1 Introduction: what counts as knowledge, whose knowledge counts? Towards authentic participatory enquiry

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The creation and use of knowledge are inherently the motivating force behind all research.

(Wallerstein and Duran 2003: 35)

Consumer involvement in health research is required in order to develop and incorporate compelling and different forms of knowledge; such knowledge cannot be considered to be knowledge or capable of incorporation without involvement; but involvement cannot proceed unless different kinds of knowledge come to be considered knowledge.

(Hodgson and Canvin 2005: 39)

As Hodgson and Canvin’s conundrum (2005) suggests, the answer to the question ‘What counts as knowledge, and whose knowledge counts?’ is crucial to realizing user participation in health and social care research. For if the creation and use of knowledge is the motivating force behind all research (Wallerstein and Duran 2003), then how we define what ‘counts’ as knowledge and whose knowledge we value, largely determine what we see as being the raison d’être for involving users in health and social care research. Addressing such concerns is far more than an academic exercise, for ‘user participation’ in its many forms impacts significantly on the lives and experiences of all those involved in health and social care, be they users or carers, practitioners, service providers, policy-makers or researchers.

The issues involved are complex and opinions often polarized, for user participation in research is still in its infancy (Hulatt and Lowes 2005), with many practical, ethical, moral, methodological and philosophical questions unanswered.
Despite this the political rhetoric, promoting the value of user participation is ‘unrelenting’. It is suggested that it currently occupies a ‘morally impervious’ position and is increasingly ‘resistant to criticism’ (Hodgson and Canvin 2005). Consequently, the inherent danger is that ‘user participation’ will join the ranks of ‘motherhood’ and ‘apple pie’.

Our aim in this book is to explore some of the contradictions and tensions that surround user participation in research, particularly whose voices are being heard (or silenced), what values drive the enterprise, and how we evaluate the processes and outcomes involved in order to know if we are doing ‘good work’ (Bradbury and Reason 2003). The bulk of the book comprises ten case studies providing accounts of differing approaches to user participation in research. These are diverse and vary considerably in their scope, ranging from the individual to the level of the community and the user group involved, including children, older people, people with dementia and their family carers, people with mental health problems and their family carers, and people with learning disabilities. We also include the voices of practitioners, as we see these as being ‘users’ of research with differing, but no less important, concerns and experiences. In several of these case studies users are co-authors, their voices being left to speak largely for themselves. In others, academic researchers have worked closely with users in ‘co-constructing’ an account, whereas in some the main voice is that of the academic researcher. Moreover, case studies come from several countries including the UK, USA, Sweden and Australia. We feel this diversity is a strength and a witness to the worldwide momentum for inclusivity in research design and conduct.

In this chapter we outline the emergence of user participation in research and then consider some of the literature and published accounts of the varying models of user involvement with a particular emphasis on whose voice is privileged and the way that knowledge is defined, the sorts of values that either implicitly or explicitly underpin user involvement in research, and, finally, we turn attention to how such efforts might be evaluated, with particular reference to an approach that some of us have been involved in co-creating and applying with older people in Sweden.

In the final chapter we distil the key messages emerging from the case studies, and provide a framework that might help others interested in user participation in research to do so in a considered and reflexive way.

**User participation: an idea whose time has come?**

Despite user participation in research being a relatively recent phenomenon (Hulatt and Lowes 2005), user participation in research is of relevance to health and social care systems throughout the Western world (Nicholson and Burr 2005). However, as Beresford (2005) suggests, it is not possible to
consider its impact fully without reference to the wider literature on user involvement more generally. We would go further and argue that three distinct but closely related trends help to inform an understanding of the issues currently surrounding user participation in research. These are:

- the emergence of participatory and emancipatory research approaches which preceded the current focus on user participation/involvement in service design and evaluation
- the political drive for greater user participation/involvement in health and social care
- the recent emphasis on evidence-based practice or evidence-based care.

Realization that the complex health and social care problems facing modern society could not be adequately addressed using an ‘outside expert’ approach to research saw the emergence of more participatory models in the 1950s and 1960s (Minkler and Wallerstein 2003). These have since diversified considerably and the ‘multiplicity’ of terms used can be daunting (Wallerstein and Duran 2003). However, there is agreement that such models are not simply about applying different methods, but rather represent differing ‘orientations to research’ (Minkler and Wallerstein 2003), sharing the common goal of forging closer connections between research, action and learning, and thereby raising questions about knowledge defined by whom, about whom, and for what purpose (Wallerstein and Duran 2003).

Whilst participatory research may share common goals, there is a continuum of participation, with studies primarily led by an outside researcher at one end, to truly emancipatory research at the other (Minkler and Wallerstein 2003). Driven by the disabled people’s movement, emancipatory research gained momentum in the 1960s and 1970s with the primary aim of empowering disadvantaged groups, both personally and politically (Beresford 2005). As will become apparent, emancipatory models continue to exert considerable influence on user participation in research by explicitly promoting user-controlled approaches.

The concept of greater user involvement in health and social care built on debates about empowerment in the 1980s (Beresford 2005) but gained greatest momentum in the 1990s (Hanley et al. 2004; Hodgson and Canvin 2005; Warren and Cook 2005). From a UK perspective the main driver was political (Hanley et al. 2004), forming part of new Labour’s modernization agenda (Warren and Cook 2005), with the initial emphasis being placed on the health service (Hodgson and Canvin 2005). The result was Labour’s vision for the ‘new NHS’ (DoH 1997), and developments such as the ‘expert patient’ initiative (DoH 2001a), whereby the knowledge and expertise of people living with long-term conditions were increasingly recognized as a valuable resource to
inform the development of better and more appropriate services. Further momentum was provided by a series of adverse events that resulted in the launch of the National Service Frameworks for Mental Health, Cardiovascular Disease and Older People’s Services (Hodgson and Canvin 2005). Subsequently the principles of user involvement and participation have rapidly influenced several areas including the education and training of professionals, the development of quality standards, occupational and professional practice, and user controlled services and support (Beresford 2005), but the emphasis on user participation in research has been a rather more recent development. Nevertheless, infrastructure to support such participation and guidance for researchers have been formalized in structures such as INVOLVE (Hanley et al. 2004). As a result of these initiatives the language of participation and partnership have become ‘part and parcel of social policy and provision’ (Humphries 2003).

The 1980s also saw the emergence of the evidence-based medicine (later evidence-based practice) movement, which originated in Canada (Jennings and Loan 2001) and arrived in the UK in the early 1990s (Rolfe 1999). This marked a shift in the rhetoric away from research-based practice and, in theory at least, signalled the acceptance of a broader view of what constitutes evidence (Rolfe 1999). However, in reality, research evidence still predominates, and the resultant hierarchy of evidence privileged one particular form of research, the Randomized Controlled Trial (RCT) (Kitson 2002; Grypdonck 2006) above all others. Therefore, although service users are considered by advocates of participatory research to be ‘active shapers’ of knowledge (Clough 2005), the reality remains different.

Indeed, commentators in the fields of both health (Kitson 2002) and social care (Humphries 2003) suggest that evidence-based practice is incompatible with other major ideological movements such as patient-centred health services (Kitson 2002), as the former is primarily a ‘practitioner engineered’ development serving practitioner interests (Humphries 2003). Therefore, despite the rhetoric of actively involving users in research, their role, it is claimed, remains largely confined to being sources of data (Kitson 2002; Humphries 2003).

Whilst Owen (2005) suggests that there are both tensions and convergences between user involvement and debates about evidence-based practice, Hodgson and Canvin (2005) are swingeing in their critique of user involvement, seeing it as little more than tokenistic. They argue, as have others (Owen 2005; Steel 2005), that users lack the ‘insider’ knowledge to truly participate in research, which is still dominated by the scientific method whose language, discourse and practice is alien to ‘lay’ people (Hodgson and Canvin 2005). Therefore, without a shared understanding of key principles and techniques, users are effectively excluded, and, consequently, the user involvement movement simply maintains the status quo (Hodgson and Canvin 2005). Beresford
(2005) contends that the ‘politics’ of knowledge creation are such that practice may never be truly evidence based, and in so doing he poses several very pertinent questions:

- Can user knowledge ever have equal status?
- What status does user knowledge have as evidence?
- How can we move from individual to collective knowledge?
- How can knowledge claims be resolved?
- Who is best placed to interpret the experience and knowledge of service users?

Such questions essentially raise issues to do with voice, power and control. It is to here that we now turn.

‘They who shout the loudest’

In the present context two issues capture the tensions within the user participation movement particularly well; these are to do with the level of participation that is seen as desirable and the increasingly contentious question of what ‘counts as evidence/knowledge’.

There is little consensus in the literature about the optimum level or degree of participation. Many commentators (Minkler and Wallerstein 2003; Hanley et al. 2004; Reed et al. 2004; Hulatt and Lowes 2005) suggest that a continuum exists ranging, for example, from the user as a source of data, through a partnership model, to users as independent researchers (Reed et al. 2004), or from consultation to collaboration to user-controlled research (Hanley et al. 2004). In thinking of respective roles for users and researchers Hulatt and Lowes (2005) suggest two continua as follows:

<table>
<thead>
<tr>
<th>User role</th>
<th>Subject</th>
<th>Partner</th>
<th>Investigator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Researcher role</td>
<td>Investigator</td>
<td>Partner</td>
<td>Mentor</td>
</tr>
</tbody>
</table>

In seeking to impose some order on the many models that exist, Beresford (2005) suggests that user participation falls into one of two broad categories:

- managerialist/consumerist – where the main goal is to modify/improve service systems with no real intention of redistributing power
- democratic – where the aim is to improve people’s lives, with the ultimate goal being emancipatory research whereby people are empowered to take greater control over their situation.
Minkler and Wallerstein (2003) suggest that emancipatory research should be the ‘gold standard’ and, in reviewing the literature on user involvement, Turner and Beresford (2005) conclude that users themselves make important distinctions between involvement and emancipatory approaches, with the former being viewed ‘unfavourably’ by users as they are seen to ‘embody inequalities of power which work to the disadvantage of service users’ (p. 3). The key question is one of control, with, for some, user controlled researcher being the only legitimate aim (Turner and Beresford 2005).

However, there is far from universal agreement with such a stance. Hanley et al. (2004), for example, argue that there is a place for consultation, collaboration and user control, with none being inherently superior to the other. Others go further and contend that privileging user-controlled research is itself potentially a form of oppression as it assumes that all users want to exercise this degree of control, when in fact there is evidence to suggest the opposite (Dewar 2005; Clough et al. 2006). Clough et al. (2006: 60) note that ‘important as power and control are to understand the research process, to judge the quality of older people’s involvement in research primarily in relation to these attributes runs the risk of missing other factors’.

Dewar (2005) is highly critical of the de facto assumption that empowerment is the ‘gold standard’, believing that more attention needs to be paid to reciprocity and shared learning in the process of user involvement in research and development. This sentiment is mirrored by Steel (2005: 21) as follows: ‘Ownership and empowerment need not always involve total control of a process. It can mean an interest, will and ability to participate and share control and responsibility with others for a mutual purpose. This is interdependence.’

Pawson et al. (2003) consider that one of the key questions is whether participation in research is really about user control or a full and equal partnership. Several authors talk about creating ‘real’ (Hulatt and Lowes 2005), ‘equal’ (Dewar 2005), ‘active’ (Hanley et al. 2004) or ‘collaborative’ (Marsh et al. 2005) partnerships between service users and researchers, based on mutual trust and respect (Reed 2005). Such partnerships are participatory (Humphries 2003) and involve users at all stages of the research process (Marsh et al. 2005), from design to dissemination. Partnerships result in ‘co-learning’ between users and researchers (Minkler and Wallerstein 2003; Faulkner 2004; Dewar 2005) by paying particular attention to the relational and social dimensions of working together (Bradbury and Reason 2003; Faulkner 2004; Morgan and Harris 2005). Within such a model participation is a defining characteristic of the ‘new world’ in which the quality of our ‘relational practices’ are a key consideration (Bradbury and Reason 2003). We return to the question of user control or relational partnerships in the concluding chapter.

The other dimension to ‘voice’ that we consider here concerns the nature and status of differing forms of evidence/knowledge.
What counts as knowledge?

The modernization of Britain’s health and social care services inevitably calls attention to the quality of the knowledge base than can underpin change and development. Research evidence forms a cornerstone of this knowledge base.

(Marsh et al. 2005: 1)

Philosophers have reflected on the nature of knowledge for centuries and researchers have long debated the role that differing types and levels of theory play in better understanding the world in which we live. Over the past 50 years or so various practice disciplines have entered the fray, challenging the supposed superiority of theoretical knowledge, promoting instead the value of practical, tacit and experiential forms of knowing (see, for example, Ryle 1949; Benner 1984; Schön 1987; Eraut 1994).

In the present context the most recent debates have been stimulated by the growing interest in evidence-based practice. As noted earlier, this was initially seen to mark a move towards a wider view of what comprises evidence (Rolfe 1999), but in reality traditional forms of scientific evidence generated using the techniques of the hard sciences, modified slightly to accommodate the less highly controlled settings of ‘real-world medicine’, still predominate. However, the emphasis now placed on greater involvement has once again challenged the ascendancy of certain types of knowing and called for a reconsideration of what constitutes knowledge (Fleming 2005; Hodgson and Canvin 2005; Morgan and Harris 2005) and how it is created and used (Wallerstein and Duran 2003).

This raises questions about the power and authority of the ‘scientist’ to define knowledge (Hodgson and Canvin 2005) and represents an implicit challenge both to universities (Bradbury and Reason 2003) and to professional knowledge and expertise (Stevens et al. 2005).

Within the field of health and social care both practitioner and user knowledge have traditionally been marginalized (Beresford 2005), but user involvement requires recognition of ‘consumer experts’ as authoritative voices (Hodgson and Canvin 2005), both about their own experience (Fleming 2005) and the use of that experience to contribute to theory-building (Hodgson and Canvin 2005). This requires that debates about the types and purpose of knowledge are not confined to the ‘institutions of normal science and academia’ (Bradbury and Reason 2003), with more attention being given to the creation of ‘living’ knowledge, whereby knowledge is seen as a verb rather than a noun (Bradbury and Reason 2003).

There are several typologies which characterize different forms of knowledge but two will serve our purpose here.
Based on their extensive work in the field of participatory action-based research Bradbury and Reason (2003) define four interdependent ways of knowing:

- **Experiential knowledge** – arising from direct encounters with the world.
- **Presentational knowledge** – growing out of experience and being concerned with how we ‘tell’ our story.
- **Propositional knowledge** – drawing on concepts, ideas and theories.
- **Practical knowledge** – which uses the above three to chart action in the world.

Therefore, whilst not undermining the importance of ‘conceptual’ knowledge, Bradbury and Reason (2003), as others, call for the widespread acceptance of differing ways of knowing (Merighi et al. 2005; Gould 2006), or ‘extended epistemologies’ (Bradbury and Reason 2003). Such debates are also increasingly apparent in the policy literature (see, for example, Pawson et al. 2003; Marsh et al. 2005), which gives wider recognition of all forms of research and calls for ‘citizens’ to be ‘directly involved in determining what sort of evidence should be sought, what research processes should be used, and what outcomes matter’ (Marsh et al. 2005: viii). Such approaches have no implied hierarchy of evidence but rather see differing types of knowledge as suiting differing purposes, so that we should not ‘privilege the viewpoints of any particular stakeholder or of any one strategy for generating knowledge. But neither should we assume that all standpoints are of equal merit on all occasions, on all issues, and for all purposes’ (Pawson et al. 2003: 3).

In their overview of the types of knowledge that should inform social care Marsh et al. (2005) draw on the work of Janet Lewis (2001) in suggesting that:

\[
\text{Knowledge} = \text{evidence} + \text{practitioner wisdom} + \text{service user and carer experiences and preferences}.
\]

They, however, note that research is of little use unless it is relevant, derives from practice concerns, and is potentially translatable into applicable ideas. They therefore add that:

\[
\text{Evidence} = \text{research findings} + \text{the interpretation of these findings}.
\]

For us this simple equation properly locates research findings as integral to, but not dominant over, other forms of knowledge.

Taking a slightly differing approach Pawson et al. (2003) analysed the varying ways that knowledge for social care policy and practice could be categorized, and concluded that it should be most usefully considered by its ‘source’. Five sources were identified:
Organizational knowledge – to do with governance and policies.
Practitioner knowledge – personal, context specific, often tacit.
User knowledge – first-hand experience and reflection, often unspoken and undervalued.
Research knowledge – the most ‘plausible’ source but requiring a ‘broad church’ interpretation of research.
Policy community – concerning societal and political drivers determining the issues of significance.

The point here is that none of the above ways of categorizing knowledge is necessarily ‘right’ or ‘better than’ the other. What is significant is that there is growing acceptance (in most, but by no means all, quarters) of a wider definition of knowledge, and at least some indication that Barnes’s (2002: 329) call to ‘transform the rules by which the game is played’ is being heeded.

What do we value?

Traditional ‘scientific’ research is viewed as being ‘value neutral’ with the researcher adopting a distant and detached stance. Such a viewpoint has long been seen as irrelevant to most researchers who adopt qualitative and participatory approaches. The subtitle to this book ‘voices, values and evaluation’ clearly indicates our position on this subject. User participation is obviously highly value-laden. However, as we have indicated, sometimes these values differ, particularly concerning the degree of involvement and the ‘value’ accorded to user-controlled research for instance. Despite such variation, Table 1.1 summarizes the range of values that commentators typically use when debating user participation. Such values should inform the way that user participation is evaluated, and it is here that we now turn.

How do we know we are doing ‘good work’? (Bradbury and Reason 2003)

The culture of the research community is generally one of academic rigour that is measured by the complexity and nuance of language, as well as ideas, and not its transparency and parsimony.

(Brehaut and Juzwishin 2005: 5)

Gauging the extent to which you are doing ‘good work’ depends in large measure on the purpose of the enterprise, a far from straightforward consideration in participatory research. Those who subscribe to a user-controlled model
view anything else ‘unfavourably’ (Turner and Beresford 2005), whilst some argue that user involvement is no more than tokenism (Hodgson and Canvin 2005). Others take a more measured stance and suggest that the characteristics of ‘good’ involvement comprise the following:

- the opportunity to have some influence and control
- the opportunity to take the lead and be proactive
- the opportunity to work in partnership with others
- to be clear about intended outcomes
- to have realistic expectations (Clough et al. 2006).

As noted earlier, several commentators suggest that at the very least user involvement should not be a ‘one-way street’ but rather as a process of ‘co-learning’ (Minkler and Wallerstein 2003; Faulkner 2004; Dewar 2005; Owen 2005), whereby everyone involved comes away with a differing perspective. In respect of user participation in health and social care research there should also be some ‘action’ taken, with the bottom line being improved services and/or experiences of services (Beresford 2005; Warren and Cook 2005) that potentially make a ‘discernable difference to people’s lives’ (Beresford 2005). Beyond this it is also suggested that user participation may lead to new theoretical understandings (Beresford 2005; Hodgson and Canvin 2005), which have the potential to result in change by stimulating action in the ‘overtly quietist’ tradition of knowledge generation (Bradbury and Reason 2003).

There is considerable debate about the need for specific ‘criteria’ by which to judge the outcomes of participatory research (see, for example, Bradbury

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### Table 1.1 Typical values informing user participation in research

<table>
<thead>
<tr>
<th>Minkler and Wallerstein 2003</th>
<th>Beresford 2005</th>
<th>Turner and Beresford 2005</th>
<th>Dewar 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
<td>Support to get people together</td>
<td>Empowerment</td>
<td>Equality</td>
</tr>
<tr>
<td>Cooperation</td>
<td>Equal opportunity to participate regardless of age, gender, race, disability, and so on</td>
<td>Emancipation</td>
<td>Fairness</td>
</tr>
<tr>
<td>Co-learning</td>
<td>Ensuring good access and support</td>
<td>Participation</td>
<td>Clear sense of purpose and roles</td>
</tr>
<tr>
<td></td>
<td>Addressing ethical issues</td>
<td>Equality</td>
<td>Commitment to learning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anti-discriminatory</td>
<td>Shared values and beliefs</td>
</tr>
</tbody>
</table>
and Reason 2003). But, as the quote above suggests, if criteria are to be applied then they need to be ‘transparent’, for one way in which voices can be controlled and power retained by certain groups is through the ‘complexity and nuance of language’ (Brehaut and Juzwishin 2005). Several commentators have argued that if users are genuinely to participate, then research must use more accessible concepts and language (Hodgson and Canvin 2005; Owen 2005; Steel 2005). Unfortunately even the writings of emancipatory researchers often effectively preclude full engagement by those who lack the relevant ‘insider knowledge’ (Hodgson and Canvin 2005): ‘It is important to develop accessible materials about user controlled research. From undertaking the literature review it becomes apparent that some of the writings on the subject can be as difficult to understand as literature on traditional research’ (Turner and Beresford 2005: 8). It was the desire to make the conduct and evaluation of participatory research more transparent and accessible that led to the development of the ÄldreVäst Sjuhärads Research Centre in Borås, Western Sweden (Magnusson et al. 2001; Nolan et al. 2003a).

ÄldreVäst Sjuhärads, established in 2001, is supported by the Department for Social Affairs for Sweden, by six municipalities in West Sweden (Bollebygd, Borås, Mark, Svenljunga, Tranemo and Ulricehamn), the county council of West Sweden and the University College of Borås. Its main aims are:

• to promote cooperation and partnerships in shaping the direction and quality of health and social care and medical treatment
• to enhance the sharing of perspectives and experiences between older people and their families, professionals, voluntary organizations, health and social care providers and researchers
• to increase the opportunities for older people and their families, together with professionals working with older people to initiate, participate in and evaluate new research-based interventions and service developments
• to raise the awareness and competence of care professionals to ensure the future quality of health and social care and medical treatment through their involvement in programmes of research, development and education.

In pursuing the above aims the research centre adopted a philosophy which sought to create an environment which facilitated a genuine dialogue between the ‘factual knowledge’ of service providers and the more ‘situated’ and ‘personal’ knowledge of those receiving services and participating in research (Barnes 1999). This decision was underpinned by the belief that there are many forms of ‘expertise’, with none being inherently superior to the other, but with each contributing to a fuller and more complete understanding (Magnusson et al. 2001).
One of the dilemmas the research centre faced was how to judge its effectiveness in order to know that we were ‘doing good work’ (Bradbury and Reason 2003). The ‘authenticity’ criteria proposed by Guba and Lincoln (1989) were attractive but there were concerns that they were not fully true to their own principles, for the manner in which they were presented, and particularly the language used, meant that they were neither accessible nor easily understandable to a non-academic audience. This seemed to belie the fundamental criterion of ‘fairness’ (Nolan et al. 2003a). Efforts were therefore made to see if these limitations could be overcome without losing the principles upon which the criteria were based.

**Authenticity criteria for constructivist research**

<table>
<thead>
<tr>
<th>Fairness</th>
<th>Are the voices of all the major interest groups heard (that is, are all their opinions listened to and valued)?</th>
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</thead>
<tbody>
<tr>
<td>Ontological authenticity</td>
<td>Does the study provide participants with new insights into their own situation?</td>
</tr>
<tr>
<td>Educatively authenticity</td>
<td>Does the study help participants to better understand the position of other interest groups?</td>
</tr>
<tr>
<td>Catalytic authenticity</td>
<td>Does the study stimulate or identify areas for change?</td>
</tr>
<tr>
<td>Tactical authenticity</td>
<td>Does the study facilitate, enable or empower change?</td>
</tr>
</tbody>
</table>

(After Guba and Lincoln 1989)

In developing the authenticity criteria further, the aim was, as far as possible, to present them in a way that could be understood by all those who might have an interest in using them. They were therefore modified and re-labelled using the terms below, each beginning with the letters EA:

<table>
<thead>
<tr>
<th>Original criteria</th>
<th>Renamed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairness</td>
<td>Equal Access</td>
</tr>
<tr>
<td>Ontological authenticity</td>
<td>Enhanced Awareness of the position/views of self/own group.</td>
</tr>
<tr>
<td>Educatively authenticity</td>
<td>Enhanced Awareness of the position/views of others.</td>
</tr>
<tr>
<td>Catalytic authenticity</td>
<td>Encouraging Action by providing a rationale or impetus for change.</td>
</tr>
<tr>
<td>Tactical authenticity</td>
<td>Enabling Action by providing the means to achieve, or potentially achieve, change.</td>
</tr>
</tbody>
</table>

(After Nolan et al. 2003a)
As will be seen, the original intention of the authenticity criteria remain largely unchanged but experience in applying them suggests that re-labelling has ensured that they now ‘speak to’ older people, family carers and practitioners, and potentially promote their more widespread usage. In other words, the criteria are now far more readily understandable and therefore should enable everyone to contribute more fully to informed debate about their relative merits (or otherwise) (Nolan et al. 2003a).

Furthermore, rather than applying the ‘authenticity’ criteria primarily to the interpersonal processes of research, as was their original intent (Rodwell 1998), at ÄldreVäst Sjughårad they are applied to all stages, as indicated in the matrix in Figure 1.1. This approach has served the centre well (see Hanson et al. 2006a) and is something we return to in the concluding chapter.

**Conclusion – where to from here?**

In setting the scene we have reflected on some of the issues concerning voices, values and evaluation that, for us, seem important in the context of participatory research. We now let other voices speak, in the form of ten case studies that describe very differing approaches to participatory research. Our original intention was for each case study to be followed by a commentary but, on reflection, this seemed unnecessarily intrusive as it is important to let you, the reader, reach your own conclusions. We therefore reserve our own thoughts for the concluding chapter, when we attempt to address some key questions needed to take the debate forward.