outcomes. Impacts are the ‘big-picture change’ or the changes in the wider world map (New Economics Foundation, 2010). Box One shows an example of impact mapping relating to child protection research.

*Insert Box One about here*

Through this example we have attempted to show the application of social impact assessment to practice. Moreover, we have embedded this practice example within a strong theoretical base in order to emphasise the importance of social impact assessment.

## **Conclusions**

Although assessing social impact has gathered momentum in many third sector organisations, the public sector has been slower to turn to social impact as a means of measuring success. However, Wood and Leighton (2010) refer to the National Health Service Social Value Project being piloted in 2009/10 in eight areas in England. These projects are considering a range of outcomes such as: public engagement; understanding competing social values; reducing health inequalities; advocacy and ethics. Thus, it appears that there may be some movement towards an interest in social value.

Additionally, the new UK government proposes to develop a health service that is focused on outcomes. A new National Health Service (NHS) Outcomes Framework, due late 2010, will underpin this vision (Department of Health, 2010). A shift from a target driven political agenda to one that is outcomes-based, may align it more readily with the next step – assessing impact. It appears that nursing and healthcare may be moving in the right direction. There is an imperative for social impact that could usefully further illuminate and articulate the value of nursing research.

## **References**



Figure One: Impact to be Assessed (Higher Education Funding Council for England, 2009)

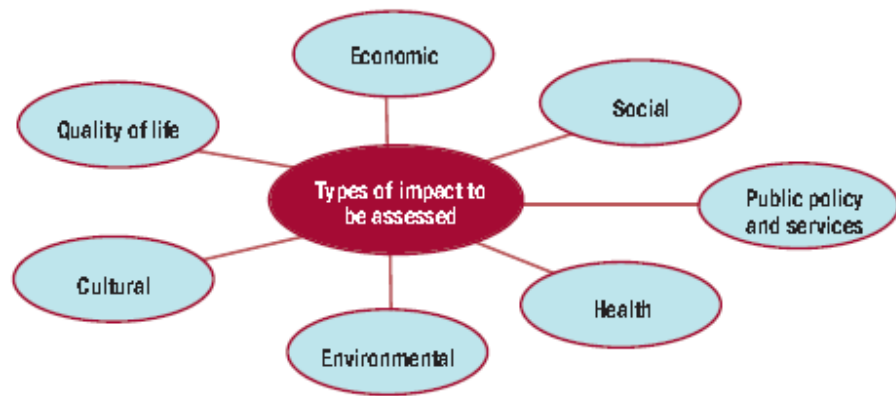


Table One: Elements of an impact map (Adapted from New Economics Foundation, 2010).

Inputs	Activities	Outputs	Outcomes	Impacts
<p>The <b>resources</b> needed to undertake the research</p> <p><i>For example, time, money, staff, overheads</i></p>	<p>The <b>things that you do</b> as part of the research</p> <p><i>Encompassing all aspects of the research process</i></p>	<p>The <b>direct results and beneficiaries</b></p> <p><i>Outputs are easy to count. The most obvious outputs are publications</i></p>	<p><b>Longer-term change.</b> Describes why the outputs are important and their implications for individuals, communities and practice</p> <p><i>This forms a link between theory and practice. This is the translational part of the research</i></p>	<p>Impacts are the <b>big-picture change</b> that relates to the wider world. A more precise definition of impacts is “<b>the outcomes less what would have happened anyway</b>”.</p> <p><i>For example, if 100 patients report improved health as the result of an intervention, how many would have improved anyway?</i></p>

Box One: Example of impact mapping relating to child protection research

For a research study into abuse in high risk families (*Activity*) to be meaningful, it needs to result in dissemination of findings to a wide audience (*Output*). Ideally the research should take a preventative, rather than a post-abuse approach (*Activity*) and would benefit from being multidisciplinary (*Inputs*). Complexity of the subject area makes it difficult to measure the success of the research, but it could result in a more co-ordinated assessment of families most at risk (*Outcome*) and more integrated support for such families (*Outcome*). In the long term if there is better assessment and support for enough high risk families, this will be associated with fewer children in care and less child deaths as a result of abuse (*Impact*). This could be associated with a gradual societal shift whereby the public takes a greater collective responsibility for protecting children (*Impact*).