STATUTORY-VOLUNTARY COLLABORATION IN SERVICE PROVISION FOR ADULTS WITH DISABILITIES

A thesis submitted for the degree of

M Phil

in the

UNIVERSITY OF WALES

by

LLINOS JEHU BA (Hons) Dip RSA

SCHOOL OF BUSINESS

UNIVERSITY OF WALES

CARDIFF

January 1990

CONTENTS

Dedicated to the memory of

Trevor Smith

ACKNOWLEDGEMENTS

I would like to thank The Spastics Society for providing financial support, without which I would have been unable to embark on this study. In addition to this support, I would like to acknowledge the moral support, encouragement and advice which I received from many people within The Spastics Society, especially the late Trevor Smith.

Also, I would like to thank the service users, the representatives of voluntary organisations and the Directors and staff of the Social Services Departments in Cleveland, Manchester, South Glamorgan and Suffolk for their patience and willingness to answer my questions, fill in questionnaires and be interviewed. The large amounts of time which many people were willing to give is greatly appreciated.

I wish to thank my Supervisors, Professor Roger Mansfield of the School and Business, Cardiff and Dr Colin Palfrey of the Policy Studies Unit, Gwent for the patience, advice and guidance which they have given throughout the course of this study.

Finally I would like to thank my husband and daughter for the help and encouragement which they have given throughout the period of my undertaking this study, and for providing an incentive for me to complete it.

DECLARATION

I hereby declare that this dissertation is the result of my independent investigation and all other sources of information have been duly acknowledged in the text.

The work has not already been accepted in substance for any degree, and is not being concurrently submitted in candidature for any other degree.

.....

.....

I declare that this dissertation is the result of the candidate's own investigation.

.....

.....

I declare that this dissertation is the result of the candidate's own investigation.

.....

.....

SUMMARY

REASON FOR THE STUDY

The aim of this study was to examine the rationale for coordinating statutory and voluntary services by examining the nature and extent of collaboration between voluntary and statutory providers of services to adults with disabilities in a sample of local authority areas, and to consider whether and in what way this partnership affected the service provided. In order to do this is was necessary first to describe the origins and development of the voluntary and statutory sectors, and then to define what is meant by the voluntary and statutory sectors by describing the development of collaboration/ coordination in welfare policy, by discussing models of coordination, and by defining what is meant by community care. The study considered and proposed 4 models of management which would enable the coordination of community care services to take place.

FINDINGS AND IMPLICATIONS

Data was collected from the voluntary and statutory sectors, and from service users, through a series of interviews and questionnaires. In its summary of the data collected, the study notes the lack of knowledge held by the voluntary and statutory sectors concerning the people they aim to serve, and questions directing resources towards encouraging coordination when there appears to be such a shortage of actual services. Finally the study contains recommendations on action which the voluntary and statutory sectors need to make if a coordinated system of service provision is to be achieved.

CHAPTER ONE

REASON FOR THE STUDY

INTRODUCTION

The promise of a major review of Social Services in England and Wales by the Secretary of State for Health and Social Security in 1984 created both interest and activity in the voluntary sector. It was generally assumed that any changes would result in the voluntary sector being enabled to take a far more active role in the planning and provision of services. Two major voluntary organisation collaborative groups were established. The National Council for Voluntary Organisations set up a Joint Planning Working Group in 1985. In the same year the Voluntary Organisation Personal Social Services Group (VOPSS), a non-party consortium of over 30 voluntary organisations, was established to consider the effects of national economic policies on the provision of social services and in particular on the clients served by private, voluntary and statutory agencies.

The reason for this study was to examine the stated and, where appropriate, the unstated official rationale for coordinating statutory and voluntary services by examining the system and degree of any "partnership" between voluntary and statutory providers of services to adults with physical or mixed disabilities in a number of local authority areas. By comparing these with the size of the consumer group in the area, the amount of services provided, and where possible the opinions of the consumers about the services they received and their ability to live independently in the community, the study aimed to consider whether and to what extent this partnership affected the service provided. The research also aimed to establish whether any model of coordination was adopted in each sample area, and comparatively to measure the effectiveness of the models concerned.

In order to achieve these aims, four stages of data collection were carried out:

(1) Collecting data concerning the identity of the sample group.

(2) Collecting data concerning available services.

(3) Collecting data concerning the role which the voluntary sector takes in planning for and providing services.

(4) Collecting data concerning the sample group's knowledge and use of services.

This was carried out in order to establish the extent to which the sample group could be identified, to identify services and the role which the voluntary sector played in planning and providing them, and to measure the effect that the services, and the ways in which they were planned and provided, had on the sample group's ability to live in the community.

THE PRESENT GOVERNMENT'S INTEREST IN ENHANCING VOLUNTARY INVOLVEMENT IN SOCIAL WELFARE

Both the main political parties have advocated the encouragement of the voluntary sector as a means of ensuring that adequate services are provided. The 1979 Conservative Party Manifesto stated:

> "In the Community, we must do more to help people to help themselves and the family to look after their own. We must also encourage the voluntary movement and self help groups acting in partnership with statutory services."

"Involve", 1983, quoted Ken Livingstone as saying:

> "...voluntary organisations can often provide a better and more sensitive pattern of service than a local authority can. They can often respond much more quickly to need and be more innovating ... Similarly voluntary groups can generally work more cost-effectively than large bureaucracies and are more likely to involve the local community so that they can have a say in how services are provided."

Margaret Thatcher, in her speech to the WRVS Annual General Meeting in 1981 stated:

> "If we want a nation distinguished by the quality and depth of its life then we are asking for a nation distinguished by the quantity and range of its voluntary service."

The present government have continued this encouragement. The opening paragraph of the DHSS circular Voluntary Organisation Representation of Joint Consultative Committees, and the Extension of the Joint Finance Arrangements (1984) stated that "voluntary organisations have a valuable contribution to make to the development of health and personal social services ... Ministers wish to encourage the participation by voluntary organisations in the planning of these services". The DHSS circular Joint Care Planning: Health and Local Authorities (1977) states that "individuals well versed in the needs and care of mentally handicapped people may contribute to the Joint Care Planning Teams on some occasions, and those experienced in the needs and care of the elderly and others. Such members may be drawn not only

from officers of the NHS or of the Local Authority but also, for example, from voluntary organisations and consumer groups". The Report of the Working Group on Joint Planning, Progress in Partnership (1985), states "Authorities should work towards a constructive partnership to ensure that the statutory and voluntary facilities are dovetailed as far as possible".

The financial encouragement given by central and local government to voluntary organisations, together with the general economic decline of recent years which has affected the amount of voluntary donations received from individuals and grant giving corporations, has had a marked effect on the overall anticipated incomes of voluntary organisations. The Charities Aid Foundation's Charity Statistics (1987), show a gradual fall in levels of voluntary income, but a rise in income from fees and grants from central and local government. Recent calculations have estimated that the level of statutory sector support to the voluntary sector, taking into account tax

concessions and hidden support is between 3 billions and £4 billions annually (Morris, 1988). Research by the University of Kent Personal Social Services Research Unit shows that the income of the voluntary sector has grown steadily since the early 1970's, and that most of this growth has come from fees and charges for services to the statutory sector. The Research Report's figures show that the aggregate income of British voluntary organisations increased by 95.6% over the ten years to 1985-86. This included a real increase in fees and charges of 248%, an increase from 1/3 to nearly 2/3rds of the aggregate (net) income. The Report's account for this increase is that it is the result of increased government contracting with voluntary organisations. The Report points out that this increase in funding has resulted in some voluntary organisations having larger annual budgets than most social services departments. For example in 1986-87 the NSPCC spent £23 million on services, and the RNIB spent £30 million. The Report also found that grants to the voluntary sector from statutory

bodies increased by 192% in real terms between 1975-85, but that these still represented only a small part of their total income. The Report found that the overall public sector support to the voluntary sector was approximately £3.1billion each year, which represents around 7% of total government expenditure on goods and services.

In the period since 1984 the government and representatives from the voluntary sector have considered the viability of any "partnership" between the two groups and have made recommendations for change, such as the report Progress in Partnership (1985). The Joint Consultative Committee (Access to Information) Act 1986, which made meetings of Joint Consultative Committees, their Sub Committees and Joint Sub Committees, along with most of their papers, open to the public and the press should allow the voluntary sector to make full use of its representatives on these Committees. The National Council for Voluntary Organisations publish a quarterly newsletter for voluntary organisation

representatives on JCC's to help to educate them in the conundra of local government planning and consultation. Elections for new representatives were held in 1977-78, and local authorities, voluntary organisations and universities held training courses to enable new representatives and voluntary organisations generally to take a more professional role. Some local authorities have established posts for support officers to the voluntary sector representatives on JCC's in the hope of enhancing the voluntary sector's contribution to planning.

SUMMARY

Almost all government reports regarding community care have encouraged the development of a partnership between the voluntary and statutory sectors. Some community care legislation has made such a partnership not only desirable but integral to the success of the planning and implementation of the policies on a national and a local scale.

It is againt this background of general political consessus regarding the potential benefits of a close working relationship between the statutory and voluntary sectors that this study has been developed, in order to evaluate the extent to which such a desired social policy is enacted in practice.

REFERENCES

Audit Commission (1987), Report on Community Care, HMSO, London

Charities Aid Foundation (1986), Charity Statistics, London

Community Care Project (1985), Joint Care Planning - A Voluntary Sector View, NCVO, London

Conservative Party (1979), Conservative Party Manifesto, p 27, Conservative Party Office, London

DHSS (1977), Joint Care Planning, Health and Local Authorities

DHSS (1984), Voluntary Organisation Representation of Joint Consultative Committees, and the Extension of Joint Finance Arrangements

DHSS (1986), draft circular on joint planning, Collaboration between the NHS, Local Government and Voluntary Organisations

Fowler N, (October 1984), Speech to Joint Social Services Conference, Buxton

Griffiths R (1988), Community Care, agenda for action - A Report to the Secretary of State for Social Services, HMSO, London

Joint Planning Working Group (1985), Progress in Partnership, NCVO, London

Joint Planning Working Group (1986), A Stake in Planning: Joint Planning and the Voluntary Sector, NCVO, London

Leat D, Tester S and Unell J (1986), A Price Worth Paying? A study of the effects of government grant aid to voluntary organisations, Policy Studies Institute, London

Morris P (25 February 1988), "No Flesh on the Bones", Community Care, piii

NAHA/NCVO (1987), Partnerships in Health: NAHA/NCVO Joint Working Party Report, Birmingham

Voluntary Organisations Personal Social Services Group (1986), The Future of Social Services, VOPSS, London

CHAPTER TWO

THE DEVELOPMENT OF THE VOLUNTARY AND STATUTORY SECTORS

Victorian Philanthropy which blossomed in the middle of the nineteenth century, showed almost limitless benevolence. Almost every religious denomination had a "benevolent" fund to cater for its own poor, and would create additional temporary charities in times of economic distress. The income of charitable organisations in London in 1850 totalled £2,500,000. This amount, which does not include expenditure on charitable works by private individuals, was greater than that spent on the Poor Law in London during the same year. The rapid growth in numbers and size of charitable organisations resulted in inefficiency as there was a lack of knowledge of the needs and the nature of the people to whom this benevolence was directed. The historian F Green commented on the situation in the East End of London:

> "A hundred different agencies for the relief of distress are at work over the same ground, without concert of cooperation or the slightest information as to the other's exertions. The result is an unparalleled growth of imposition, mendicancy and sheer shameless pauperism."
> (De Schweinitz, 1942, from Fraser 1973, p142)

Charitable organisations were accused of leading the working classes to depend upon the bounty of others in times of need, encouraging them to become idle and improvident. They were "not public charities but public evils"(McCord 1958, from Fraser 1973, p 27)

The cause of this over zealous philanthropy which was, at face value at least, opposed to current laissez faire principles, was partly the result of a growing need of individuals to establish personal identity and purpose. The Industrial Revolution and the sudden growth of industrial based conurbations had swept away the social and

moral positions which had been endowed automatically on individuals under the feudal, agricultural society's system. There was a growing psychological and social need among people to obtain recognition in some sort of social order and this could be satisfied by being benevolent or charitable to those less fortunate. By accepting charity one group showed themselves to be less fortunate: the givers therefore must be more fortunate. Charitable giving also appeased the less fortunate and controlled the threat of social disorder, and was accepted as a sign of humanitarian concern for the suffering and so could be applauded. The Rev Joseph Townsend, who spoke so strongly against the Poor Law, felt that benevolence in the rich would induce "love, reverence and gratitude in the poor"(Bahmueller, 1981). Gratitude was a glue for social cohesion. It is difficult to reconcile Townsend's writings against the Poor law with those in favour of charitable works:

> "... nothing more beautiful than the mild complacency of benevolence, hastening to the humble cottage to relieve the wants of

> industry and virtue, to feed the hungry, to clothe the naked, and to soothe the sorrow of the widow with her tender orphans; nothing can be more pleasing, unless it be their sparkling eyes, their bursting tears, and their uplifted hands, the artless expression of unfeigned gratitude for unexpected favours."
> (Bahmueller, 1981)

The difference between aid received under the Poor Law and aid received from charitable organisations was that the latter aimed to improve the moral tone of the recipients. CS Loch described charity as a "social regenerator ... we have to use charity to create the power of self help"(Woodroffe, 1984).

There was recognition by various charitable organisations that some sort of coordination was necessary, and suggestions were made. The Charity Organisation Society was established in 1869. Its aim was to define proper areas of competence, to devise and execute scientific methods of social case work and to educate and reform the recipients of charity so that they may become once more independent, self respecting individuals. The early leaders of the Charity Organisation Society,

Charles Bosanquet, Edward Dennison, Octavia Hill and CS Lock, believed that all casework methods should be geared to the moral improvement of the poor. The Charity Organisation Society Annual Report of 1883 stated that the Society had no interest in the person whose "condition is due to improvidence or thriftlessness and there is no hope of being able to make him independent in the future"(Fraser 1973).

Most charitable organisations at this time had comparatively narrow and specific purposes. There were some national organisations, such as the YMCA founded in 1844, but their aim was to coordinate the work of locally established branches in order to cover the country with a network of services. The Charity Organisation Society was London based, and its coordinating work was mainly limited to trying to organise the great body of willing charitable workers. Its work on building a relationship between voluntary and statutory bodies was small.

The Royal Commission on the Poor Law and Relief of Distress (1834) produced two reports: The Minority Report which was predominantly the work of Sydney and Beatrice Webb, and The Majority Report which was signed by the Commission's Chairman, Lord George Hamilton, and 14 of its members including CS Loch, Helen Bosanquet and Octavia Hill from the Charity Organisation Society. The Majority Report envisaged all social services coming under the remit of the Public Assistance Committees, which were to make effective use of voluntary charities and casework agencies. In some respects the voluntary agencies were to act as a sieve through which only the really destitute would need to pass. The Report recommended that each county should have a Voluntary Aid Council, distinct and separate from the Public Assistance Authority, but associated with it by cross representation. The Voluntary Aid Councils would appoint Voluntary Aid Committees for each locality to work in parallel with the Public Assistance Committees. The Majority Report summed up by recommending:

> "... a general and intimate cooperation between the Poor Law and Charity, so as to give to the latter not merely the opportunity to cooperate, if it may, but the status and encouragement that may enable it to become both in town and country the responsible and competent fellow worker of the administrators of public assistance."
> (The Majority Report of the Royal Commission on the Poor Law, 1834)

Following the recommendation of the Report schemes could be submitted to the Charity Commissioners for approval, voluntary societies were encouraged to register on similar lines to Friendly Societies, and help and relief given by each group was to be noted on a mutual register.

Work had been started by some sections within the voluntary or charity movement to make suggestions of cooperation plausible. In 1904 the first Guild of Help had been formed in Bradford. Four-hundred and fifty volunteers had offered their services, enough to form 48 groups to cover most of the town. This Guild, which was made up predominantly of working class people, made a significant mark against the tradition of social service being good done by a favoured class to a devalued class.

Guilds of Help were established in other areas, culminating with the formation of the National Association of Guilds of Help in 1911. The Guilds made a new effort to form links with civic authorities, such as by stipulating that the town mayor should be president. In Birmingham aid committees which aimed to administer relief had been formed by progressive manufacturers. These joined to form the Civic Aid Society, and in 1906 they amalgamated with the Charity Organisation Society to form the City of Birmingham Aid Society. It established a firm basis for a scheme of mutual registration for the city's 300 charities. At the same time Thomas H Nunn, a Poor Law Guardian in London, formed the Council of Social Welfare which worked for the inter-relation of all voluntary schemes with the municipal and statutory services. However there was rivalry between Nunn, the Charity Organisation Society and the Guilds which was as unproductive as that between individual charities.

The British Institute of Social Services was

established in London in 1907, with aims "to promote civic, social and industrial betterment; to collect, register and disseminate information relating to all forms of social service in all parts of the world" (Fraser, 1973). Some level of coordination was attained in the north of England through the work of SP Grundy and FG D'Aeth. As a result of their work the Guilds of Help and the Charity Organisation Society met in Newcastle-upon-Tyne shortly before the outbreak of war in 1914; many difficulties were smoothed out and a hope for a further meeting was expressed.

The outbreak of war, for which the country was totally unprepared, created new social problems and needs. Within two years over 10,000 charities such as the Soldiers' and Sailors' Families Association were created. There was a desperate need for coordination of voluntary work and integration with government agencies. The Joint Committee on Social Services was created in 1915. Originally it was made up of representatives from the Charity Organisation Society, the Guilds of

Help and major charities, but soon these were joined by representatives from the Local Government Board, the Ministry of Pensions and the Charity Commissioners. The Joint Committee worked at coordinating voluntary effort throughout the War and in 1919 established the National Council for Social Services, which had the objective of promoting the systematic organisation of voluntary social work securing the coordination of voluntary organisations and cooperation with official agencies. Whilst the Royal Commission on the Poor Law had been strongly influenced by representatives from bodies such as the Charity Organisation Society, steps towards coordination or even rationalisation of the voluntary sector were now being influenced by statutory sector representatives. The National Council for Social Services received its income from the Guilds of Help, shared premises with the British Institute of Social Services and was even able to employ an Honorary Secretary. However its first President was JW Lowther KC MP and Speaker of the House of Commons, and it had very strong links with the

statutory sector generally.

In 1923 Sydney Webb's letter to the Prime Minister, Bonar Law, complaining of people failing to get provision because of gaps and imperfections in the coordination of government services resulted in an enquiry being set up. The Inquiry used prominent leaders from the voluntary sector, such as D'Aeth and Grundy, as witnesses, and the group had a considerable influence on the enquiry's unanimous recommendation:

> "That the central and local authorities concerned should promote the formation by voluntary efforts, in areas where such organisation seems desirable, of local councils of social service ... The existence of such councils would, we believe, be of great value in promoting the smooth administration of the public service of the country by bringing into close and systematic association persons engaged locally in administering public and voluntary assistance."
>
> (Brasnett M, 1969)

Throughout the mid-war period the role of the statutory and voluntary sectors became increasingly blurred. Much of the responsibility

for restoring the social stability which the War had destroyed was given to the voluntary sector, which started to engage in work aimed at enhancing the quality of life for people who were not paupers, destitute, crippled or insane. Increasingly, voluntary sector work was being carried out by people who were employed to do it, and in some cases the service provided was not an "alternative" or one which was generated as a response to a failure by the statutory sector to provide a service. These services were established by the voluntary sector through the encouragement of the statutory sector because the latter recognised a service need and felt that the voluntary sector was the more appropriate provider.

There was some opposition from the Labour Party and the Communist Party to the role which the voluntary sector was taking , especially in its use as a solution to unemployment. However the outbreak of the Second World War meant that the voluntary sector had to be relied on again to

provide services which the state could not treat as a priority. In 1940 the National Assistance Board, which was responsible for supplementary pensions for the elderly, sought assistance from the National Council for Social Service which resulted in the establishment of the Old People's Welfare Committee. In the years immediately following the War, when the basis for a British welfare state system was established, the voluntary sector included groups which had sole responsibility for supplying or coordinating certain services and it included people who saw themselves as professionals and who were employed to provide services. The relationship between the voluntary and statutory sectors might not have been described as a partnership, but each group was capable of having some influence over the other.

Soon after the end of the Second World War, the National Health Services and the National Insurance Acts of 1946 were both prepared and ratified by Parliament with an acceptance that the

Voluntary Sector would continue to play an important role in identifying and providing what were to become known as "social services". The Report by Sir William Beveridge on Social Insurance and Allied Services, published in 1942 noted that "The State in organising security should not stifle incentive, opportunity responsibility;... ". Beveridge's Report of 1948, Voluntary Action, which came after the passing of these two Acts, admitted "a need for political intervention to find new ways of fruitful cooperation between public authorities and voluntary agencies" and was presented as a contribution towards this end.

THE RELATIONSHIP OF THE VOLUNTARY AND STATUTORY SECTORS 1946 - 1979

The relationships between the public authorities and the voluntary agencies has changed since the introduction of the Welfare State. This has been partly because Beveridge's Report Voluntary Action and subsequent attempts to define a method of cooperation between the two groups have been unsuccessful. The main factor unifying voluntary organisations continues to be that they are not statutory organisations. As such they continue to assess and manage as individuals their relationships with other agencies, both statutory and voluntary. Beveridge stated that voluntary action "is needed to pioneer ahead of the State and make experiments". However by 1948 much of the work which could be described as "pioneering" had been completed, or had been transferred to or was funded by the statutory sector. Most pioneering work during the 10-15 years following the end of the Second World War arose from the discovery of neglected groups, as with the

formation of The Spastics Society in 1952, or the improvement of methods of service provision which were already accepted by both the voluntary and the statutory sectors.

In its Introduction the Report of the Wolfenden Committee (1978) suggests that during this period voluntary agencies generally "seem in some ways to have been marking time". The Report goes on to note significant developments within the voluntary sector from the 1950's onwards:

> "These included (a) a reorientation of some service organisations to differentiate their contribution from that of statutory agencies (eg the provision of specialist services, not available in the statutory sector, by Barnardo's and the Church of England Children's Society), (b) the rapid growth of pressure group organisations, seeking to change government policy (eg Shelter, Disablement Income Group, Child Poverty Action Group), (c) the growing mutual help groups in fields from preschool play to the drug addict and the single parent family, (d) the growth of coordinating bodies at local and national level, and (e) the increasing encouragement of voluntary organisations by local and central government, including most recently the Voluntary Services Unit, through grant aid."

The development coincided with changes being made within the Welfare State. During the 15 years immediately following the introduction of the Welfare State, services for the elderly and for people with physical or mental disabilities were provided by local health and welfare departments. The system of organisation of these services resulted in their becoming increasingly unapproachable and bureaucratic. Also their division into "specialist" sections resulted in client groups receiving services in isolation from and without consideration for other factors affecting the consumer or the cause of the handicap. The Younghusband Report of the Working Party on Social Workers in the Local Authority Health and Welfare Service (1959) gave impetus to an increase in supply of trained social workers during the first part of the 1960's. This increase enabled greater attention to be paid to the needs of elderly and handicapped adults. The Development of Community Care - Plans for the Health and Welfare Services of the Local Authorities of England and Wales, which was

presented to parliament in April 1963, was one of the first actions by the newly elected Labour government to consider a change in the system of service provision. This movement culminated with the work of the Family Service Committee (1965-68)(10), commonly known as the Personal Social Services Committee, chaired by Frederic Seebohm; and led to the creation of Local Authority Social Services Departments in 1971. These changes had an effect on how statutory and voluntary service providers functioned, as individual organisations and in relation to each other. The change is apparent in the concluding paragraph of the Wolfenden Report:

> "We repeat and underline the appeal we have made to the voluntary organisations to maintain, improve and extend the vital contribution which they are making to the pluralistic system of social provision. By the same token we address an appeal to the government, as the central strategic makers of social policy. It is for them to take, urgently, the initiative in working out, with the variety of agencies which are now operative in this field, a collaborative social plan which will make the optimum and maximum use of resources."

Suggestions of involvement, participation and of a "partnership" between the Voluntary and Statutory sectors are made in the Report. Moreover, these suggestions are not made on the understanding that such a partnership would improve an already acceptable service, but on the basis that failure to do so would result in an "inadequate provision of help to our fellow citizens who need it" (Wolfenden, 1978) .

Over 30 years after the introduction of a National Health Service and National Insurance for everyone, and even after the introduction of Social Services Departments which were proposed in order for services to be "directed to the wellbeing of the whole community and not only of social casualties"(Local Authority Social Services Act, 1970) , the Wolfenden Committee questioned the ability of the State to provide such services and saw the contribution of the voluntary sector as essential.

THE RELATIONSHIP OF THE VOLUNTARY AND STATUTORY SECTORS SINCE 1979

As outlined in Chapter 1, since the present government came into office in 1979 the moral and the financial support given by statutory bodies to the voluntary sector has increased substantially. Concern that a potential dependence on income from government sources may cause the voluntary Sector to lose its independence has grown in relation to this. Maria Brenton (1985) accused voluntary organisations of being "flowers in the government's window box". Brenton argued that by giving grants the government can be seen to be doing something but it does not need to become too involved, has no long-term commitments, and is possibly saving money as well.

The present government's view of the role which voluntary organisations should take is ambiguous, and the Charity Law is long overdue for reform. In an attempt to clarify the position, Timothy Raison, the then Minister of State for the Home

Office, stated that charities can "pursue political activities provided that they are ancillary to their charitable purposes and are kept in due subordination to them"(Speech to Northampton CVO AGM, 10 July 1981). The proper limits of such activity were defined as "not.. campaigning for (or against) change". One interpretation of this could be that voluntary organisations can give to the poor but may not try to prevent poverty, and such action could result in a loss of funding to do anything. A study of the effects of government grant aid to voluntary organisations in four local authority areas, carried out by Leat, Tester and Unell of the Policy Studies Institute in 1986 found that:

> "Organisations receiving higher levels of aid are more likely to perceive loss of independence as a disadvantage of such aid. (authors' underlining)
>
> Organisations receiving higher levels of statutory funding are more likely to take the availability of funds into account in planning their work. But whereas in the outer London Boroughs statutory funding influences with (existing) priorities are translated into activity, in the shire counties funding actually shaped the priorities of the organisation"
>
> (Leat et al, 1986)

Clare Short, Labour MP for Birmingham Ladywood, summed up the fears for the independence of the voluntary sector, and the effect which the rise in government funding might have on it:

> "The voluntary sector must reassess how it can best advance the causes of the people it stands for. Sometimes this will mean not walking in as a substitute and inadequate replacement and not accepting every financial inducement offered by the government."(Involve, November 1983)

Despite the verbal, and to some extent practical encouragement given to the voluntary sector, there is scepticism about the effect that this has had on enabling statutory and voluntary bodies to work as partners, and there is scepticism about the effect that this has on the services received. The report of the National Council for Voluntary Organisations Joint Planning Working Group, A Stake in Planning notes that many problems are still being caused in joint planning initiatives because of the inherent differences between Health and Local Authorities, such as structural, geographical and financial. The Report also notes that many voluntary organisations are not

contributing to the planning at present due to a lack of willingness to coordinate their efforts:

> "Working more closely together on planning will require an acceptance that the value of doing so outweighs the difficulties created by the very different structure of voluntary and statutory sectors".
> (Joint Planning Working Group, 1986)

The Report indicates that many Joint Consultative Committees view voluntary sector representatives as token members of the group, agendas for meetings being sent out too late for the representatives to discuss matters with other voluntary organisations and discussions for many items having taken place before the meetings, so that the JCC is effectively only a rubber stamping committee not a forum for debate on what decisions should be made.

Increasingly, voluntary organisations are receiving funding and support from a variety of public agencies. This has generally been regarded as a cause for increased bureaucratisation as the costs of obtaining, receiving and accounting for

public support can become burdensome (Knapp et al, 1987). Arguments regarding the advantages of multiplicity of funding sources show that whilst the administrative burden tended to be greater when an organisation received funding from more than one public sector agency, a multiplicity of funding sources may be less threatening to an organisation's authority (Knapp et al, 1987).

The Report of the Audit Commission was critical of the relationship between the voluntary sector and the statutory sector for its mutual lack of knowledge, understanding and consequent ability to allow either group to influence the other. However, it has been suggested (Morris, 1987)) that the financial incentives for the voluntary sector to cooperate with the statutory sector are so great that the Secretary of State's promised Green Paper on coordination of the two sectors is no longer necessary. The principle of social services departments acting as the coordinating core of a range of private and voluntary provision in any local authority area is happening by a

process of natural evolution. The argument of Manser (Manser, 1974), that "an agency's freedom and effectiveness in social action or advocacy are in inverse proportion to the amount of public money it receives", might have some significance.

In its Conclusion, the Griffiths Report Community Care: Agenda for Action (1988) states that "The opportunity exists to create a partnership in the delivery of care ... between government and the private and voluntary sectors". The Conclusion also states that "merely to tinker with the present system (of community care) would not address the central issues and would forego the benefits that could be obtained from more concentrated action".

The Griffiths Report, like many previous reports on community care, for example the Barclay Report (1982), saw advantages in such a coordinated approach. The voluntary sector (referred to in the Report as "not-for profit bodies") could provide services as does the statutory sector but

could also act in other ways such as organising self-help groups, providing a source of information and/or expertise, providing befriending or advocacy agencies, constructively criticising service providers, and acting in the capacity of public educator, campaigner and pilot of new approaches to services. However, the Griffiths Report also recommended that such a coordinated approach sould employ clear objectives and use identifiable and quantifiable resources. These recommendations aimed to substitute "for the discredited refuge of imploring collaboration and exhorting action a new requirement that collaboration and action are present normally as a condition for grant".

REFERENCES

Audit Commission (1987), Report on Community Care, HMSO, London

Bahmueller CR (1981), The National Charity Company, University of Californai Press

Barclay Report (1982), Social Workers; their role and tasks, Bedford Square Press for National Institute of Social Work

Lord Beveridge and Wells AF ed (1949), The Evidence for Voluntary Action, Blackfriars Press Ltd, Leicester

Brasnett M (1969), Voluntary Social Action. NCSS, London

Brenton M (1985), The Voluntary Sector in British Social Services, Longman

Fraser D (1973), Evolution of the British Welfare State, The Macmillan Press Ltd, London

Griffiths R (1988), Community Care, agenda for action - A Report to the Secretary of State for Social Services, HMSO, London

Joint Planning Working Group (1986), A Stake in Planning: Joint Planning and the Voluntary Sector, NCVO, London

Knapp M, Roberson E, Thomason C (May 1987), "Public Money, Voluntary Action: Whose Welfare?", Discussion Paper 514, University of Kent

Leat D, Tester S and Unell J (1986), A Price Worth Paying? A study of the effects of government grant aid to voluntary organisations, Policy Studies Institute, London

Local Authority Social Services Act, 1970, HMSO, London

The Majority Report of the Royal Commission on the Poor Law, first published 1984, Pelican Books edition 1974

Manser G (1974), "Further thoughts on Purchase of Service", Social Casework, no 55, p 421-474

Ministry of Health (1963), The Development of Community Care - Plans for the Health and Welfare Services of the Local Authorities of England and Wales

Morris P (25 February 1988), "No Flesh on the Bones", Community Care, p iii

Seebohm Report (1968), Report of the Committee on Local Authorities and Allied Personal Social Services, CMND 3703, HMSO, London

Short C (November 1983), published interview Involve, no 28

Raison T (10 July 1981), speech to Northampton CVO AGM, Northampton CVO, Wardington Court, Northampton

Wolfenden Committee Report (1978), The Future of Voluntary Organisations, Joseph Rowntree Memorial Trust and the Carnegie UK Trust, Croom Helm Ltd, London

Woodroffe (27 September 1984), "From Charity to Social Work", Charity Organisation Reporter, p 27

Younghusband Report (1959), Report of the Working Party on Social Workers in the Local Authority health and Welfare Services, HMSO, London

CHAPTER THREE

MODELS OF COORDINATION AND KEY CONCEPTS

DEFINITION OF VOLUNTARY SECTOR

Although literature concerning the voluntary or charity sector is plentiful, there have been very few attempts to define this sector or place it into any sort of perspective. Probably the most recent definition of the voluntary sector was given by the Wolfenden Committee in 1978
Their report defined four systems of social helping; the informal system, the commercial system, the statutory system and the voluntary system. Under this definition the informal system covered people who carried out work for the common good on a purely voluntary, unpaid basis, such as friends, neighbours or relatives of an individual requiring assistance. The voluntary system, whilst separate from the commercial and statutory

systems, would include those individuals who could be included in the informal system, but also professional service providers, such as administrators, social workers or doctors who would receive payment for their services if their controlling body was outside of the commercial or statutory systems.

For the purpose of this study, the voluntary sector is taken to include all non-profit making service-providing organisations or individuals which/who are not controlled directly by a statutory or commercial agency. Therefore organisations such as MIND, The Spastics Society or Barnardos which include service providers who receive remuneration for providing services would be included, even though such individuals are acting for personal gain. Organisations or individuals which ask for payment from a service user, or his/her guardian or local authority for providing a service, such as the John Grooms organisation which provides residential accommodation, would also be included if this fee

did not prohibit the service provider from registering as a charity under current legislation.

DEFINITION OF STATUTORY SECTOR

For the purpose of this study, the statutory sector is taken to include all service-providing agencies which are controlled and funded by the government, for example: Local Authority Departments and Health Authorities.

COORDINATION AND COLLABORATION AS ASPECTS OF WELFARE POLICY

Beveridge, in his highly influential report on the then current system of social insurance (Beveridge 1942), identified five areas of social need: idleness, squalor, ignorance, want and disease. The government policies introduced in 1946-48 as a

result of this report sought to address these individually, and consequently Ministries of National Insurance, Labour, Housing, Education and Health were established as autonomous units which acted independently of each other. The separatist nature of welfare policy was developed further through legislation. The National Health Service Act 1946 introduced a tripartite structure of administration for hospitals, medical services, and local authority health and welfare services. This resulted in health service becoming increasingly fragmented. In pregnancy, for example, a woman would have contact with a midwife who reported to the local authority, a GP who reported to an Executive Council made up of professionals and volunteers, and with a consultant who reported to the Regional Hospital Board. The National Assistance Act 1948 gave local authorities responsibility for the residential care of destitute people, but not financial care; and the Childrens Act 1948 also divided responsibility for the care of children.

This somewhat fragmented approach to welfare policy caused many inadequacies and inefficiencies. It was wasteful of time, and many other resources for a person's needs to be dealt with by a variety of professionals spread over a number of departments which had little contact with each other.Consequently within 20 years of the establishment of the Welfare State, recommendations were being made and action taken towards introducing a system of service provision which encouraged collaboration between service providers. The South East Study of 1961-81, and the North West Joint Planning Team Strategic Plan for the North West of 1974 are examples of coordinated plans by the Ministries of Housing and Local Government, Labour, Agriculture Food and Fisheries, Transport, and the Board of Trade.

The structure of the personal social services expanded greatly after 1948, and further powers and duties were given to local authorities by the Mental Health Act 1959 and the Children and Young Persons Act 1963. A series of committees were

established to examine individual parts of the service, such as the Guillebaud Committee on the Cost of the NHS 1956, the Royal Commission of the Law Relating of Mental Illness and Mental Deficiency 1957, the Albermarle Committee on the Youth Service 1958, the Younghusband Working Party on Social Workers in the Local Authority Health and Welfare Services 1959 and the Ingleby Committee on Children and Young Persons 1960. The Younghusband and Ingleby Reports highlighted the need for increased collaboration between local authority services and the Ingleby Report suggested a possible need to reorganise the services.

The Report of the Committee on Local Authorities and Allied Personal Social Services 1968, commonly known as the Seebohm Report recommended the introduction of Local Authority Social Services Departments which would provide a "community based and family oriented service, which will be available to all". The Report noted that "coordination between the various social agencies

is considered deficient, with the result that families and individuals have received less than adequate services and scarce resources have been inefficiently deployed" (Seebohm, 1968). The establishment of Social Services Departments aimed to alleviate this problem.

Since the introduction of Social Services Departments in 1974, further steps have been taken to establish coordinating systems between local authorities and health authorities, housing departments and with the private and voluntary sectors. Following the DHSS Report Priorities of the Health and Personal Social Services in 1976 various pieces of legislation have been passed to facilitate joint responsibility for planning the transfer of services such as residential and day care from health to local authorities, and to enable financial commitments to be shared. In 1984 the Department of Health and Social Security Circular Voluntary Organisation representation on Joint Consultative Committees and Extension of the Joint Finance Arrangements enabled the voluntary

sector to take some role in planning services with these two statutory bodies.

The structure of service providing agencies changed partly in response to the move from separatist towards collaborative policies. Both the health and local authorities had been based on hierarchical, bureaucratic models of management, but with the introduction of collaborative policies there were attempts to establish models which were non-hierarchical and aimed to be responsive to need and internally democratic. Many local authorities introduced "Patch" systems (Hadley & McGrath, 1984) which were multi-disciplinary. In some areas, such as South Glamorgan, these have been expanded to include personnel from health authorities as well as local authorities. However, as noted by Billis et al (1980), these have continued to retain a hierarchical model as their base. Consequently, in order to pursue collaborative policies systems of management have emerged which combine both hierarchical and collaborative models.

Multi-disciplinary teams have team leaders, following the hierarchical model, but there can be problems clarifying their hierarchical role and managerial responsibility in that it is difficult to define the extent to which a person is accountable for the work of his/her counterparts.

This combination of hierarchical and non-hierarchical models and the consequent lack of definition of accountability is prominent throughout the attempts which have been made to establish collaborative policies, both within local authorities and between local authorities and other service providers. However, whilst advocating collaboration, no legislation or government report has indicated how a collaborative approach to service provision is to be achieved. The recommendations of the Griffiths Report (1988) stated that "joint local planning and action will continue to be essential, ..", and that "Authorities should have powers to enable them to undertake joint action, or to act as agents for each other". The Report also

recommended that the adequacy of arrangements for joint planning should be "a central area for scrutiny as part of the conditions for grant".

DEFINITIONS OF COMMUNITY CARE

(1) "COMMUNITY CARE" WELFARE POLICY

National policy over the past 30 years has emphasised the desirability of diverting care for most handicapped groups, such as the elderly, the chronically sick and the physically and mentally incapacitated from large residential establishments into the community. Over the past decade this policy has gained impetus, in part because of the present government's advocacy of the notion of "self help" and its

consequent placing of financial restraints on the public services sector, and in part because of the tradition within personal social services work of placing higher status on work carried out outside residential settings. However the concept of "community care" has not been well developed (4), and it remains impossible to determine the level to which such policies are proposing that care should be provided in the community rather than by the community.

Even before the 1914-18 War, the Local Government Boards had made recommendations that workhouses should be replaced by "more homely" accommodation (5). The Royal Commission on Lunacy and Mental Disorder, 1924-26, called for the appointment of almoners (medical social workers) to keep families together and to give assistance to patients and their families.

After 1946 there was a conscious and determined move by all statutory authorities concerned with providing care away from the harsh, separatist services traditionally associated with the Poor Law. The Curtis Committee, 1946, recommended that a preference be given to the care of children in private homes or small group homes. The Children Act. 1948, established this principle and similar legislation for the mentally handicapped and elderly soon followed. The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1957, recommended a shift in emphasis away from hospital care to community care. This was the first use of the term "community care" in official literature, and it was defined to cover:

> "all forms of care (including residential care) which it is appropriate for local health or welfare authorities to provide"(p208)

The Mental Handicap Act 1959, was to establish a comprehensive community care service to meet the needs of mentally handicapped people not requiring hospital treatment. At the same time the Ministry of Health stated:

> "one of the main principles which we are seeking to prove is the reorientation of the mental handicap services away from institutional care towards care in the community"
> (House of Commons, 1959, col 719)

The Ministry of Health also issued a report A Hospital Plan for England and Wales in 1962 which announced increased spending on hospital services "complementary to the expected development of the services for prevention and for care in the community". Successive statements have been made, outlining a commitment to community care and what it is meant to entail. Priorities for Health and Personal Social Services, a report published by the Department of Health and

Social Security in 1976, repeated the aim "to help people live an independent life in their own homes as long as possible". However, no attempt had been or was being made to identify how this was to take place, or to specify who was to be involved. This lack of precision is exemplified in the definition of community care given by the DHSS in 1977:

> "In this document, the term 'community' covers a whole range of provision, including hospitals, hostels, day hospitals, residential homes, day centres and domiciliary support. The term 'community care' embraces primary health care and all the above services, whether provided by health authorities, local authorities, independent contractors, voluntary bodies, community self-help or family and friends."
>
> (DHSS, 1977, Joint Care Planning, Health and Local Authorities)

Possibly the most accurate definition of Community Care as a policy was made in the Barclay Report of 1982:

> "a very general trend away from centralism and towards a belief in ordinary people"

Community care policies have been, and continue to be unspecific. In an article "Why is community care so popular?" White argued that the acceptance of community care as a policy was due to the collapse of the paternalistic, colonial "treatment" or "medical" model as a base of case provision. Community care policies complemented a change in philosophy from treatment to care (White, 1987). White went on to argue that the old institutions were representative of a certain moral base; it is worth noting that even today most long-term psychiatric and mental handicap hospitals are in buildings which were originally workhouses. In contrast

to this, White argued that community care policies have no moral base, they represent no values or norms. As there is no commitment to one idea, there are many different models. White believed that community care policies were popular because by avoiding being specific they united people against institutionalisation and incarceration.

Community care policies have been criticised for the same reasons as they have been applauded. Some have felt a danger that the unclear objectives which lead a move away from rather than towards something have the potential to result in any service which is not an institution being valued simply because it is not an institution. This in turn could lead to further problems of staff from institutions feeling undervalued, and service users having no clear outline of

what they are entitled, just what they can not have(Tyne, 1982).

Wilmott and Thomas (1984) outlined eight objectives which community care policies should aim to achieve:

(1) effective delivery of service

(2) link formal and informal care

(3) devolve power and develop consultation

(4) improve the local environment and collective welfare

(5) help people develop their capacities

(6) develop a pluralistic society

(7) develop political education

(8) develop a sense of community

Historically the government has taken little action to ensure that such or similar objectives were set or achieved. In fact very little attempt has ever been made even to define and measure the need for community care, let alone set goals

for achieving it. Figures presented by the Ministry of Health in 1963 forecast a rise in local authority spending on home helps between 1962-72 of 45%, whilst the forecasted rise in spending on residential staff was put at 87%. Thus at a time when statutory services were stating a commitment to community care in principle, in financial terms it was not a priority. This dichotomy has continued. The Seebohm Report (1968) and the White Paper Better Services for the Mentally Handicapped (1971)confirmed a commitment to community care but did not propose a strategy and presented public opinion and resource constraints as major barriers to its achievement.

Financial restraints, or incentives, have been the main influence on the formation and implementation of community care policies. The introduction of joint finance arrangements between health and

local authorities in 1976 coincided with a reduction in expenditure growth. Although new guidelines were introduced in 1981 which enabled health authorities to joint fund community care projects for a total of 13 years, local authorities still have to be content with having to work within a limited budget. The terms of reference of the Griffiths Report (1988) were "to review the way in which public funds are used to support community care policy and to advise...action that would improve the use of thes funds as a contribution to more effective community care". The Secretary of State did not ask for consideration of improvements which called for an increase in funds. The White Paper Caring for People (1989), places responsibility on local authorities to "explore ways of further stimulating private and voluntary provision of domicilary, day and respite care wherever possible ...to stimulate the setting up of

'not for profit' agencies and the development of new voluntary activity". However the White Paper does not give guidance as to how this stimulation is to be achieved. Neither does the White Paper recognise that an increase in local authority resources will be needed if these authorities are to coordinate the delivery of a high-quality, consumer-sensitive package of care to individuals living in their own homes by a collection of multi-discipline, multi-agency personnel.

The Fourth Report from the Social Services Committee (1985-86) Public Expenditure on the Social Services estimated that by 1987 expenditure by the Health Service would still be almost six times that spent by central and local government on personal social services (£15,642 million and £2,614 million respectively). Whilst NHS spending on personal social services grew

in cost terms by 9.5% from 1908/81 - 1984/85, in the same period only 15% of all local authorities increased their spending on personal social services by more than 5%, 58% increased spending by less than 5%, and 27% actually decreased their expenditure. Financial resources for meeting the needs of people cared for in the community are diminishing rather than increasing in line with the increase in the number of people requiring such care.

(2) COMMUNITY CARE AND SUPPORT NETWORKS

The word "community" is described by Raymond Williams (1976) as a "warmly persuasive word ... it seems never to be used unfavourably". Willmott and Thomas (1984) describe various types of communities: groups with a common interest; an area, territory or physical proximity. Community sense is reflected in common feelings, sentiments, social networks and patterns of behaviour.

The principle of community is not apparent in community care policies. The practice of labelling client groups, such as "people with challenging behaviour", or "EMI's" (Elderly Mentally Infirm)has continued and been transferred to community care policy use. For clients moving into the community this has resulted in their continuing to use social networks and patterns of behaviour which

are alien to the community into which they have moved, such as by turning to a social worker rather than a neighbour for advice, or attending an Adult Training Centre rather than a place of paid employment during the day. Thus, despite local proximity, the people themselves remain alien to the community. It has been argued that unless current professionally based structures are dismantled completely community care will only ever be able to substitute large institutions with smaller ones.

The majority of people who require some form of care have always lived in the community. However, this need itself alienates them and their families from their community if only because of the change in interests, social networks and patterns of behaviour which this need causes. Research into community behaviour (Wilmott, 1986) has found a vast

difference in the amount of care carried out by even very close relations Commonly a mother will carry out the majority of the caring work, siblings far less, and relations such as cousins often none. Whilst there might be a strong sense of obligation in modern society to care for others, in practical terms this is extremely limited. The 1985 Select Committee Report noted:

> "there is no evidence of any involvement by the wider community - friends, volunteers, neighbours or even extended family members - in providing any of the care which is needed from day to day."

Community care policies have continued to maintain institutions, such as long stay hospitals or residential establishments housing over six people, where many have to share one room. People have continued to be segregated into different groups according to clinical traditions; a reflection of professional interests

rather than "community" principles. The 1971 White Paper Better Services for the Mentally Handicapped compromised due to pressure from professional groups and agreed that some people would always need institutions, resulting in a fundamental division of policies. The government recognised this in its paper Mental Handicap, Progress, Problems and Priorities:

> "It is difficult to reconcile a policy of providing services (for mentally handicapped people) with the perpetuation of existing large hospitals, ... joint funding is not by itself enough to bring about a major switch in the balance between health and social services."

To conclude, although community care as a principle has been accepted for many years, policies have been largely undefined and primarily influenced by financial and professional rather than community interests. There has never been

any financial incentive to support the development of informal care, and decentralist policies have carved up areas with no real knowledge of how communities, rather than postal districts, are divided.

(3) CARE IN OR BY THE COMMUNITY

There are an increasing number of people, both professionals and service users, calling into question the assumption that community care policies automatically result in improvements of service. No effective "community audit" has been devised, and indeed it is difficult to imagine a system for evaluating the time, labour, training, stress, emotions and care which community care policies require. However, recommendations on what a community care policy should contain

> have been made (Webb & Wistow, 1988). Whether the policy's aim is to provide care in or by the community, issues such as the capacity of the community to care - the state of its housing, employment, community resources - the orientation of professional values, the ability of a policy to support different types of family situation and to respond to actual need, are issues which any evaluation process would need to address.

For the purpose of this study, community care is taken to involve care provided to an individual who is living alone, with members of his/her family, or with a group of less than six other people. People living in solo accommodation which is part of a purpose built sheltered housing complex would be included.

MODELS OF COORDINATION

As Wilson and Butler (1986) have pointed out, organisations in the voluntary sector have received relatively little attention by researchers in the field of organisational analysis. Wilson and Butler questioned what they called the "stereo-typical image of cooperation", and following their examination of the strategies of four leading British voluntary organisations they argued that the primary influences which shape the choice of strategy in voluntary organisations are those created by inter-dependence.

Bulmer (1986) proposed five different forms of relationship between formal and informal care:

(1) colonisation, eg a day-care centre owned and controlled by a voluntary organisation which has no other services in the area and has no contact with other service providers in the area.

(2) competition/conflict eg a area which has both private and state-run homes for the elderly

(3) coexistence eg where one type of

organisation may make occasional referrals, but usually the two sectors ignore each other

(4) collaboration - equal partnership

(5) confusion

In order to investigate the nature and extent of "partnership" between voluntary and statutory sector service providers, an analysis of the models developed by Wilson and Butler and by Bulmer, provided the following four paradigms for a system of service coordination:

MODEL A

In this model responsibility for coordination is held by a specified Department or Named Individual. Thus non-statutory agencies have an easily identifiable contact point should they wish to liaise with the statutory body, and all the Department's/Individual's energies are directed towards improving communication and support systems between the two groups.

This model takes little account of Wilson and Butler's theory of inter-dependence, but bears some resemblence to Bulmer's proposal of a competitive and/or conflicting relationship.

MODEL B

In this model responsibility for coordinating statutory services with voluntary ones is held equally by all field staff. This model provides opportunities for groups to coordinate their efforts at all management levels and gives a large number of statutory staff a responsibility for building up contacts with and an awareness of voluntary sector activity.

This model also takes little account of Wilson and Butler's theory, but , in certain aspects, it resembles Bulmer's proposals for coexisting and collaborating partnerships.

MODEL C

In this model coordination is sought with service users themselves. Efforts and resources are directed towards identifying service users who would be prepared to take part in consultation on service issues, enabling consultation with service users to take place and supporting the efforts of services users to organise themselves into a fully representative and effective lobbying group.

This model reflects Wilson and Butler's theory on coordination, and also resembles Bulmer's collaboration model.

MODEL D

This model would aim to utilise aspects of the previous three models to varying degrees according to the perceived circumstances of the area.

Whilst the stated aim of all four models might be that of collaboration and equal partnership with the voluntary sector, all four might also result in the other forms of relationship proposed by Bulmer, such as competition, conflict or confusion. The success or otherwise of each model to enhance collaboration would enable further measurement of Wilson and Butler's argument that influences of inter-dependency are more important to strategy than task-related influence.

REFERENCES

Albermarle Committee (1958), Report on Youth Services

Beveridge (1942), Social Insurance and Allied Services, HMSO, London

DHSS (1977), Joint Care Planning, Health and Local Authorities

Guillbaud Committee (1956), Report on the Cost of the NHS

Hadley R & McGrath m (1984), When social services are Local, George Allen and Uniwin, London

House of Commons (1980), Mental Handicap: Progress, Prolems and Priorities

Ingleby Committee (1960), Report on Children and Young Persons

Palfrey C (1987), Elderly People and Community Care: a literature review for the Communiity Health Unit, Gwent Health Authority, Newport

Walker A ed (1982), Community Care - The Family, the State and Social Policy, Basil Blackwell Publishers ltd & Martin Robertson & Co Ltd

Webb A & Wistow G (22 march 1983), "Can you spare a policy?", Social Work Today, p 10-12

White K (18 January 1987), "Why is Community Care so Popular?", Community Care, p 16-18

(1989) White Paper, Caring for People

Willmott P (1986), Social networks, Informal Care and Public Policy, Plicy Studies Institute, London

Willmott P and Thomas D (1984), Community in social Policy, Policy Studies Institute, London

CHAPTER FOUR

THE RESEARCH SAMPLE AND METHODS OF INQUIRY

THE SAMPLE AREA

Empirical data for this research was collected between June 1987 and March 1988. The sample consisted of four areas whose geographical boundaries reflected those of their Local Authorities, as defined in the Local Authorities (Qualification of Membership) Act 1971, namely Cleveland County Council, Manchester Metropolitan District Council, Suffolk County Council and South Glamorgan County Council.

Consideration was given to population numbers and patterns, historical influences, and political influences. This considceration was given in order to obtain sample areas which provided examples of services being managed and coordinated in a variety of situations. Cleveland has areas

which are densely populated following the rapid growth of Middlesbrough and Stockton during the 19th Century, but is now an area of high unemployment due to the collapse of the heavy industries on which it relied; Manchester is a heavily populated city which has retained its importance as a commercial and industrial centre for the North West of England; Suffolk is predominantly rural and in terms of its high levels of employment and home ownership it could be considered to be the most affluent of the four areas; South Glamorgan contains aspects of all of the other three areas in terms of population distribution and the strength of its economy. The four areas also reflect a mixture of party political influences.

Local Authority boundaries, rather than those of the corresponding Health Authorities, were chosen because members of the sample group already living in the community generally used more Local Authority Social Services Department services than

those of their Health Authority, and those living in Health Authority accommodation at present would require more services provided by their Local Authority when they moved into the community.

THE SAMPLE GROUP

The term "Disabled Person" was used in the National Assistance Act 1948 to describe any person who is blind, deaf or dumb or who suffers from mental disorder of any description or who is substantially and permanently handicapped by illness, injury or congenital deformity. The term and accompanying definition has continued to be used in legislation, including the Disabled Persons (Services, Consultation and Representation) Act 1986. The term poses two problems for local authorities required by virtue of the various welfare legislation concerning

Disabled Persons to provide services to them. Firstly the term is extremely general. Services required by people with sensory disabilities can be very different from those required by people with a mental disorder or those with a permanent physical injury, and the services for each group need to be considered separately from each other. Secondly the term gives no indication of levels of disability, leaving a local authority to decide what constitutes a "substantial" handicap or illness, and thus decide whether or not an individual comes under the remit of legislation.

Problems arising from the nature of the term "Disabled person" are compounded because, whilst the relevant legislation requires local authorities to provide services for such people, authorities are not required to keep up-to-date records of the names and numbers of such people, the nature of their disability and the services which they currently require or are likely to require in the future. For example, the Disabled Persons (Services, Consultation and

Representation) Act 1986 requires local authorities to carry out assessments of the needs of individual disabled persons, and if in the opinion of the local authority these needs call for the provision of any statutory services the local authority must inform the person of how they propose to meet those needs. However, with the exception of children under the age of 14, whose needs will already have been assessed under section 7 of the Education Act 1981, where the education authorities have been obliged to notify the local authorities of a child's existence and needs before the child leaves full-time education, a local authority is not required to identify people for assessment. If people are not identified and called for assessment, and as a result of this no services are assessed as required, the local authority need supply none.

For the purpose of this research, the sample group have been described as people with severe physical or multiple disabilities, between the ages of 20 and 60, who are expected to live in the community

within the next 10 years. The term is general, but not to the extent of that given in legislation, and it was proposed with the anticipation that local authorities do sub-divide services for disabled persons, and even services for people with physical disabilities, into those for people whose disability is of a minor nature and those whose disability prevents them from making use of services and amenities which are available to most people.

METHOD OF DATA COLLECTION

Data was collected in four stages. The research method adopted for the first three sections of data collection made use of questionnaires and interviews. Draft questionnaires were produced with the assistance of representatives from some of the sample areas. These draft questionnaires were discussed fully with each of the people who were to have responsibility for their completion

before a final questionnaire form was produced and distributed.

STAFF QUESTIONNAIRES

Questionnaire I (see Appendix 1 page x) sought to establish each sample Local Authority's definition of "severe disability", and the known and estimated number of people who could be included in the sample group in each area.

Although there has been general approval for community care principles for many years it has also been recognised that the majority of people in need of personal social services are currently living in their original community. In order to establish the percentage of clients already living in the community in the four sample areas the Social Services Department for each area was asked to complete Questionnaires IIa and IIb (pages xi -xiii), and where possible a coordinating voluntary agency in the area was asked to comment on their findings. The Questionnaires sought to

establish the number of residential establishments in each area, according to type. Information regarding staff:client ratios was sought in order to determine the level of independence of residents; and information regarding age and sex was sought in order to determine whether certain types of residential establishments attracted specific age or sex groups. The Questionnaires also requested information regarding the age and sex groupings of people living in the community in order to determine whether there was a predominance of people of a specific group living with parents, alone, with partners or in sheltered accommodation complexes.

Questionnaire III (pages xiv-xxi) was compiled with the assistance of the Research and Development Officer of Manchester Social Services Department, and the appropriateness of the Questionnaire's form was discussed with the other sample area Departments. The Questionnaire aimed to obtain information regarding the variety and quantity of services available in each area.

STAFF INTERVIEWS

The interviews for these sections were carried out on a one-to-one basis in the offices of the Interviewees. The interviews were semi-structured, and followed specific interview plans (Appendix 2 pages xxxii-xxxv). The interview questions were open, and required the Interviewees to elaborate and illustrate their responses. Interviewees were supplied with information concerning the objective of the interview before it took place, and if appropriate supplied additional information themselves, such as charts of their organisation structure, or planning documents. According to the preference of the interviewee, interviews were recorded by tape recorder or by shorthand notes being made whilst the interview was taking place. It was anticipated that the data collected for these sections would identify the role, if any, that the voluntary sector played in planning and providing services.

CLIENT QUESTIONNAIRES

Questionnaire V (Appendix 1, pages xxiii-xxx), was produced in order to collect information from service users. Consideration was given to the physical and the intellectual abilities of the people who might be asked to complete the questionnaire. Advice on the appropriateness of draft questionnaires was sought from four people with disabilities, and a pilot distribution of questionnaires was carried out before the questionnaire was finalised and distributed. The preliminary data collected during the pilot distribution highlighted the problems related to the ambiguity of some questions, as well as problems specific to people who may never have been asked to complete any sort of form previously, may have physical difficulties in doing so, or may have intellectual disabilities which limit their ability to answer certain questions.

Collecting this data was more difficult than

collecting that for the previous sections of research because the sample group were more difficult to find. These difficulties were greater in some sample areas than in others. This problem was exacerbated by a greater lack of motivation to complete questionnaires in the sample group than might be apparent in other groups of people from whom data is sought. For example many people who were personally approached refused to complete questionnaires as they claimed that they were frequently being asked about their disabilities and their needs but nothing ever seemed to improve as a result. As a consequence of these difficulties, the number of responses to the client questionnaires was disappointingly low throughout the sample areas.

The purpose of this section of this research was to gather data on the sample group's knowledge and use of services in the four sample areas; and by comparing findings from the different areas to measure the effect that the services, and the ways in which they were planned and provided, had on

the sample groups' ability to live in the community.

Whilst accepting that there was considerable variance in the quality of responses from individual consumers, and that some findings were practically unmeasurable, the receivers of the service are such an important group for the purpose of this study that it was considered essential to seek their views. This decision was also made in the light of there being no research carried out by a major body, and a dearth of any research generally which has sought to collect or to consider the views of this particular group.

CHAPTER FIVE

THE FOUR SAMPLE AREAS

As stated in Chapter 4, the sample areas were chosen in order to provide examples of a variety of situations.

CLEVELAND COUNTY COUNCIL

Area 852.87 square kms (a)

Population:		
	Total	565,775
	Town	562,222
	Rural	23,553

Cleveland County Council was established in 1973 as part of the reorganisation of county council boundaries. Previously the area north of the river Tees had been part of County Durham, the

(a) All figures obtained from census material

area south of the river part of Yorkshire. The area around the Tees estuary, which includes the conurbation of Stockton-on-Tees and Middlesbrough, is dependent on long-established heavy industries. This is the most densely populated area within the County. Housing is predominantly Victorian terraced or 1960's-70's housing estates. Unemployment in this area is very high: up to 16.5% . The other significant population centre is Hartlepool, a seaside resort in the north of the county which is generally less depressed financially than the area around the Tees. The remaining parts of the county are sparsely populated.

Cleveland Social Services Department has its headquarters in Middlesbrough. It has two District Offices which are also based in Middlesbrough, but the administration of the Department is primarily centralised. There are three Health Authorities operating in Cleveland. Their boundaries reflect the old county council boundaries.

MANCHESTER METROPOLITAN DISTRICT COUNCIL

Area: 110.30 square kms

Population:		
	Total	2,594,778
	Town	2,570,728
	Rural	24,050

All of the area for which Manchester Metropolitan District Council is responsible is urban. The Social Services Department's headquarters is in the Town Hall, in the centre of the city. This accommodates the Director, the Senior Assistant Director who is responsible for the Residential and Day Care Services Division, two Assistant Directors who are responsible for the Casework Services Division and the Administration and Management Division, and the Research/ Planning/Publicity Unit. Services have, to some extent, been decentralised. The Casework Services Division has been divided into four areas; each Area Team is made up of a comprehensive selection of social workers, court/schools/police liaison officers, rehabilitation officers, day care

coordinators and so forth, as well as volunteer organisers. The Residential and Day Care Services Division has also decentralised into district services. However, because the organisation is so large, and in some ways confusing, certain levels of communication problems are inevitable. There are areas where duplication of effort is a potential hazard, for instance between the Casework Services Division's Area Volunteers Organisers and the Research/Planning/Publicity Unit's Community Development Organisers.

For the purpose of this research, at levels below that of the Department's Headquarters, responses were sought only from people in Area 4 which covers the northern part of the city, and is administered by one of the decentralised Residential and Day Care Services Districts. Unemployment in the area is relatively high - up to 9.7% , and housing is mainly council stock, built during the past 40 years. There are large areas of derelict housing, made up of 1960's tower blocks.

There is only one Health Authority covering all of the Manchester Metropolitan District Council area. However, the planning process within the health Authority differs considerably from that of the Local Authority and consequently issues of joint planning for community care are not necessarily less complicated than those in sample areas with more than one Health Authority.

SUFFOLK COUNTY COUNCIL

Area: 387.29 square kms

Population:	Total	596,354
	Town	323,015
	Rural	235,003

Suffolk is the largest of the sample areas, but has the lowest population. Ipswich is the main population centre. Although the area is possibly more affluent than the other sample areas (unemployment level around 3.6%), it faces

problems of poor public transport and road links which are common to all rural areas.

Suffolk Social Services Department is divided into four geographical areas, the boundaries of which reflect those of the two Health Authorities in the Area, and has a central headquarters in Ipswich. In terms of personnel, Suffolk has the smallest management/administrative headquarters of all the sample areas. The actual site is very compact: the Director and Principal Officers all have offices in the same corridor. Consequently general communications take place on a very informal basis and formal lines of communication can remain relatively uncomplicated.

SOUTH GLAMORGAN COUNTY COUNCIL

Area: 416.05 square kms

Population:	Total	384,633
	Town	341,833
	Rural	42,800

The County of South Glamorgan was established in 1973 when the old county of Glamorganshire was divided into three. South Glamorgan covers the area of the city of Cardiff plus the rural suburbs of the Vale of Glamorgan to the West. The Vale of Glamorgan includes several small towns, such as Barry, Cowbridge and Llantwit Major, plus numerous smaller villages. Cardiff is the civic capital for Wales, and the city centre has undergone substantial redevelopments during the past 10 years. Unemployment is higher than the national average (9.2%) though this is mainly concentrated around the city centre area and the near-by towns of Barry and Penarth.

During the period when data was being collected for this study, South Glamorgan Local Authority was undergoing a reorganisation of its Social Services Division. Following the reorganisation services were decentralised, and specialist multi-disciplinary teams were established with responsibility for specific areas. However, the areas covered varied according to the client group; for example services for people with mental handicaps were divided into four areas, but services for the elderly were divided into eight areas. Services for people with a physical disability were divided into four areas. The overall boundaries of South Glamorgan Local Authority are the same as those of South Glamorgan Health Authority.

SOURCE OF DATA COLLECTED FROM THE STATUTORY SECTOR

The choice of statutory sector representatives to be interviewed was made by the Social Services Department in each sample area. Consequently different Social Services Department Officers were interviewed in each area; a reflection of how the departments' structure and method of coordination with the voluntary sector varied.

On the advice of the Director of Social Services for Cleveland an interview was arranged with the Principal Officer (Mental Handicap). The suggestion to interview the Principal Officer for Mental Handicap rather than the Principal Officer for Physical Handicap reflected Cleveland's definition of "severe disability" in relation to the sample client group. During this interview the Principal Officer proposed that I should visit two of the Department's Adult Training Centres which had special provisions for people who could be included in the sample client group, in order

for me to observe any links which these Centres had with voluntary organisations and their local community generally.

In order to obtain the required data from Manchester Social Services, an interview was carried out with the District Planning Officer for Area 4. In order to obtain a perspective of voluntary sector/statutory sector relationships in Manchester as a whole, this data was supplemented with written information supplied by the Voluntary Organisations Section of Manchester Social Services Department. This was provided in response to a letter which asked for the information which normally would have been sought by an interview following Interview Plan III(Appendix 2, page xxxiv).

To obtain information from South Glamorgan Social Services, an interview was arranged with the Principal Officer with responsibility for Physical Handicap. The Principal Officer also had a

responsibility for liaising with voluntary organisations, but a similar responsibility was held by all field workers.

Following an introductory interview with the Senior Researcher for Suffolk Social Services Department, interviews were arranged with three people within the Department: the Principal Officer (Physical Handicap), the Principal Officer (Mental Handicap) and the Principal Officer (Community and Voluntary Resources). The Principal Officer (Physical Handicap) was responsible for planning and providing services for people with physical disabilities throughout Suffolk. The Principal Officer was also a major contributor to Suffolk Social Services' Strategic Development Plan (1985), which currently was being followed. The Principal Officer (Mental Handicap) was responsible for planning and providing services for people with mental handicaps throughout Suffolk. The Principal Officer (Community and Voluntary Resources) had links with

the Social Services Officers working in the community and those based in Ipswich.

SOURCES OF DATA COLLECTED FROM THE VOLUNTARY SECTOR

Representatives from the voluntary sector were identified partly from contacting the sample areas' local branches of national umbrella organisations for voluntary organisations, such as Councils for Voluntary Service, and partly from following the advice of the areas' Social Services Departments.

Two groups were approached in Cleveland, the Cleveland Liaison Group for the Mentally Handicapped and the Cleveland Council for Voluntary Service. An interview was arranged with the Senior Officer for CCVS. It was not possible

to arrange an interview with a representative from Cleveland Liaison Group for the Mentally Handicapped and so information from this group was obtained by questionnaire and from copies of minutes of the Group's recent meetings.

Four people who were involved with voluntary sector and service user organisations in Manchester were interviewed. One of these was the Development Worker from Manchester Council for Voluntary Service; one was a former Chair of the Manchester Disability Forum who was also a member of the District Planning and Liaison Group (DPLG) for Area 4 and a member of the team working at establishing the North Manchester Disability Forum; the third person was a Support Officer for the voluntary sector representatives on Manchester's Joint Consultative Committee and for Manchester Alliance for Community Care (MACC); the fourth person had been employed for a year as a Community Development Worker for Area 1, and had links with Manchester Disability Forum, the Equal

Opportunities Committee and the Greater Manchester Coalition for Disabled People (b).

Two people were interviewed in the South Glamorgan area. The first was the Director/Secretary of INTERVOL, an organisation partly funded by South Glamorgan Local Authority, Cardiff City Council, South Glamorgan Health Authority and the Welsh Office which aims to assist the voluntary sector. INTERVOL advises the Local Authority on the distribution of finance to the voluntary sector and is often asked to comment on and/or support Local Authority projects. As there was no other voluntary sector umbrella group in South Glamorgan, a further interview was arranged with a representative of the Wales Council for Voluntary Service which is involved with the voluntary sector throughout Wales.

(b) This Interviewee could not speak as a representative of any of these organisations, but gave her personal views and interpretations of the voluntary and statutory sectors.

In order to obtain information in Suffolk an interview was held with the Chair of RETHINK. This organisation acts as a pressure group to improve facilities for all people with disabilities living in Mid Suffolk, and is controlled by service users.

REFERENCES

AREA: All area figures are approximate. Refer to Bartholomew Gazetter of Places in Britain, 1986, John Bartholomew and Son Ltd, Edinburgh

POPULATION: All population figures obtained from Census 1981, Office of Population Censuses and Surveys Preliminary Report for Towns, HMSO

EMPLOYMENT: All unemployment figures are approximate. Refer to Employment Gazette, Feb 1989, HMSO

Seasonally adjusted figures for unemployment levels in travel to work areas:

Hartlepool	16.5%
Middlesbrough	15.5%
Stockton-on-Tees	12.9%
Manchester	9.7%
Ipswich	3.6%
Cardiff	9.2%
Bridgend	10.9%

CHAPTER SIX

EMPIRICAL DATA - THE STATUTORY SECTOR

In order to examine the stated and unstated official rationale for coordinating statutory and voluntary services, and to identify the presence of any models of coordination in the four sample areas, it was necessary to interview representatives from the statutory sector

Data was collected primarily through a series of interviews following Interview Plans II and IV (Appendix 2, pages xxxiii and xxxiv) as appropriate. The Interviewees also received written information prior to the interview indicating the areas which were to be discussed. The data was supplemented with literature describing organisation structures, five-year plans and any other literature relevant to strategy, which was provided by the individual sample Local Authorities. In Cleveland further data was collected through informal interviews with staff and clients, and through observations

made during visits to the Social Service Department's ATC's in Stockton and Guisbrough. These visits were proposed and arranged by the Department.

METHODS OF COMMUNICATING WITH THE VOLUNTARY SECTOR

The Principal Officer (Mental Handicap) for Cleveland stated that she had many personal links with the small, local voluntary organisations which were active in Cleveland, and also welcomed contact with the larger national organisations.

In Manchester the Area 1 District Planning Officer's main contact with the voluntary sector was either with small, local voluntary organisations or with groups of people who used services provided by statutory or voluntary agencies. The DPLG's had working groups which reported to them on specific issues, and there was one such group for Physical Handicap issues and

one for Mental Handicap issues. These groups were intended to enable greater consumer participation, but the District Planning Officer believed that there had been some problems caused as a result of this, as generally people from outside Social Services found social service type meetings intimidating because of the dominance of professionals and their excessive use of jargon. Attempts were being made to seek the views of consumers in other ways such as by administering questionnaires. The DPLG in Area 1 had managed to obtain finance for a Community Development Worker to work within Social Services promoting involvement from consumers on issues relating to physical disability and to establish a North Manchester Forum to help link service users with the DPLG.

The Principal Officer (Physical Handicap) in South Glamorgan initially spoke about South Glamorgan's proposals to increase its work with small, local groups of service users. Its long term aim was to increase the amount of control service users have,

and to become facilitators and advisors for this. As South Glamorgan had only recently introduced these proposals as part of its reorganisation of its Social Services Department, it was too early to measure the success of the proposals.

To ensure links with the voluntary sector and the community generally, Suffolk Social Services Department had a Principal Officer (Community and Voluntary Services) and a series of Community Development Officers. Three of Suffolk's four Areas had a Community Development Officer; the remaining Area, which included Ipswich and had the largest population, had two. The Community Development Officers reported to the respective Assistant Directors in each Area; the Principal Officer (Community and Voluntary Services) reported to the Director. The Community Development Officers formed links with voluntary organisations and volunteers at a local level, whilst the Principal Officer (CVR), who had one assistant, was concerned with issues relating to

voluntary organisations and volunteers at "Head Quarters" level.

THE ROLE WHICH THE VOLUNTARY SECTOR SHOULD TAKE

Cleveland Social Services Department used a system of Individual Programme Planning (IPP) for all people who received services on a regular basis. These were training programmes which aimed to cover all training and experience requirements to enable individual clients to achieve maximum independence. The planning of these programmes was completed by the clients with the staff at the relevant Centres and other statutory sector professionals, such as social workers or psychologists. However the services of voluntary sector groups and MSC Community Programmes were used. For instance horse riding classes provided by MENCAP were included in some people's

programmes.

At a local level, Manchester Social Services Department encouraged the participation of service users on an individual or group basis, and there was no obvious role for voluntary organisations apart from these groups in planning or providing services. The Voluntary Organisation Section, which dealt with voluntary organisations in Manchester on a city-wide level stated that the non-statutory sector could provide alternative services, lobby for additional services and initiate new services. However, the specific role performed would depend on the agreed purpose for which funding was provided. The Voluntary Organisation Section's role was to ensure that, as far as possible, schemes continued to carry out the work for which they were originally funded.

The Principal Officer (Physical Handicap) for Suffolk, admitted that Suffolk Social Services' Strategic Development Plan had no identifiable area within which the voluntary sector had a role.

He felt that there were many areas in which the voluntary sector could develop its role to the benefit of both Social Services and the people dependent on its services. The voluntary sector should provide information on needs to Social Services on a local level, should seek to monitor and influence developments within Social Services and should pressurise Social Services and other relevant sections within the statutory sector to provide suitable services. The Principal Officer (Mental Handicap) felt that greater use should be made of the voluntary sector for a variety of reasons. Local authorities could receive financial encouragement from central government for developing services with voluntary organisations; the recently introduced residential care laws which enabled a variety of agencies to provide specialist accommodation made monitoring of such accommodation complicated and making better use of the voluntary sector's services in this area would place the statutory sector in a better position for monitoring and controlling them.

The Principal Officer also felt that voluntary organisations had specialist knowledge of certain aspects of disability or needs; and finally he felt that building links with voluntary organisations could be beneficial to a Social Services Department's image. He believed,for example, that the general public thought it a "good thing" of Social Services to give support to such groups as The Childrens Society. The Principal Officer (CVR) agreed with his colleague that the voluntary sector could offer specialist knowledge to the statutory sector, especially in areas such as advocacy. He felt that the voluntary sector could play an important part in identifying and providing services which would not be provided by the Social Services Department, especially those of an informal nature which can be of special importance in rural areas, such as community transport services.

The Principal Officer for South Glamorgan agreed with the Principal Officer for Suffolk that there were opportunities for Social Services and

national voluntary organisations to work together on projects which were eligible for joint finance. However she felt that South Glamorgan Social Services would prefer to develop relationships with those national voluntary organisations which work closely with service users. The Principal Officer stated that because of this, when considering work with the voluntary sector she would prefer to work with local groups than to risk taking the initiative away from them by working directly with national voluntary organisations whose decision makers were based outside the area. The Principal Officer believed that voluntary organisations had a responsibility to gather information and views from Social Services and to be aware of their aims and objectives. The voluntary sector could work with South Glamorgan in order to achieve its aim of passing more control to service users, but it could not expect backing from Social Services if its objectives were contrary to those of the Department. With regard to the types of services which the voluntary sector could or should

provide, the Principal Officer said that the voluntary sector possibly could supply services which might have been provided by the statutory sector. However the suggestion of sub-contracting services to the voluntary sector was a very sensitive issue with staff and unions, and South Glamorgan would wait until there had been a government directive before doing so. The Principal Officer believed that ideally service users should have the money to choose and buy their own services, and that Social Services should be able to give them the money to do this. The Principal Officer emphasised that the voluntary sector could not provide services unless they had suitable finance to do so and that the "good will" of the voluntary sector could not be considered an endless resource. Whether the choice to use the voluntary sector was made by Central Government, the Social Services Department or the service user, the services supplied must be paid for and service needs were going to increase in the future.

RELATIONSHIPS BETWEEN THE VOLUNTARY SECTOR AND THE STATUTORY SECTOR

The Principal Officer (Mental Handicap) for Cleveland appeared happy with the relationship that the Department had with the voluntary sector, although she felt that links with actual service users could always be improved and should continually be encouraged. The Principal Officer felt that the Department had a reasonable relationship with the Health Authorities in Cleveland, but did not speak in detail about the work of the JCC's. The Principal Officer stated that she found the work of the Cleveland Liaison Group for the Mentally Handicapped very useful; she felt it disappointing that the Department had been unable to establish a similar group concerned with Physical Handicap issues although a number of attempts had been made to do so.

The District Planning Officer for Manchester Social Services admitted that although part of her responsibilities included liaising with

representatives from the voluntary sector she was not fully aware of what services were currently available from the voluntary sector. This was partly because to do so would be extremely time consuming as the voluntary sector appeared to be a very large, uncoordinated group of organisations. The Manchester Disability Forum was recognised as being a powerful influence on Social Services by groups within the Social Services Department and by voluntary organisations. Both groups tried to secure the support of the Forum when lobbying the Department. The Forum was also one of the groups consulted by the Social Services Department when matters affecting people with disabilities were proposed and planned. The Voluntary Organisations Section felt that the character of its relationship with the voluntary sector varied considerably. In some instances there was extremely close cooperation between the Voluntary Organisation Section and a non-statutory organisation in relation to day-to-day work, whilst in other instances an organisation may choose to carry out work in an independent manner.

Manchester Local Authority Social Services Committee provided approximately £3million per year in annual revenue grant aid to non-statutory organisations. Additional finance was provided through other committees.

The Principal Officer (Mental Handicap) for Suffolk Social Services stated that he tried to involve the voluntary sector in planning and providing services as he wished to involve as many people as possible in its decision making and to encourage "bottom up" management. In spite of this the Principal Officer still found "the voluntary sector" a complex group. For example he felt that there were almost two different MENCAP's: there were the people who were involved on a voluntary basis with the local MENCAP groups, and there were those who were employed nationally to provide a professional service. Because of such problems, which are common to many national voluntary organisations, the Principal Officer preferred to work with local voluntary organisations. Because of the anxieties over

efficiently monitoring special accommodation, the Principal Officer (MH) said that Suffolk Social Services was giving encouragement to voluntary organisations such as MENCAP and United Response to develop residential services. However if this strategy was to be successful the Principal Officer believed that the voluntary sector needed to become more professional in its approach.

The Principal Officer (PH) agreed with these sentiments. With the exception of the Suffolk RETHINK organisations, the Principal Officer (PH) felt that the voluntary organisations in Suffolk were not professional. He believed that their approach to statutory organisations was cowering, that they always appeared grateful for anything which they were given rather than pressurising the statutory sector to give services which people had a right to deserve, and that consequently the statutory sector tended not to take them seriously. The Principal Officer also had a preference for working with small, local voluntary organisations and groups of volunteers. He

believed that ideally there should be corporate management and monitoring, rather than the current situation whereby financial assistance is given to voluntary organisations without there being any formal contract concerning what they are expected to do with it. He believed that there was a need for an umbrella organisation for voluntary organisations in Suffolk, to collate, consider and pass through bids for finance to the Social Services Department. This would be better than the present situation where Social Services decided who to finance. Finance was applied for on an annual basis and there was no contractual agreement between the voluntary organisations and Social Services.

The Principal Officer (CVR) recognised that there was a danger that the voluntary sector would be seen as a cheap option when providing services. However he believed that the voluntary sector could be a valuable resource. He felt that the Social Services Department's role was to "plant seeds and nurture" voluntary services and then

withdraw. Currently the Social Services Department had no plans to develop specific areas of voluntary services, their strategy being to encourage natural growth and to respond to need rather than to search for it.

The Principal Officer (CVR) felt that the two Joint Consultative Committees which operate in Suffolk were rubber stamping groups; actual planning and consultation took place at Joint Care Planning Team level and below. Currently JCPT's were supported by Joint Care Working Groups, most of which had voluntary sector representatives. There was no formula for selecting the voluntary sector representative on JCWG's, and there was no formal structure for these representatives to report back to the various sections within the voluntary sector which they were supposed to represent. The Principal Officer (CVR) felt that the voluntary sector representatives on JCC's and JCWG's faced many problems which hindered their effectiveness. Voluntary sector representatives

had received no training and so might not understand the workings of the statutory sector. The elections for voluntary sector representatives on JCC's were arranged by the Rural Council at very short notice and there was no mechanism for anyone elected to obtain views from the voluntary sector or report back to it. Consequently the representatives had become ineffectual, the deputy representatives had had no contact with the JCC's since their election, and the situation caused frustration amongst the voluntary sector representatives.

In financial terms, 15% of Suffolk Social Services' Mental Health budget was spent on the voluntary sector in 1985, and this figure had since increased. The Department also provided funding for people wishing to attend the Ipswich and East Suffolk Spastics Society Work Centre and for a number of Gateway and Phab Clubs, but this accounted for a relatively small percentage of their total expenditure on the voluntary sector.

The Principal Officer for South Glamorgan felt that there were two main problems hindering the development of the Department's relationship with the voluntary sector: firstly the problem which was common to the other statutory sector representatives interviewed of the vast number of voluntary organisations, and secondly South Glamorgan wished to target service users by need and this did not complement the aims of voluntary organisations who target their members according to disability, such as the MS Society.

The Principal Officer stated that South Glamorgan was unable to allocate a large amount of financial assistance to the voluntary sector. Apart from the financial assistance given to INTERVOL, the Social Services Department sponsored approximately 30 people to attend The Spastics Society Skills Development Centre and other Local Authority Departments made smaller individual grants to local voluntary groups. The Principal Officer stated that the Social Services Department did not plan to increase the number of people it was

willing to finance attending The Spastics Society centre, and was unlikely to be able to support similar services that voluntary groups might propose.

PLANS TO DEVELOP VOLUNTARY SECTOR/STATUTORY SECTOR COORDINATION

Although it was evident from visits to the Adult Training Centres in Cleveland that the Social Services Department made use of services supplied by the voluntary sector, discussions with the staff at the Centres indicated a common belief that the systems of Individual Programme Planning which the Centres used would be the main frame for future developments. As such, although voluntary sector services would be utilised, there was no real place for "voluntary sector representatives" in the meetings which decided the Programme Plans for individual clients and so any partnership between the two groups would be limited.

The District Planning Officer in Manchester felt that despite a lack of basic information on the voluntary sector and who it represents, the proposed cuts in Manchester Local Authority's spending would result in the Social Services Department looking for greater cooperation with the large, national voluntary organisations In response to the question of future development the Voluntary Organisations Section responded that there had been very little additional finance available for non-statutory organisations in Manchester in the past three years, and that other than to continue its current general responsibility it was not possible to identify particular plans for the next five years. The Voluntary Organisations Section stated that this was "particularly so having regard to the City Council's financial position at the present time".

The Principal Officer (CVR) in Suffolk explained that a seminar to help voluntary organisations take a more active part in planning services

through JCC representatives had been held in May 1987. The seminar highlighted the areas of basic ignorance about the voluntary sector among all members of the JCC, and also showed their lack of knowledge about joint planning and the function of JCC's. The seminar discussed establishing a forum for all groups interested in joint care planning, including voluntary groups and housing groups, and it was agreed to establish four Forums - one in each Social Services area. The Principal Officer felt that the establishing of these Forums would be an important step towards encouraging and enabling greater voluntary sector participation. The Principal Officer believed that members of the JCC's or even the JCPT's were not strongly calling for a change to make them more "community" representative. However the Forums could be used as a base for the next JCC elections and could be utilised to ensure that representatives made effective use of their responsibilities.

South Glamorgan aimed to establish local planning groups which would include voluntary organisation

representatives as well as representatives from the Social Services Department and service users. The Principal Officer (PH) stated that whilst involving the voluntary sector at this level would have some benefits, the Department had become aware of the necessity of involving service users and in some ways limiting the input of voluntary organisations as service users did not necessarily accept that the voluntary organisations represented them. The Social Services Department was also making efforts to increase its direct links with service users. Although it faced problems in doing this as did the voluntary sector, it had already had some success. Finally the Principal Officer stated that she was encouraged at the way in which some voluntary organisations had started to work together as a result of some of the Social Services Department's initiatives to form working groups. The Principal Officer felt that without these initiatives the various organisations would have continued to work completely separately from each other.

SUMMARY

The existance of three of the five forms of relationship between formal and informal care proposed by Bulmer could be identified following these interviews. In Suffolk the possibility of "colonisation" resulting from the establishment of private residential centres was recognised by the Social Services Department as a potential problem. The most common form of relationship in all four sample areas was coexistence, with the voluntary and statutory sectors making occasional referrals to each other, but generally working independently of each other. Confusion, mainly as a result of a lack of information or a lack of resources to obtain relevent information, was also present in all four areas.

Although all four sample areas had some organisation structure for integrating the services of the voluntary sector, they all relied on personal links as their main source of

information and contact. All the staff interviewed experienced problems gathering comprehensive information from or about the voluntary sector and preferred to work with small, local voluntary organisations. The feeling that contact with some national voluntary organisations was best avoided as their organisation and management was unwieldy was a common one.

Suffolk's organisation structure gave the most support to the philosophy of a statutory authority having a responsibility for developing links with and supporting the voluntary sector. Although the other three areas did not discourage voluntary sector developments, they relied on voluntary organisations to approach them with proposals for joint service developments or to request assistance, rather than making approaches themselves. Although representatives from all four areas believed that the voluntary sector representatives on JCC's were not effective, only two areas were taking some action to rectify the position, and this action was limited.

The views which the inteviewees gave concerning the role which voluntary organisations should take varied considerably. However it is difficult to measure the extent to which these views reflect the "official" view of their Departments, and the extent to which they are personal. For example, the views of the three staff from Suffolk Social Services Department who were interviewed varied. Possibly similar variances would have been recorded if more than one representative was interviewed in the other sample areas.

The data collected from these interviews showed that all four Local Authorities were willing to make use of some voluntary sector services, believed that some sort of voluntary sector should exist, and were willing to encourage some form of partnership between themselves and the voluntary sector when planning and providing services. However, even though the levels of support varied between sample areas, in every area developing links with the voluntary sector was a low priority

in comparison with the other work of the Social Services Department. All the interviewees admitted openly that they had limited knowledge of the voluntary sector. Resources of time, money and personnel which were allocated to developing services in partnership with the voluntary sector were far less than those allocated to the Social Services Departments' development of their own services. There was a willingness to develop a partnership with the voluntary sector, but the practical effects of this were secondary to those of the Social Services Departments' self development.

Interviewees from all four sample areas considered communication with service users to be not necessarily the same as communication with the voluntary sector. The strategy of South Glamorgan and, to a certain extent, Manchester was aimed at developing links with service users. Interviewees from both areas stated that they were aware that some service users felt strongly that voluntary

organisations could not and did not represent them, and therefore wished to deal with service users direct. In Cleveland the interviewee had retained many of the links with service users which she had built up through previous work, and felt that this gave her an important insight into the effects of her Department's work. In Suffolk, much of the Community Development Officers' work was with voluntary organisations who were also service users. However it is difficult to measure how much of the Department's preference for working with RETHINK was due to the organisation's being made up of service users, and how much was due to the organisation's professional image.

With regard to the forms of relationship proposed by Bulmer, colonisation, coexistence and confusion could be seen to exist but competition or conflict could not. The voluntary and statutory sectors did not compete to attract service users and did not appear to be competing to provide similar but superior services to each other. Neither did a

relationship of collaboration or equal partnership appear to be established in any of the sample areas. With regard to the models of coordination of services proposed for this study, Cleveland, Suffolk and South Glamorgan incorporated Model A, giving responsibility for coordination with the voluntary sector to specified staff; only South Glamorgan followed Model B in also giving some responsibility for coordination to all field staff; Model C, which seeks coordination with service users themselves, was only apparent in two of the four sample areas, South Glamorgan and Manchester. None of the sample areas reflected Model D, utilising aspects of all the three previous models.

Whilst there were variances, therefore, in data collected from the four areas, no sample area expressed the view that coordination with the voluntary sector was to be avoided and identifiable models for enabling this coordination to take place were apparent. However, the claims that the voluntary sector represented service

users or that it was better than the statutory sector at supplying some services were not accepted by those people interviewed.

CHAPTER SEVEN

EMPIRICAL DATA - THE VOLUNTARY SECTOR

In order to ascertain the level of involvement of the voluntary sector and consumers in the planning and provision of services, information was sought from voluntary sector "umbrella" groups through a series of questionnaires and interviews. The amount of data gathered varied between sample areas. This was a result of the variance in number and type of umbrella groups in each area.

GENERAL COMMUNICATION WITH THE STATUTORY SECTOR

The Senior Officer of Cleveland Council for Voluntary Service stated that recent work carried out jointly by CCVS, Cleveland Social Services Department and/or the Health Authorities in the area had made her aware of the huge gaps in communication between these three groups. The Development Worker for Manchester Council for

Voluntary Service felt that the main hindrance to relationships between the statutory and voluntary sectors in Manchester was also the lack of knowledge each group had of each other. Consequently the statutory sector sometimes appeared to feel that voluntary organisations could be controlled in the same way as Social Services.

The representatives from South Glamorgan and Suffolk were slightly more optimistic in their descriptions of general communications between the two groups. The Director of Intervol in South Glamorgan opened his interview by describing the support that South Glamorgan had given Intervol since the organisation was formed in the early 1970's. The Director pointed out that South Glamorgan gave five times as much financial support as the rest of Wales combined into supporting voluntary agencies. RETHINK in Suffolk was started partly due to the proposals of the Community Development Officer for Mid Suffolk, and the organisation had continued to have a good

relationship with Community Development Officers. Its Chair felt that RETHINK had managed to put people with disabilities in the public eye and draw them to the attention of the Social Services Department.

JOINT PLANNING ISSUES

Many of the issues relating to joint planning were common to all four areas. Although Cleveland CVS had responsibility for holding the elections, the Senior Officer was extremely critical of the way in which the JCC voluntary sector representatives were selected:

> "People came to the meeting, stood up, said this is what I do, these are my interests and they took a vote by hand and elected people. At that moment we lost them. They went, they didn't really ever come back in a general liaison way."

The Senior Officer went on to explain that she did not believe that the system of having voluntary sector representatives on JCC's could work to

build links between the three groups because no one was charged with that responsibility, and the representatives worked as individuals. CCVS were making a bid for joint finance from the three Health Authorities in Cleveland for a support worker to assist the JCC representatives in order to make them more effective. However the Senior Officer acknowledged that it was unlikely that funding for this would be forthcoming, even though one full-time support officer would only fit their minimum requirements.

The elections for the voluntary sector representatives on Manchester's JCC were organised and carried out by MACC. The Support Officer confirmed that the JCC was, however, very much a "rubber stamping" committee. The voluntary sector representatives received papers from the JCPT meetings only a few days before the JCC meetings, and as these were usually voluminous documents the representatives did not have enough time to take any action before the meetings. The JCC meetings

usually took only one hour as all discussions and decisions had been made during the JCPT meetings. The Support Officer went on to state that he believed that "community care" was only of marginal interest to the voluntary sector. It was something which did not concern many voluntary agencies In view of this, he felt that joint planning for providing community care was not a major issue; most big voluntary organisations had built up their own relationships with local authorities and dealt with them as individuals rather than collectively.

The Director of Intervol (South Glamorgan) felt that the Welsh Office decision on how to choose representatives for JCC's was arbitrary, and not representative. Intervol was not involved in the elections of representatives, and although Intervol offered to give full support to the representatives, this offer was not taken up. Since the elections two JCC representatives had lost their position because of non attendance. Neither the Welsh Office nor the representatives

themselves had any contact with Intervol over JCC matters. However, the Director did not feel that the JCC was particularly effective anyway, but tended to be made up of "committee collectors", and used for rubberstamping previously agreed matters.

The Chair of RETHINK (Suffolk) felt that the voluntary sector's relationship with the statutory sector was marred by the voluntary sector's ignorance of the workings of local authorities. When RETHINK was established its members had no idea of how social services departments worked. Some voluntary organisations probably still did not know that JCC's existed, and were unaware that they included representatives from the voluntary sector. RETHINK had no formal contact with the JCC representatives and, as with the other three areas , the representatives had received no training to gather views from the voluntary sector or to feed back from meetings.

OTHER OPPORTUNITIES FOR JOINT PLANNING

To illustrate the situation in Cleveland, the Senior Officer for CCVS described how North and South Tees Area Health Authorities had formed their 10 year plans without consulting the voluntary sector. Although these Authorities now held meetings with the voluntary sector and said they needed a partnership, they had no mechanism to develop one. The Senior Officer concluded by expressing her concern that the statutory sector made assumptions about what the voluntary sector wanted to or could cope with. The voluntary sector played no part in the decision making process.

Similar views about an ignorance of what the voluntary sector was capable of doing were expressed by some of the representatives from Manchester and Suffolk. In Manchester the Support Officer for MACC felt that many voluntary organisations were not interested in joint planning because there was nothing in it for them.

They were put off by the statutory sector's ignorance of the voluntary sector - there was a tendency for the statutory sector to make assumptions about what the voluntary sector was able to do without making resources available to them. The Support Officer also thought that the voluntary sector was included in plans as an afterthought; consultation documents were often difficult to understand and voluntary organisations were never informed of the response their recommendations received.

The Interviewee who had worked as a Community Development Worker in Manchester was critical of local authorities claiming to consult with different groups. She felt that although Manchester Local Authority advocated consultation with a wide range of interest groups these groups could not actually participate in decision making. She believed that much enthusiasm and interest in joint planning had been killed because people gradually came to realise that whilst they could give their thoughts on proposals there was no

guarantee that these would be inplemented in any way.

The Chair of Suffolk's RETHINK felt that the desire to retain independence held by many voluntary groups conflicted with the attitude of some groups within Suffolk Social Services who saw voluntary organisations as members of a common organisation. She felt that there was a tendency for Social Services to depend on voluntary organisations whilst there was also a tendency for voluntary organisations to be slow to criticise Social Services and the demands which they placed on them.

Representatives from Manchester also felt that financial pressures affected how plans for developing the voluntary sector were made. The Development Worker for MCVS felt that there was a strong possibility that Manchester would be rate capped and that this would probably result in enormous cuts to voluntary sector finance. In

view of this she felt that there was a danger that some voluntary organisations would accept financial support without giving due consideration to the drawbacks of accepting the support. Similarly, the Support Officer for MACC felt that the financial arrangements required by the Local Authority when supporting the voluntary sector limited the role which the voluntary sector took. Currently there was no mechanism for applying for joint funding, the voluntary sector was not represented at the prioritising meetings which decided on grant allocation and so voluntary organisations had to apply and simply hope for the best.

Only Manchester and South Glamorgan had formal mechanisms for developing joint planning initiatives apart from the Joint Consultative Committees. The former Chair of Manchester Disability Forum had been involved with a number or organisations made up of people who used services supplied by Manchester Local Authority. Since it had been established in 1981 the Forum

had gained a significant amount of credibility among members of the statutory sector and the voluntary sector as a lobbyist on various issues. Manchester Local Authority had also established an Equal Opportunities Committee which had a section which dealt with issues concerning people with disabilities. These two groups worked on many areas jointly. The interviewee believed that, especially because of this, these two groups were able to influence decision making within Social Services. However she had very little knowledge of the JCC and the role of JCC's and JCPT's in planning and providing services. She believed that service users had greater influence on planning via the opportunities afforded by the Equal Opportunities Committee and the Forum.

The interviewee who had worked as a Community Development Worker in Manchester felt that the gap between the community sector and the statutory sector was diminishing in Manchester because of the work of the Equal Opportunities Committee, and especially its Disabled Persons Steering Group.

She also believed that the Steering Group was stopping much of the contact between the Local Authority and the large national voluntary organisations, and that the Health Authority had the support of the Equal Opportunities Committee.

The Director of Intervol in South Glamorgan felt that Intervol's involvement with South Glamorgan's Joint Forward Planning Forums, which were established by the Local Authority in 1981, were of greater importance than the JCC. As someone involved with voluntary/statutory sector relationships throughout Wales, the WCVO representative felt that South Glamorgan Social Services preferred to work with individual voluntary organisations rather than with "The Voluntary Sector". This preference was exemplified in South Glamorgan's "patch" system which required individual officers to build up links with voluntary organisations, and in the fact that it did not give Intervol financial support to develop community/service user links. However the WCVO representative also noted that

whilst the voluntary sector JCC representatives had been of little effect, South Glamorgan had started to introduce opportunities for parent involvement in Mental Handicap issues on JCPP's (JCPT's). These parents were not truly representative of service users generally, but they had begun to have some influence at the meetings and their presence may encourage opportunities for more service user involvement.

SUMMARY

The data collected from voluntary sector representatives confirmed the findings of research referred to in Chapter 6 which found that the voluntary sector believed the statutory sector generally to be ignorant of the workings and capabilities of the voluntary sector and as a consequence tended to attempt to treat it as though it were an extension of the statutory sector. The data also confirmed previous findings that the mechanism of consulting with the voluntary sector through Joint Consultative

Committees' voluntary sector representatives was not effective. One further finding which was apparent in varying degrees in all four sample areas was the difference in the ways in which the statutory sector worked with national voluntary organisations as opposed to local voluntary organisations or organisations made up of service users. The statutory sectors in South Glamorgan and Manchester had introduced mechanisms for working with the voluntary sector in addition to the statutory requirements for JCC representatives because of their wish to encourage participation in planning by local voluntary organisations and service users. Without these additional systems any participation in planning the provision of services by the voluntary sector would be negligible.

CHAPTER EIGHT

EMPIRICAL DATA

SAMPLE GROUP NUMBERS, ACCOMMODATION ISSUES AND SERVICES AVAILABLE

The statutory sectors and voluntary sectors in each area were asked to provide information regarding:

(1) their definition of eligibility for inclusion in the sample group,

(2) the number of people who could be included in the sample group living in each area,

(3) their accommodation circumstances and the services available to them.

They were unable to to so. For this reason, some further research was needed in order to gather this relevant information for these three catagories of data.

SAMPLE GROUP NUMBERS

The research findings showed that local authorities do sub-divide services in the way anticipated, but also that definitions of "severe disability" vary considerably, as does the authorities' knowledge of numbers of people who could be included in such a group.

Suffolk Social Services Department defined the sample group as:

> (a) the permanently bedfast;
>
> (b) those confined to a chair being unable to get in or out without assistance;
>
> (c) those who cannot feed themselves and need help with toiletting or cannot perform two of the three functions of getting in and out of bed, washing hands and face and dressing;
>
> (d) the severely mentally handicapped with or without other handicaps.

Cleveland Social Services Department defined members of the sample group as "someone whose ability to care for themselves is impaired to the extent that they require considerable assistance

to function both mentally and physically". Neither South Glamorgan nor Manchester Social Services Departments had an official definition of "severe disability", although they both provided a variety of services which would be more appropriate for use by people with certain ranges of ability or disability than others, and people usually obtained access to these services via referrals from their local authority social worker.

All four sample areas had difficulty in stating how many people who could be included in the sample group lived in their area. Both Manchester and South Glamorgan only held such information at field worker level; as a result Manchester was unable to provide any information. South Glamorgan was able to identify 38 people, but as the information was provided by a number of Social Workers, Community Mental Health Teams and managers of various Day Centres, each of whom used their individual discretion to identify people who could be included in the sample group, the accuracy of the information is limited. The

number of people identified by each person ranged from 1 to 16, and the final total number would not have included people who were not known to the Social Services Department - for example those who were not on a Social Worker's current case load South Glamorgan was unable to give an estimated number of people who would fall into the sample group.

Suffolk was unable to give a known number of people who would fall into the sample group. The reason given was that regular reviews were not carried out and so it was not known whether the individuals of whom they had a record were still living in Suffolk, or were indeed still alive. Suffolk gave an estimated figure of 300 people, with another 50 living outside Suffolk in special residential accommodation financed by Suffolk County Council.

Cleveland was able to give a known figure of 146 people, all of whom were currently attending an

Adult Training Centre, and estimated that there were another 900 people who would fall into the sample group. These had been identified in a Mental Handicap Survey which had been carried out by the Local Authority. None of the sample areas had a voluntary organisation which could provide more precise information on the numbers of people with severe disabilities, or even the number of people with any sort of disability in the area.

ACCOMMODATION ISSUES

One hundred and fifty seven of the total of the possible 900 people who would fall into the sample group in Cleveland currently lived in residential accommodation provided by the Local Authority, of these 20 lived in Group Homes which did not employ care staff of any sort. The remaining 137 people lived in the Local Authority's 10 residential homes. These homes had a high staff:resident ration; approximately 1:1.5, and the age and sex groupings of the residents were evenly spread.

Numbers and ages of the remaining people who lived in the community were not available. However when interviewed the Principal Officer stated that a constant concern was the number of adults with disabilities who lived with elderly parents and were dependent on them for care, and also an area of growing concern was the increasing number of people under the age of 18 who had remained living in their parents' home whilst at school and who had no opportunity to seek alternative accommodation (and care) after leaving school. Therefore of the people already living in the community a probable pattern would be one of older people who had not had a great deal of independence having to prepare to live without the full support of parents, and of younger people, possibly with more severe levels of disability but with greater personal independence seeking to live independently of parents but requiring high levels of services.

For the same reasons as those given regarding completion of Questionnaire 1, Manchester Social

Services Department was unable to complete the Questionnaires for this section. However interviews with representatives from the Department indicated that the vast majority of people who would fall within the Sample Group did not live in "special" accommodation but were living alone, or with parents, spouses or other untrained, unpaid carers.

South Glamorgan was also unable to give detailed information regarding accommodation circumstances of members of the sample group, but the written information supplied, plus that gained from interviews with representatives from the Social Services Department indicated that in this area also the majority of people were already living in the community, and South Glamorgan shared the problem of older people living with and being cared for by their elderly parents.

Suffolk Social Services were able to provide information concerning around 300 people's

accommodation circumstances. It was not known how many people who could be included in the sample group were living in psychiatric hospitals, but 38 people currently lived in long stay hospitals. Fifty people lived in private or voluntary residential centres, some outside Suffolk. Suffolk had no adult house units, group homes, or any other form of sheltered, community based accommodation. The remaining people identified (about 80% of the total) lived in the community, either with parents or other carers, and 10 people lived alone. Suffolk was unable to give any information regarding ages of the people identified.

SERVICES AVAILABLE

Collecting information on numbers and types of services available proved the most complex aspect of this phase of the research. Although none of the sample Social Services Department had objected to the form of Questionnaire III (Appendix 1,

pages xiv - xxi), all were unable to complete it thoroughly.

Cleveland and Suffolk Social Services Departments were able to complete the questionnaire to some extent. Cleveland Social Services Department was able to complete the Questionnaire with the greatest level of detail, and was able to give information concerning voluntary sector services as well as those in the statutory sector. However, the information given predominantly concerned services for people with mental disabilities. Copies of the completed Questionnaire were forwarded to the Cleveland CVS Information Team and to The Spastics Society Development Officer for comment. The Spastics Society (which was responsible for the MSC Community Programme Agency in the area) was able to give information regarding proposed developments for some MSC/The Spastics Society services mentioned by the Social Services Department, and noted that the local Spastics Society Work and Welfare Centre had not been mentioned. Apart from this The Spastics

Society was unable to give further information on services. The Cleveland CVS responded that their role was "to refer people to the appropriate organisation which could help with their particular problem, rather than to hold all the information ourselves". They went on to point out that their knowledge was also limited because their organisation's concerns were very broad based.

Suffolk Social Services Department's ability to complete the questionnaire was made simple by there being so few services available in the area. A copy of the completed questionnaire was forwarded to the Chair of RETHINK who commented that it was "fairly accurate".

At the suggestion of South Glamorgan Social Services Department's Research Department, the questionnaire was forwarded to the Disabled Persons Information Centre, which is based in the Regional Office of The Spastics Society for completion as the Social Services Department did

not have a central information source which would hold the information required.

Manchester Social Services Department also failed to return a completed questionnaire. The person who had been given responsibility for completing the questionnaire left his post within the Department, and due to financial restraints was not replaced. As a consequence Manchester Social Services Department revealed that, whilst they felt the questions asked were sensible and much of the information existed, they did not have the staff time to extract it until such a time as it was required by the Social Services Department to plan and develop their own services. Although it was not possible to gather the required information from a central point, Manchester had many more sources of advice, such as the Disability Forum, the Greater Manchester Coalition of Disabled People, and the Manchester Equal Opportunities Committee.

SUMMARY

There is an obvious need to recognise differences in levels of disability, and so it is significant that in two of the sample areas the local authority concerned did not have a considered definition and left it to the discretion of individual field workers to decide whether a person's disability was "severe", "average", or "mild", and the level of service that the disability required. It is also worth noting that whereas in Suffolk one would be considered as severely disabled if unable to get in and out of a wheelchair, a person living in Cleveland who was unable to eat, toilet, wash, dress and communicate without assistance but who could not be assessed as having a mental disability might not be thought to be severely handicapped. The huge variance in numbers estimated by each local authority is also noteworthy. The total population of South Glamorgan is estimated at 384,633 and that of Cleveland is estimated at 565,775. In view of this it seems unlikely that Cleveland should have

over twenty times the number of severely disabled people in its population as South Glamorgan. However, whilst it is more probable that there is an equal proportion of people with disabilities in South Glamorgan, if the local authority is not aware of these people and the services which they may require, it cannot plan for and provide such services. At a time when many local authorities are complaining of difficulties in providing services at their current level, it would not be surprising if they were loath to give further resources in order to ascertain properly the service need of the area, especially when any attempt to meet additional needs would stretch their resources even further.

None of the voluntary sector agencies in the four areas was able to provide more definite information on numbers of people who would fall into the sample group. None of the coordinating voluntary agencies, such as Intervol in South Glamorgan, or CCVS in Cleveland, had the research facilities to gather such information. The small

voluntary organisations who were concerned with a particular group of people, such as people with a specific type of disability, or people living in a certain area, probably had better knowledge of local needs than the statutory agencies but there was no means of centralising this information.

Before starting to gather information for this research the looseness of definitions relating to people with disabilities and the lack of duty placed on local authorities to identify such people and their service needs, as defined in the Chronically Sick and Disabled Persons Act (1971) and all consequent legislation, indicated that the sample areas probably would not be able to provide substantial amounts of information. However, the research findings indicate that the looseness of the definitions given in legislation are further complicated by the wide variety of interpretation given to them at local authority level. Whilst not underestimating the difficulty involved in keeping up-to-date records of people with disabilities and their needs, the lack of

information held by all four sample areas on this matter raises questions of how a local authority is able to plan for or provide services when it is so unsure of the numbers and needs of its client group.

The findings from the section concerning accommodation issues reflect those obtained with Questionnaire I. All four sample Social Services Departments had extremely limited knowledge of the accommodation circumstances of the people for whom they had some duty of care. The findings reflect the original assumption that the majority of people who could be included in the sample group already live in the community. However the findings, and the areas of accepted ignorance, highlight how little information the Social Services Departments have to assist them when planning services for this group. For example, Cleveland was the only Social Services Department able to provide information on staff:client ratios in its residential establishments. Suffolk's main

by private or voluntary organisations, but the Social Services Department did not know what the staff:client ratio was in these establishments and so could not judge whether the ratios were sufficient and could not assess how much formal support clients who moved from such establishments into the community would need. As with the previous section, all four areas had very little specific knowledge to assist them in planning accommodation related services.

The information gathered from the four sample areas concerning the availability of services indicated quite contrasting situations regarding both the service available to the client group, and the basic level of coordination between the statutory and voluntary sectors in the areas. From the information held by the various advice centres in Manchester it would appear that the number of services available was high, but as there was no central source of information easily available it was not possible to ascertain whether these services were evenly spread throughout the area,

or whether problems of duplication of services arose. Cleveland and South Glamorgan had a central source of information, but alternative sources of information such as community newsletters or publicity material of individual voluntary organisations suggest that their information was far from exhaustive. These areas therefore pose the same problems for gathering sufficient information to make any substantial conclusions as Manchester. Suffolk was the only sample area where the information received could be accepted as a reasonable reflection of the services available. Unfortunately this was because the statutory sector and the voluntary sector agreed that services for the sample client group were practically non-existent.

CHAPTER NINE

EMPIRICAL DATA - SERVICE USERS

Both the statutory sector and the voluntary sector at management levels above that of field worker had extremely limited knowledge of the numbers of people who could be included in the sample group living in their areas, and even less knowledge of their domestic situation and service needs. Consequently it was felt that these groups could not represent properly the views of the sample group on the services they received.

In Cleveland 75 copies of Questionnaire 5 (Appendix 1,pages xxiii-xxx), were distributed by The Spastics Society's Development Officer to centres with which The Spastics Society was involved. A further 40 were sent to the Local Authority's ATC's at Guisbrough and Stockton. In Manchester 75 questionnaires were distributed by a

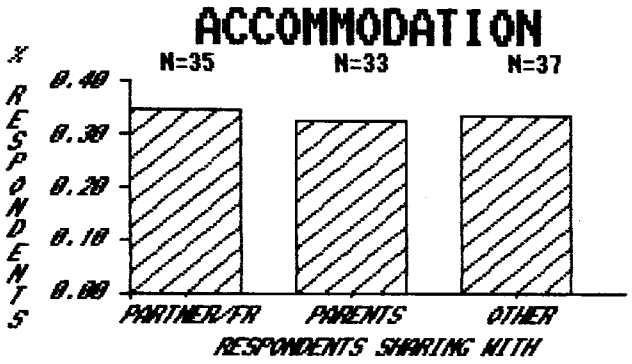
person with disabilities via her links with various consumer groups and DIAL offices, and a further 30 were distributed by an Associate of The Spastics Society's Skills Development Centre in North Manchester who also had links with Phab clubs in the area. In South Glamorgan 75 questionnaires were distributed to Phab clubs, ATC's and Day Centres for the Physically Handicapped, and others were distributed during personal visits to meetings of the MS Society, the Muscular Dystrophy Society and the Association of Disabled Drivers. The Suffolk RETHINK organisation coordinated the distribution of 75 questionnaires throughout Suffolk.

All the questionnaires were distributed with a stamped addressed envelope for their return. They were returned over a period of four months. The people or organisations coordinating the distribution of the questionnaires were contacted approximately every four weeks by telephone and/or letter to ensure that every effort was being made to distribute the forms to members of the sample

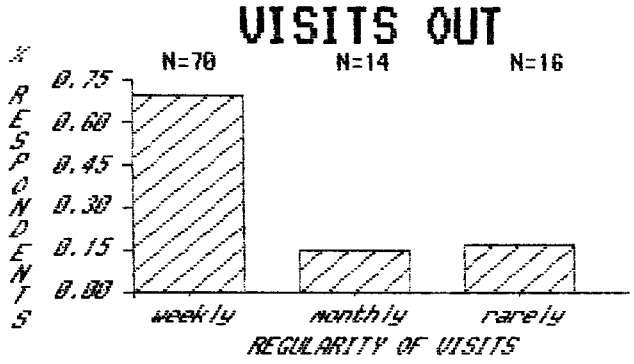
group who were willing to complete them. Seventeen questionnaires were returned from Cleveland, 20 were returned from Manchester, 20 were returned from South Glamorgan and 48 were returned from Suffolk, a total of 105. The low response is a further indication of the problems facing both voluntary and statutory organisations attempting to build links with service users. The response was sufficient to enable some analysis to be carried out, although making comparisons between the four sample areas was difficult which such little material.

INTEGRATION INTO THE COMMUNITY

In all four areas the majority of people lived with a partner or friend (34.4%) or with parents (32.4%) rather than in local authority run group homes, hospitals, residential complexes or purpose build sheltered accommodation.

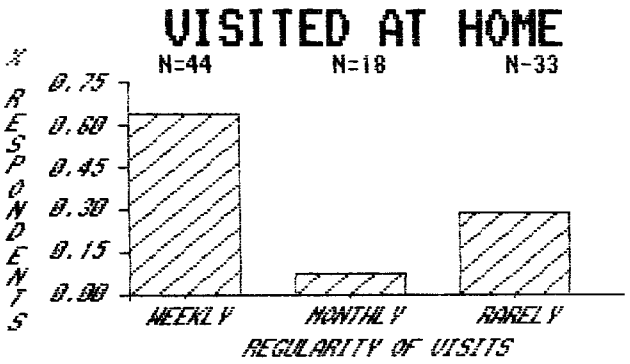


The variation in people's visits to friends outside their home and visits by friends to their home was also similar in all four areas. The majority of people (69.0%) went out between once a week and a few times each month (14.6%).



The majority of people (63.7%) were visited by friends between once a week and a few times each month (7.6%). Cumulatively there was a range of less than 10% between people having a predominance of friends of a similar age, with disabilities, or with common membership of a church or club; although only 19.6% of people had friends who were mostly older than them. In all four areas, where the respondent gave the name of a club where they met friends, it was a club with an interest in disability (eg Phab or MS clubs) rather than one

interested in a leisure pursuit or other matter.

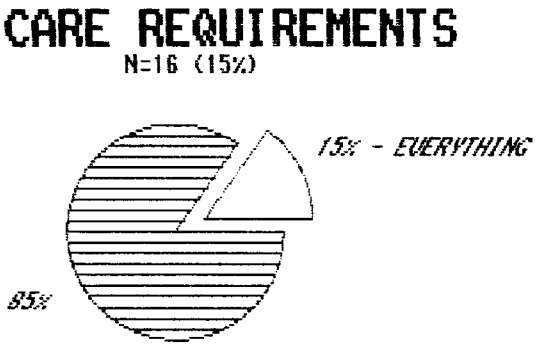


The frequencies give some indication of what "living in the community" meant to the people who fell into the sample group. Whilst the number of people living alone or with a partner or friend appears normal, the number of people living with parents is far higher than one would expect of a group of people aged between 20 and 60. Although the majority of people had at least monthly contact with people outside their home a

significant number had no contact either by going out themselves, or by being visited (12.6% and 15.7% respectively).

LIVING SKILLS AND SERVICE REQUIREMENTS

Over 15% of the total sample required assistance with all of the tasks mentioned in Section Two of the Questionnaire. Over 40% required assistance with all the tasks except using private transport, eating and moving around their homes. Over 40% required help cleaning their homes, doing their own laundry, shopping, decorating and using public transport: probably the skills for which assistance is most readily available in the community.



The percentage of people requiring assistance for any of the tasks was higher in Suffolk (by an average of 10%) than in the other three areas.

All the samples had people who required assistance shopping, decorating, cleaning their homes and using public or private transport but did not receive any. The highest incidence of people requiring but not receiving assistance cleaning their homes and eating occurred in Cleveland and Manchester; and of people requiring but not receiving assistance washing and dressing, using the bathroom and doing laundry in Cleveland, South

Glamorgan and Suffolk.

Assistance supplied by a statutory agency varied between 6% and 16% for all tasks except decorating, where the level of assistance supplied by a statutory agency rose to 55%. The frequency of statutory sector involvement was similar in all four areas. None of the replies mentioned a voluntary agency supplying assistance for cleaning the home, doing laundry or shopping, and the level of voluntary assistance for the other tasks, with the exception of moving around the home, varied between 3% and 7%. 15% of replies concerning moving around the home referred to a voluntary agency, but these were all referring to the Crossroads Care Attendant Scheme in Suffolk. The majority of other replies referring to the voluntary sector also came from the Suffolk area.

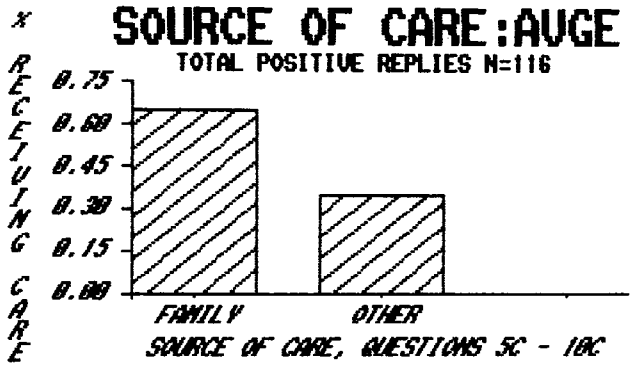
Less than 50% of the replies stated whether or not they knew of an alternative source of assistance, and an average of only 25% were able to name an alternative. Of these 35% were a family member or

friend, 34% were statutory agencies and 31% were voluntary agencies. As with the previous question, a significant proportion of replies naming a voluntary agency were for the Crossroads Care Attendant Scheme in Suffolk. The response to the question of whether an alternative would be preferred was also very low - less than 50%. Of these, positive replies varied between 3% and 27%. Reasons for wanting an alternative fell into three broad catagories: some were concerned with what would happen when their relative could no longer care for them, some felt that their reliance on (unpaid) relatives and friends caused inconvenience to the carers and limited their own independence, and many of those receiving assistance from the statutory sector felt that the assistance was insufficient and/or inappropriate. One person illustrated this common feeling:

> "Home helps today are simply not geared into action coping with ordinary house work. They like little old people for whom they can get pensions and shopping and light duties. I need a family assistant. Someone who will do the things I cannot manage and leave me to get on

with what I can, such as dusting, cooking - I cannot manage floors and windows, I can wash but not hang it out to dry."

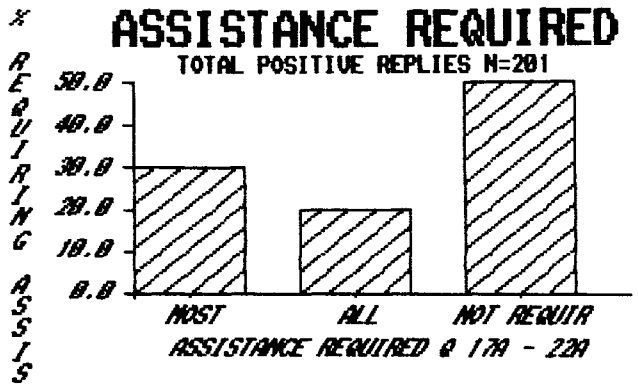
PERSONAL MANAGEMENT AND DEGREE OF INDEPENDENCE/AUTONOMY



In the cases where assistance was received, at least 50% of the assistance in each case was given by a family member, usually a parent or spouse.

The level of family assistance rose to over 65% for eating, washing and dressing, using the bathroom, doing laundry and shopping. Assistance for these tasks would be required a number of times throughout each day.

Between 30% and 50% of people who replied to the questions in Section Three of the Questionnaire required assistance. The incidence of positive replies varied between the sample areas: whilst Suffolk had the highest incidence of positive replies in Section 2, it had the lowest incidence in Section 3 - 28.0% of all replies from Suffolk were positive. Manchester and South Glamorgan had an incidence of positive replies of 36%-37%, and Cleveland had the highest rate of positive responses at 61.0%.



For every question there were people from Cleveland, Manchester and Suffolk who stated that they needed assistance but did not receive it. This also occurred in replies from South Glamorgan with the exception of the questions concerning the ability to understand important letters and bills, and the ability to arrange to pay bills.

TYPES OF ASSISTANCE REQUIRED

The nature of the problems incurred were similar in all four areas. Only 12% of people who had problems reading and understanding important

letters or bills were visually impaired. The remaining replies were evenly divided between those who had difficulty understanding them either because of a lack of experience or mental disability, and those who did not have reading skills.

The majority of people who replied that they had difficulty arranging to pay bills stated that their carers had total responsibility for these matters. Five people stated that they had mobility problems, and two said that their problems were related to a lack of money from being reliant on Invalidity and Supplementary Benefits (changed to Income Support following the DSS arrangements introduced in April 1988), rather than an inability to understand or control their finances.

One third of the people who had problems finding out about statutory benefits had passed responsibility for this to their carers. Of those remaining, the replies commented on difficulties

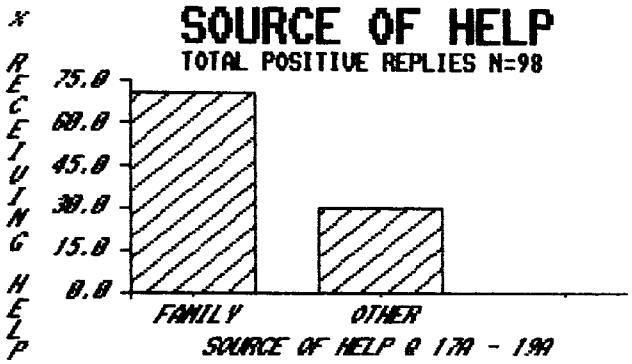
finding out about benefits, the lack of information available and the difficulty in understanding it. Over 30% of those who replied stated that they were not sure that they were claiming everything to which they were entitled.

Over 30% of people who said they had problems using post offices or banks had a mental disability and/or had passed responsibility for dealing with such matters to their carers. The remaining replies indicated problems with access to post office or bank buildings, or problems with the height of counters for people who used wheelchairs or for one person who used his feet to write.

The response from people who had problems talking with people in authority were divided evenly between those who passed responsibility for this to their carers, those who had physical or intellectual disabilities which caused problems and those who felt nervous of such people or found

them uncaring or unhelpful.

With the exception of problems finding out about the then DHSS and Social Security Benefits, over 70% of the sample who received assistance received it from members of their family.



Only one person received assistance from a voluntary agency, the DIAL in Suffolk, and no one received assistance from a voluntary agency for problems linked to arranging to pay bills, using post offices or banks, or talking to people in authority. The most even distribution of sources of help was for people who had problems finding

out about DHSS benefits: 56.0% received assistance from their family, 22.0% from statutory agencies, 16.0% from voluntary agencies and 6.0% from friends.

Almost 70% of the sample did not reply to the question of whether they knew of an alternative source of help, or whether they would prefer to use one. However it is significant that of those replies received, only four gave another family member as an alternative source of help; 19 people named a statutory agency whereas 24 had named one as an actual source of help, and 13 people named a voluntary agency as an alternative when only 7 had named one as an actual source of help. It is also significant that of the 43 replies which named a statutory agency as an actual or alternative source of help, only 12 (29%) named a Social Worker or DHSS adviser. The other replies named hostel or day centre staff or home helps, none of whom is usually specifically trained in or responsible for giving such help.

Less than 30% of those who responded stated that they would prefer to use an alternative source of assistance, and few of those who did gave a reason for wanting to do so. No reason was given for preferring alternative assistance understanding important letters or arranging to pay bills. The only reason given for wanting an alternative when finding out about DHSS benefits was that "too many people are losing out through being unaware of benefits". The response to problems concerning use of post offices and banks was a wish for the access problems to be eliminated. Only one person explained why an alternative source of help when talking to people in authority would be preferred: "I would prefer someone to work on my behalf - I don't feel able to take on the Housing (Department), the very thought makes me suicidal".

SUMMARY

The data collected for Chapter 8 indicated that the vast majority of people in the sample group already live in the community. The data collected for this Chapter indicates that, whilst many of those who completed questionnaires lived with partners of a similar age and had regular contact with people outside their home, the majority lived with parents or alone and a significant number had very little contact with his or her local community.

Over a third of the sample questioned needed assistance with tasks which they had to complete daily, if not hourly. However the data showed that in all four areas there were people who did not receive required assistance, and where assistance was available it was from a family member rather than a statutory sector or voluntary sector organisation. The respondents relied more on the statutory sector than the voluntary sector as an actual source of help. The incidence of responses

naming a voluntary organisation, statutory sector organisation or family member as an alternative source of help were similar. However, as the numbers who could actually name an alternative were so low - less than 30% - the amount of support offered as an alternative source of help by any of these groups appears almost insignificant.

The pattern of responses to questions concerning the sample groups' personal management independence were similar to those concerning living skills and service requirements. In all four areas there were incidents of people requiring assistance but not receiving it. By far the majority of assistance came from family and friends, and more people relied on statutory services than those offered by voluntary organisations. Few people gave reasons for wanting an alternative source of assistance. The finding that more people named the statutory sector as an actual source of assistance than an alternative, and more people named a voluntary

organisation as an alternative source of assistance may be significant. Possibly those who used the statutory sector felt they were receiving all the assistance that was available. Those not using a service offered by a voluntary organisation may have been totally satisfied with the assistance they received, or they may have felt there was a stigma attached to receiving help from a charity. Alternatively their not using such a service may indicate a lack of knowledge either of how to obtain such a service, or the appropriateness of the service to their needs.

The findings from the data emphasise the underdeveloped role which both the statutory and the voluntary sectors play in providing services to this sample group, but they also emphasise the need for more services to be provided. In respect of the data collected for Chapters 6 and 7, this data highlighted the futility of any concept of the statutory and voluntary sectors having a collaborative system of service provision; providing alternative services or working as

partners to provide the most suitable service. The sample group mainly used whatever service was offered because there was a dearth of most services. The data does not present a picture of service users shopping around between the two sectors, discarding one service for another. Voluntary organisations and the statutory sector might have to compete for resources, but their market appears totally guaranteed.

CHAPTER TEN

CONCLUSIONS

The aim of this study was to examine the rationale for coordinating statutory and voluntary services by examining the nature and extent of partnerships between voluntary and statutory providers of services to adults with disabilities in a number of local authority areas, and to consider whether and to what extent this partnership affected the service provided.

As stated in Chapter 1, this was carried out through four stages of data collection which aimed to establish the extent to which the sample group could be identified, to identify services and the role which the voluntary sector played in planning and providing them, and to measure the effect that the services, and the ways in which they were planned and provided, had on the sample group's ability to live in the community.

THE EXTENT TO WHICH THE SAMPLE GROUP WERE IDENTIFIED

The findings from the data collected for this section of the study highlighted three points:

(1) The range of terms used to describe levels of ability and disability was not consistent throughout the statutory sector; neither was the interpretation of these terms consistent throughout the statutory sector.

(2) Neither statutory nor voluntary agencies had, or were able to assemble, a comprehensive record of the numbers of people with a disability living in their service area, or a record of such people's present and future needs.

(3) The majority of people who could be included in this study's sample group already lived in the community, although the statutory and voluntary agencies' knowledge of their accommodation circumstances was extremely limited.

SERVICES AVAILABLE TO THE SAMPLE GROUP

The aim of collecting data for this section was to establish the range of services available to the sample group. Ultimately all that the data collected showed was the lack of any central source of information on available services in any of the sample areas. This lack of success in identifying services does not indicate that services did not exist. However it does indicate the level of difficulty which anyone else wishing to gather information concerning services available, such as a person with a disability who personally required a service, could expect.

THE ROLE OF THE VOLUNTARY SECTOR IN PLANNING AND PROVIDING SERVICES

(1) Data collected from statutory agencies showed a common belief that the voluntary sector should play some part in planning and providing services.

(2) Regarding Models of Coordination, there was an apparent preference for Model A, (as described in Chapter 3) whereby clearly identifiable people within the statutory sector had responsibility for liaising with the voluntary sector rather than Model B, whereby this responsibility was held by everyone. Only South Glamorgan followed this model. As the amount of data relating to strategy for coordinating services which it had been possible to collect was limited, it was not possible to ascertain whether South Glamorgan had more or better links with the voluntary sector as a result of its

differing strategy.

Although there was variance in degree, all four sample areas followed Model C in seeking to establish liaisons with service users themselves.

(3) Whilst opinions on the amount of control or influence which the voluntary sector should have varied, similar perceptions of problems inherent in working with the voluntary sector were held by all the agencies approached.

(4) The data collected from representatives of the voluntary sector confirmed the findings of the data collected from the statutory sector that communication between the two groups was poor, and that there was a mutual lack of understanding of each group's aims and management organisation.

(5) It was apparent that the voluntary sector did play some role in the planning and providing of services. It was also obvious that there were problems, mainly resulting from poor communication between the two groups, which restricted this role.

(6) Whilst the amount of resources directed towards encouraging the development of this role varied between the sample areas, such development was not a major objective for any of the Social Services Departments approached.

(7) Due to the lack of data collected concerning services available it was not possible to measure any link between the method of statutory sector/voluntary sector coordination and the comprehensiveness of service provision.

(8) Concern over the voluntary sector's dependence on the statutory sector as its source of funding was expressed by representatives from both groups. Although, due to the limited nature of the data collected, it would not be possible to endorse Wilson and Butler's argument that the primary influences which shape the choice of strategy in voluntary organisations are those created by inter-dependence, it was apparent from the interviews carried out with representatives from the voluntary sector that many voluntary organisations would not be able to function without the financial assistance they receive from the statutory sector. Consequently much of their work is planned and carried out partly with a view to securing such funding.

(9) The statutory sector representatives did not consider liaison with the voluntary

sector automatically provided communication with service users. Although it was difficult obtaining data on this subject from service users themselves, those who did supply responses did not feel that organisations made up predominantly of non-service users could represent them properly.

(10) Both the statutory sector representatives and the services users reported a lack of trust in large, national voluntary organisations controlled by highly paid, professional service providers who were not service users themselves.

THE EFFECT OF STATUTORY SECTOR/VOLUNTARY SECTOR COORDINATION ON THE SAMPLE GROUP'S ABILITY TO LIVE IN THE COMMUNITY

(1) The data collected from service users concerning their choice and use of services indicated that there was a great shortage of services available, regardless of sample area. In every area there were people who required some assistance in order to have a standard of life-style similar to a person without a disability, but who did not receive sufficient assistance or even received no assistance at all.

(2) From the data collected it appeared that in all four sample areas, the statutory sector played a slightly more active role in providing assistance than the voluntary sector. Service users named family members, statutory organisations and

voluntary organisations as alternative sources of assistance in equal proportions.

(3) Family members, especially mothers and spouses, were by far the main providers of assistance. This dependence on (unpaid, untrained) assistance from family members became even more apparent when one considered that less than 30% of those questioned were able to name any alternative source of help, and some of these replies included names of other family members.

(4) The voluntary sector (excluding "volunteers" such as family and close friends) played the least significant role in providing services generally in any of the four sample areas. Further data collection would be necessary to ascertain whether this was due to services users' inability to find out what the voluntary

sector had to offer, or whether they felt there was a stigma attached to receiving help from a charity.

(5) The voluntary sector in all four sample areas played a greater role as a provider of information and advice than as a provider of practical assistance, such as eating, washing, dressing or shopping.

(6) The data collected concerning personal characteristics of the sample group indicated that the majority were living in the community despite having disabilities which could be described as profound and who required large amounts of assistance, in some cases constantly throughout the day. None of the sample areas was significantly better or worse than the others regarding the provision of services. There was a slightly lower incidence of people requiring physical care but higher incidence of people

requiring assistance to enable them to manage their lives more independently in Suffolk. This might have been due to Suffolk Local Authority's past policy of sending people who required high levels of physical care to centres outside the area, but further research would be needed to establish the cause.

The high number of people in the four sample areas who required but did not receive assistance suggests that the majority of the sample group would continue to live in the community even if the voluntary sector services were withdrawn. On this basis, it would be possible to state that the voluntary sector had no influence on individual members of the sample group's ability to live in the community. However the distinct lack of available services, and the amount of time and effort given by close friends and relatives of the

individuals because of this suggests that all services, regardless of provider, were of some importance. As stated at the end of Chapter 9, none of the service users were able to choose between services offered by the voluntary sector or statutory sector, discarding one for another. Although help from the voluntary sector was less than that from the statutory agencies, for the person who lives in but is almost totally isolated from the community because of his/her special needs, or for the person who provides care for a friend or relative 24 hours a day, every day, any help is important regardless of how small it is. On this basis, the voluntary sector had a vital influence on the sample group's ability to live in the community.

(7) Although not a major objective, the Social Services Departments involved in this

study did direct some of their resources towards improving coordination with the voluntary sector. The data on services received by the sample group poses the question of whether it is appropriate for resources to be directed towards this end when there is such a shortage of resources available for providing actual services, and when the amount of resources directed to improving coordination with the voluntary sector is insufficient to have any noticeable effect on service provision.

CHAPTER ELEVEN

RECOMMENDATIONS

Whilst it was not possible to measure the effect of any of the proposed models of coordination, it was apparent that the success of any attempt to establish a coordinated approach to service provision would be limited by problems common to all four sample areas. In order to enable such an approach to be implemented successfully the following recommendations would need to be considered:

(1) Individual voluntary organisations must recognise their responsibility to the service users they claim to represent. By encouraging and maintaining opportunities for service users to take an active part in the management of such organisations

the voluntary sector will be able to continue with its claim to represent and have an expert knowledge of issues relating to specific groups within society.

(2) The voluntary sector must take steps to ensure that its objectives are set according to the interests of the groups it represents, and that the setting of objectives is not controlled by the financial incentives or otherwise offered by the statutory sector or any other source of funding. Whilst it might occur that some objectives may never be achieved because of lack of funding, this can be balanced against the erosion of the voluntary sector's independence and consequent ability to advocate for the rights of certain groups if it merely carries out tasks identified and funded by a different sector.

(3) Individual voluntary organisation must identify clearly whom they wish to represent and what they wish to achieve, and this should be made obvious to all other organisations or individuals with which it deals.

(4) By identifying whom they represent and their main objectives, voluntary organisations will then be in a position to decide whether it is possible, or even logical for them to work with other voluntary or statutory organisations.

(5) The statutory sector must increase its knowledge of the make-up of the voluntary sector, and the objectives and capabilities of individual voluntary organisations in order to prevent the making of assumptions of what "the voluntary sector" can and will do.

(6) The statutory sector must show a commitment to the stated aim of establishing a coordinated system of service provision by making available funds for training and other opportunities to the voluntary sector to enable representatives from the voluntary sector to negotiate with statutory sector members as equal partners.

(7) Furthermore, the statutory sector must make available resources to enable any voluntary sector representative to establish a network for passing information to and gaining views from individual voluntary organisations.

(8) Finally, the statutory and voluntary sectors must follow the lines of any other organisations who establish a partnership in order to achieve a specified task. If the two groups decide that a voluntary organisation should carry out a task the

> organisation must be given adequate resources for doing so; this would include being guaranteed funding for the whole period over which the task is to be achieved, or if the task does not have a forseeable end for a period long enough to measure the effects of any adopted strategy and to plan for future developments. At the same time, the voluntary organisation should be required to report to the funding body on its progress towards achieving a task. The system and criteria used to measure progress should be agreed by the two groups at the outset.

In its response to the Griffiths Report (1989), the government has stated that the statutory sector should delegate most of its responsibility for actually providing services to people who are elderly, mentally ill or mentally or physically disabled to voluntary or private organisations, and should take on a coordinating role. If the

statutory sector is to do this whilst remaining accountable to the general public not only for the amount of money spent on services but also for the quality of those services, steps similar to these recommendations will have to be taken. Currently any partnership between the voluntary sector and the statutory sector is marred by inequalities based on ignorance and lack of proper resources.

APPENDIX I

SAMPLE QUESTIONNAIRES

RESEARCH PROJECT QUESTIONNAIRE I

Aim of Questionnaire

The aim of this Questionnaire is to establish the size of the Sample Group in this Local Authority area.

Definition of Sample Group

People with severe physical or multiple disabilities between the ages of 20 and 60, who are expected to live in the community within the next 10 years.

For ease of reference members of the Sample Group will be referred to as "Clients".

* * * * * * *

AREA: .....

DEFINITION OF "SEVERE" DISABILITY (eg someone who is ineligible for a place at an ERC, or someone whose daily functioning is significantly impaired in the opinion of his/her Social Worker):

.....

.....

.....

.....

.....

KNOWN NUMBER OF CLIENTS IN THIS AREA:

MALE: .....

FEMALE: .....

SOURCES OF INFORMATION FOR KNOWN FIGURE: .....

.....

.....

ESTIMATED NUMBER OF CLIENTS IN THIS AREA: .....

BASIS FOR PRODUCING THIS FIGURE: .....

.....

.....

Form completed by: ..... Date: .....

RESEARCH PROJECT QUESTIONNAIRE II

Aim of Questionnaire

1 To establish numbers and types of accommodation

2 To compare numbers and types of accommodation available with client numbers

Definition of Sample Group

People with severe physical or multiple disabilities between the ages of 20 and 60, who are expected to live in the community within the next 10 years.

RESEARCH PROJECT QUESTIONNAIRE IIa

TYPE	NO OF ESTABLISHMENTS	NO OF CLIENTS	AGE RANGE								NO OF CARE STAFF	
			MALE				FEMALE				F/TIME	P/TIME
			20-30	31-40	41-50	51-60	20-30	31-40	41-50	51-60		
Psychiatric Hospital												
Long Stay Hospital												
Residential Home												
Adult House Unit												
Group Home												
Core & Cluster Unit												
Sheltered Housing Complex												
Other (Please specify)												

AREA: .....

DATE: .....

FORM COMPLETED BY: .....

RESEARCH PROJECT QUESTIONNAIRE IIb

TYPE	NO OF CLIENTS	AGE RANGE							
		MALE				FEMALE			
		20-30	31-40	41-50	51-60	20-30	31-40	41-50	51-60
With Parents									
Alone									
Other (Please specify)									

AREA: ..... DATE: .....

FORM COMPLETED BY: .....

RESEARCH PROJECT QUESTIONNAIRE III

Aim of Questionnaire

The aim of this Questionnaire is to establish the quantity of services available in this area and to define the limits of each service.

Definition of Sample Group

People with severe physical or multiple disabilities between the ages of 20 and 60, who are expected to live in the community within the next 10 years.

Example of Completed Questionnaire

SERVICES	CONSUMER LIMIT	GEOGRAPHIC LIMIT	TIME LIMIT	ACCESS LIMIT	OTHER LIMITS
ATC	65 places	Must live in Blacon, Arran or Dewlare Areas	9.00 - 4.00 Mon - Fri	No facilities for wheelchairs	Must have Social Worker referral. Must have no "personal" needs.
ADVOCACY	N/A	None	None	None	Some delay in finding a suitable advocate
PUBLIC TRANSPORT-SPECIAL Dial-a-ride	N/A	Must live within 5 miles of City Centre	8.00 am-8.00pm	None	Must have access to telephone. Average cost of £1.50 per journey
RESPITE CARE	10 places	None	None	None	Must have social worker referral

RESEARCH PROJECT QUESTIONNAIRE IIIa

SERVICE PROVISION : DAY CARE

SERVICE	CONSUMER LIMIT	GEOGRAPHIC LIMIT	TIME LIMIT	ACCESS LIMIT	OTHER LIMITS

RESEARCH PROJECT QUESTIONNAIRE IIIb

SERVICE PROVISION : DAY CARE

For each service recorded in Questionnaire IIIa, please give a brief outline of the service/training offered, including those arranged by an establishment which take place in the community:

(Continue on another page if necessary)

AREA: ..... DATE: .....

FROM COMPLETED BY: .....

RESEARCH PROJECT QUESTIONNAIRE IIIc

SERVICE PROVISION : EDUCATION

SERVICE	CONSUMER LIMIT	GEOGRAPHIC LIMIT	TIME LIMIT	ACCESS LIMIT	OTHER LIMITS

RESEARCH PROJECT QUESTIONNAIRE IIId

SERVICE PROVISION : EDUCATION

If appropriate please give a brief outline of the services recorded in Questionnaire IIIc:

(Continue on another page if necessary)

AREA: ..... DATE: .....

FROM COMPLETED BY: .....

RESEARCH PROJECT QUESTIONNAIRE IIIe

SERVICE PROVISION : GENERAL

SERVICE	CONSUMER LIMIT	GEOGRAPHIC LIMIT	TIME LIMIT	ACCESS LIMIT	OTHER LIMITS
Home Help Service					
Laundry Service					
Advocacy					
Advice					
Social Skills Training					
Respite Care					

CONT ...

RESEARCH PROJECT QUESTIONNAIRE IIIe (Cont)

SERVICE	CONSUMER LIMIT	GEOGRAPHIC LIMIT	TIME LIMIT	ACCESS LIMIT	OTHER LIMITS
Transport Services					
Other Services: please specify					

AREA: .....

DATE: .....

FORM COMPLETED BY: .....

RESEARCH PROJECT QUESTIONNAIRE IIIf

SERVICE PROVISION : GENERAL

If appropriate, please give a brief outline of the service recorded in Questionnaire IIIe:

(Continue on another page if necessary)

AREA: ..... DATE: .....

FORM COMPLETED BY: .....

RESEARCH PROJECT QUESTIONNAIRE IV

NAME OF COORDINATING GROUP: .....

How are the Chairman and Secretary selected? .....

.....

.....

How are the voluntary organisation representatives selected? .....

.....

.....

How are the Social Services representatives selected? .....

.....

.....

How are the agenda items proposed and selected? .....

.....

.....

How long before the meetings are agenda distributed? .....

Are the meetings open to the public and the press? .....

How often do meetings take place? .....

How often have meetings been cancelled and/or postponed over the past 5 years? .....

Are the minutes available to the public and the press? .....

How long do the meetings last? .....

Do all members of the Group have equal voting rights - if not, how are voting rights distributed? .....

.....

.....

FORM COMPLETED BY: .....

DATE: .....

RESEARCH PROJECT QUESTIONNAIRE V

Thank you for agreeing to complete this questionnaire, your help is greatly appreciated.

SECTION ONE

Please put a tick in the box by the answer which applies to you:

1 DO YOU LIVE:

(a) ALONE ☐

(b) WITH YOUR PARENTS ☐

(c) WITH YOUR PARTNER OR FRIEND ☐

(d) IN SHELTERED ACCOMMODATION WITH SPECIALLY EMPLOYED STAFF ☐

(e) OTHER (Please specify below) ☐

.....

2 DO YOU GO OUT WITH FRIENDS:

(a) EVERY DAY ☐

(b) A FEW TIMES EVERY WEEK ☐

(c) ONCE A WEEK ☐

(d) MORE THAN ONCE A MONTH ☐

(e) LESS THAN ONCE A MONTH ☐

(f) NEVER ☐

3 DO FRIENDS VISIT YOU AT HOME:

(a) EVERY DAY ☐

(b) A FEW TIMES EVERY WEEK ☐

(c) ONCE A WEEK ☐

(d) MORE THAN ONCE A MONTH ☐

(e) LESS THAN ONCE A MONTH ☐

(f) NEVER ☐

4 For the following question tick more than one box if necessary. If you tick the box for answer (d) please give the name of the club or church.

ARE YOUR FRIENDS MOSTLY:

(a) PEOPLE THE SAME AGE AS YOU ☐

(b) PEOPLE OLDER THAN YOU ☐

(c) PEOPLE WITH DISABILITIES ☐

(d) PEOPLE WHO ATTEND THE SAME CLUB/CHURCH AS YOU ☐

Name of club or church: .....

SECTION TWO

5 DO YOU NEED ASSISTANCE GETTING AROUND YOUR HOME YES/NO

If NO, go to Question 6

If YES DO YOU GET ASSISTANCE YES/NO

If NO go to Question 6

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

6 DO YOU NEED ASSISTANCE EATING YES/NO

If NO, go to Question 7

If YES, DO YOU GET ASSISTANCE YES/NO

If NO, to go Question 7

cont ...

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

8 DO YOU NEED ASSISTANCE EATING: YES/NO

If NO, go to Question 9

If YES, DO YOU GET ASSISTANCE YES/NO

If NO go to Question 9

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

9 DO YOU NEED ASSISTANCE WASHING AND DRESSING: YES/NO

If NO, go to Question 10

If YES, DO YOU GET ASSISTANCE YES/NO

If No, go to Question 10

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

10 DO YOU NEED ASSISTANCE USING THE BATHROOM: YES/NO

If NO, go to Question 11

If YES, DO YOU GET ASSISTANCE YES/NO

If NO, go to Question 11

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

11 DO YOU NEED ASSISTANCE CLEANING YOUR HOME YES/NO

If NO, go to Question 12

If YES, DO YOU GET ASSISTANCE YES/NO

If NO, go to Question 12

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

12 DO YOU NEED ASSISTANCE DOING LAUNDRY YES/NO

If NO, go to Question 13

If YES, DO YOU GET ASSISTANCE YES/NO

If NO, go to Question 13

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

13 DO YOU NEED ASSISTANCE SHOPPING: YES/NO

If NO, go to Question 14

If YES, DO YOU GET ASSISTANCE YES/NO

If NO, go to Question 14

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

14 DO YOU NEED ASSISTANCE DECORATING YOUR HOME: YES/NO

If No, go to Question 15

If YES, DO YOU GET ASSISTANCE YES/NO

If NO, go to Question 15

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

15 DO YOU NEED ASSISTANCE USING PUBLIC TRANSPORT: YES/NO

If NO, go to question 16

If YES, DO YOU GET ASSISTANCE YES/NO

If NO, go to Question 16

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

16 DO YOU NEED ASSISTANCE USING PRIVATE TRANSPORT YES/NO

If NO, go to Question 17

If YES, DO YOU GET ASSISTANCE YES/NO

If NO, go to Question 17

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

SECTION THREE

17 DO YOU HAVE ANY PROBLEMS UNDERSTANDING BILLS AND IMPORTANT LETTERS: YES/NO

If NO, go to Question 18

If YES, WHAT SORT OF PROBLEMS: .....

.....

DO YOU GET ASSISTANCE WITH THESE PROBLEMS: YES/NO

If NO, go to Question 18

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

18 DO YOU HAVE ANY PROBLEMS ARRANGING TO PAY BILLS: YES/NO

If NO, go to Question 19

If YES, WHAT SORT OF PROBLEMS: .....

.....

DO YOU GET ASSISTANCE WITH THESE PROBLEMS: YES/NO

If NO, go to Question 19

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

19 DO YOU HAVE ANY PROBLEMS FINDING OUT ABOUT DHSS & SOCIAL SECURITY BENEFITS: YES/NO

If NO, go to Question 20

If YES, WHAT SORT OF PROBLEMS: .....

.....

DO YOU GET ASSISTANCE WITH THESE PROBLEMS YES/NO

If NO, go to Question 20

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

20 DO YOU HAVE ANY PROBLEMS USING POST OFFICES AND BANKS: YES/NO

If NO, go to Question 21

If YES, WHAT SORT OF PROBLEMS: .....

.....

DO YOU GET ASSISTANCE WITH THESE PROBLEMS YES/NO

If NO, go to Question 21

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

21 DO YOU HAVE ANY PROBLEMS TALKING TO PEOPLE FROM THE DHSS, SOCIAL SECURITY, OR OTHER PEOPLE IN AUTHORITY: YES/NO

If NO, go to Question 22

If YES, WHAT SORT OR PROBLEMS: .....

.....

DO YOU GET ASSISTANCE WITH THESE PROBLEMS: YES/NO

If NO, go to Question 22

If YES:

(a) WHO PROVIDES ASSISTANCE: .....

(b) DO YOU KNOW OF ANY OTHER PERSON OR ORGANISATION WHO COULD PROVIDE ASSISTANCE: YES/NO

(c) IF YES, WHO: .....

(d) WOULD YOU PREFER SOME OTHER PERSON OR ORGANISATION TO PROVIDE IT: YES/NO

(e) IF YES, WHY: .....

22 If you would like to make any further comments regarding the range, adequacy and accessibility of the services you use; or comments regarding your control of these services, please do so in the space below. Additional sheets may be added if required.

THIS QUESTIONNAIRE HAS BEEN COMPLETED BY:
(Please tick the appropriate box)

(a) A person with disabilities ☐

(b) A person with disabilities, with assistance from another person ☐

(c) A carer of a person with disabilities ☐

Thank you again for agreeing to complete this questionnaire. Please return it in the enclosed envelope.

Llinos M Jehu
October 1987

APPENDIX II

SAMPLE INTERVIEW PLANS

RESEARCH PROJECT INTERVIEW PLAN 1

Aim of Interview

To investigate the degree of coordination of services within a Sample Area.

Interviewee

Chair/Secretary of the Sample Area's Voluntary Organisations/Social Services Department liaison group - there may be more than one group in a Sample Area.

Additional Material Required

1 Obtain minutes of meetings held by the Group over the last 5 years.

2 Attend a meeting of the Group as an observer

3 Pre-interview questionnaire:

1 How is the Chair/Secretary selected
2 How are the voluntary organisation representatives selected
3 How are the Social Services representatives selected
4 How are agenda items proposed and selected
5 How long before the meetings are agenda distributed
6 Are the meetings open to the public/press
7 How often do meetings take place
8 How often are meetings cancelled or postponed
9 Are the minutes available to the public/press
10 How long do the meetings last
11 Do all members of the Group have equal voting rights - if not, how are voting rights distributed

4 Obtain a list of members of the Group

Area to Cover during Interview

1 Interviewee's view of the function/purpose of the Group

2 Interviewee's view of how the Group was established, members chosen, voting rights established etc.

3 Interviewee's view of the achievements of the Group to date.

(Letteroutlining areas to be covered in indterview to be sent to Interviewee with the pre-interview questionnaire c 2 weeks before the interview)

RESEARCH PROJECT INTERVIEW PLAN II

Aim of Interview

To investigate the degree of voluntary sector coordination of services within a Sample Area.

Interviewee

Representative from the Sample Area's Council for Voluntary Organisations and/or Council for Voluntary Services.

Additional Material Required

Pre-interview questionnaire to be sent to the Interviewee with letter outlining areas to be covered in the interview.

Pre-interview questionnaire:

1 Whom does the Council represent
2 Does the Council work through anything apart from meetings
3 If so, how
4 What projects has the Council worked on over the past 5 years
5 How are members selected
6 How often do they have meetings
7 How long do meetings last
8 How are agenda items proposed and selected
9 How long before the meetings are agenda distributed
10 How often are meetings cancelled or postponed
11 Are meetings open to the public/press
12 Are minutes open to the public/press
13 Does the Council liaise as a body with local statutory organisations - how - to what effect
14 Does the Council liaise as a body with national statutory organisations (eg MSC/ECC) - how - to what effect

Areas fo Cover during Interview

1 Interviewees views on relationships between the Council and statutory organisations in the area.

2 Interviewees views on relationships between individual voluntary organisations and statutory organisations in the area.

3 Interviewee's views on why such relationships exist (or do not exist)

4 Interviewee's views on the advantages/disadvantages of such relationships

5 Interviewee's views on relationships between voluntary organisations in the area, the cause of such relationships, and the effect of these relationships on services.

RESEARCH PROJECT INTERVIEW PLAN III

Aim of Interview

To investigate the degree of coordination of services within a Sample Area.

Interviewee

The Sample Area's Social Services/Health Authority Voluntary Organisation Liaison Officer - if one exists.

Additional Material Required

Pre-interview questionnaire to be sent to the Interviewee with letter outlining areas to be covered in the interview.

Pre-interview questionnaire:

1 Is the role of Liaison Officer the main aspect of the person's job
2 How does the job function in relation to the rest of the Local Authority
3 How does the Liaison officer form links with voluntary organisations
4 With how many voluntary organisations have links been made
5 What effect (projects etc) does the Liaison Officer have on service provision

Areas to Cover during Interview

1 Interviewee's view of the voluntary sector's role in providing services: should they aim to provide alternative services, additional but similar services, act purely as pressure groups to highlight the need for additional services etc.

2 Interviewee's view of his/her role in helping to provide services.

3 Interviewee's view of relationships between voluntary and statutory organisations (including individual voluntary organisations and/or individual government departments), and of the ideas of there being a "partnership" between the various groups.

4 Interviewee's view of his/her achievements (or potential for achieving anything), and view of obstacles to achievements.

RESEARCH PROJECT INTERVIEW PLAN IV

Aim of Interview

To investigate the degree of informal coordination of services within a Sample Area.

Interviewee

Principal Officer for Mental Handicap/Physical Handicap (according to Area)

Area to Cover during Interview

1 Interviewee's views of the role which the Voluntary sector does and should take in considering, planning and providing services. What role does/can the Voluntary sector play in each of these stages?

2 Information on informal coordination - how does it happen - what effect does it have.

3 Information on how the Local Authority can and/or does support the Voluntary sector: financially and otherwise eg supporting applications for EEC/ government grants

BIBLIOGRAPHY

BOOKS AND REPORTS

Albermarle Committee (1958), Report on Youth Services, HMSO, London

Audit Commission (1987), Report on Community Care, HMSO. London

Bartholomew Gazetter Places in Britain (1986), John Bartholomew and Son Ltd, Edinburgh

Bahmueller CR (1981), The National Charity Company, University of California Press

Barclay Report (1982), Social Workers; their role and tasks, Bedford Square Press for National Institute of Social Work

Beresford P and Croft S (1986), Whose Welfare? Private Care or Public Services, The Lewis Cohen Urban Studies Centre, Brighton

Beveridge (1942), Social Insurance and Allied Services, HMSO, London

Lord Beveridge and Wells AF ed (1949), The Evidence for Voluntary Action, Blackfriars Press Ltd, Leicester

Billis D, Bromley G, Hey A, Rowbottom R (1980), Organising Social Services DepartmentsBrunel Social Services Unit, Heinemann, London

Bonny S (1984), Who Cares in Southwark?, Association of Carers, Kent

Brasnett M (1969), Voluntary Social Action, NCSS London

Brenton M (1985), The Voluntary Sector in British Social Services, Longman

Bristow AK and Brenig-Jones J (1982), Wirral Crossroads Care Attendant Scheme, Association of Crossroads Care Attendant Schemes, Ltd, Rugby

Brown RGS (1975) The Management of Welfare: a Study of British Social Services Administration, Fontana

Burley D (1985), Issues Concerning Voluntary and Statutory Relationships in Leicester and Leicestershire, Leicester Council for Voluntary Services, Leicester

Census (1981), Office of Population Censuses and Surveys Preliminary Report for Towns, HMSO

Charities Aid Foundation (1986), Charity Statistics, London

Community Care Project (1985), Joint Planning - A Voluntary Sector View, National Council for Voluntary Organisations, London

Conservative Party (1979), Conservative Party Manifesto, Conservative Party Office, London

Dalley G (1988), Ideologies of Caring, Macmillan Education Ltd, London

Dartington T (1986), The Limits of Altruism, Holland Street Press

Dorset Social Services (1982), Home Care Services for the Younger Physically Disabled, Dorset

The Family Welfare Association (1986), 1986 Guide to Social Services, London

Fraser D (1973), Evolution of the British Welfare State, The Macmillan Press Ltd, London

Glendinning C (1983), Unshared Care: Parents and their disabled children, London, Routledge and Kegan Paul

Goldberg E and Hatch S (1981), A New Look at the Personal Social Services, Policies Studies Institute, London

Grand J and Robinson R ed (1984), Privatisation and the Welfare State, Allen and Unwin, London

Griffiths R (1988), Community Care, agenda for action - A Report to the Secretary of State for Social Services, HMSO, London

Guillebaud Committee (1956), Report on the Cost on the NHS, HMSO, London

Hadley R, McGrath M (1984), When Social Services are Local, George Allen and Unwin, London
Hatch S (1980), Outside the State, Cromm Helm, London

Ingleby Committee (1960), Report on Children and Young Persons, HMSO, London

Jenkin P (1981), Care in Action: A handbook of policies and priorities for the Health and Personal Social Services in England and Wales, DHSS, London

Joint Planning Working Group (1985), Progress in Partnership, NAHA/NCVO Joint Working Party, 1987, Partnerships of Health, Birmingham

Joint Planning Working Group (1986), A Stake in Planning: Joint Planning and the Voluntary Sector, National Council for Voluntary Organisations, London

Leat D, Tester S, Unell J (1981), Voluntary and Statutory Collaboration, Rhetoric or Reality?, Bedford Square Press, London

Leat D, Tester S and Unell J (1986), A Price Worth Paying? A study of the effects of government grant aid to voluntary organisations, Policy Studies Institute, London

Local Government Campaign Unit (1985), Defending Local Democracy Services and Jobs, LGCU, London

Local Government Campaign Unit (1985), Local Democracy and the Voluntary Sector, LGCU, London

Local Government Campaign Unit (1985), Local Government Finance and Local Democracy, LGCU, London

The Majority Report of the Royal Commission on the Poor Law, first published 1834. Pelican Books edition 1974, Middlesex, introduction by SG and EOA Checkland

MIND, Annual Conference Report (1983), Care in the Community: Keeping it Local

Moroney RM (1980), Families, Social Services and Social Policies, Washington US Department of Health and Human Services

NAHA/NCVO (1987), Partnerships of Health: NAHA/NCVO Joint Working Party Report, NAHA, Birmingham

O'Brien J (1980), The Principle of Normalisation; a foundation for effective service, Atlanta, Georgia

Palfrey C (1987), Elderly People and Community Care; a literature review for the Community Health Unit, Gwent Health Authority, Gwent CHE, Newport

Payne J (1984), Making Partnerships Work, School of Advanced Urban Studies, Bristol

Seebohm Report (1968), Report of the Committee on Local Authorities and Allied Personal Social Services, CMND 3703, HMSO, London

South Glamorgan Social Services Committee (1986), Forward Planning for Personal Social Services, Cardiff

Suffolk Social Services (1982), The Need for Special Care, Ipswich

Suffolk County Council Social Services Committee (1985), Strategic Development Plan, Ipswich

Tutt and Jones (1983), A Way of Life for the Handicapped?

Voluntary Organisations Personal Social Services Group (1986), The Future of Social Services, VOPSS, London

Voluntary Organisations Personal Social Services Group (1986), Paying for Local Government, VOPSS, London

Walker A ed (1982), Community Care - The Family, the State and Social Policy, Basil Blackwell Publishers Ltd & Martin Robertson & Co Ltd, Oxford

Wilkin D (1979), Caring for the Mentally Handicapped Child, London, Croom Helm

Williams R (1976), Keywords, Fontana/Croom Helm

Willmott P and Thomas D (1984), Community in Social Policy, Policy Studies Institute, London

Willmott P (1986), Social Networks, Informal Care and Public Policy, Policy Studies Institute, London

Wolfenden Committee Report (1978), The Future of Voluntary Organisations, Joseph Rowntree Memorial Trust and the Carnegie UK Trust, Croom Helm Ltd, London

Wolfensberger W (1972), The Principle of Normalisation in Human Services, Toronto, national institute on Mental Retardation

Younghusband Report (1959), Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services, HMSO, London

OFFICIAL PUBLICATIONS

(1576), Poor Relief Act

(1601), Poor Law Act

(1817), Report of the Select Committee on the Poor Law

(1834), Poor Law Report

(1834), Poor Law Amendment Act

(1901), Report of the Royal Commission on the Poor Law and Relief of Distress, XXXXVII, Appendix vol 1, Minutes of Evidence, Q22230

(1948), The Children Act

(1957), Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency

(1959), Mental Handicap Act

Ministry of Health (1962), A Hospital Plan for England and Wales, Cmnd 1604, HMSO

(1963), Children and Young Persons Act

Ministry of Health (1963), The Development of Community Care - Plan for the Health and Welfare Services of the Local Authorities of England and Wales

(1970), Chronically Sick and Disabled Persons Act

(1970), Local Authority Social Services Act

DHSS White Paper (1971), Better Services for the Mentally Handicapped

Home Office North West Joint Planning Team (1974), Strategic Plan for the North West

DHSS (1976), Priorities for Health and Personal Social Services

DHSS, Local Authority Circular (1976), Joint Care Planning, Health and Local Authorities

Department of Health and Social Security, Health Circular and Local Authority Circular (1976), Joint Care Planning, Health and Local Authorities

Department of Health and Social Security (1976), Priorities for Health and Personal Social Services

(1976), Rating (Disabled Persons) Act

House of Commons (1980), Mental Handicap: Progress Problems and Priorities

(1981), Disabled Persons Act

(1981), Education Act

Home Office North West Joint Planning Team (1981), The South East Study, 1961-81

House of Commons (1981-82), Report from the Select Committee on Social Services: Public Expenditure by the Social Services

House of Commons (1983), The Development of Community Care - Plans for the Health and Welfare Services of the Local Authorities of England and Wales, HMSO, London

Department of Health and Social Security, Health Circular (1984), Voluntary Organisation Representation on Joint Consultative Committees and Extention of the Joint Finance Arrangements

House of Commons, HC339 (1984-85), Report from the Social Services Select Committee, part 6, Paragraph 6 "Opportunities for Volunteering", Paragraph 9 "Helping the Community to Care"

House of Commons, HC 13 I-III (1984-85), Minutes of Evidence Taken Before the Social Services Committee submitted by MENCAP and The Spastics Society, Memoranda submitted by the Department of Health and Social Security, MENCAP, The Spastics Society and Suffolk Social Services Department

(1985), Government Response to the Second Report from the Social Services Committee 1984-85 Session: Community Care

(1985), Select Committee Report on Community Care

House of Commons (1985-86), Fourth Report from the Social Services Committee: Public Expenditure on the Social Services

(1986), Draft circular on Joint Planning, Collaboration between the NHS, Local Government and Voluntary Organisations

(1986), Disabled Persons (Services, Consultation and Representation) Act

House of Commons (1986), Social Services Committee Report: Public Expenditure on the Social Services

DHSS (1988), Information in respect of Joint Arrangements for the Care of Former Patients, London

DHSS White Paper (1989), Caring for People

PERIODICALS AND ARTICLES

Crine A (30 September 1982),"A Commitment to the Community", Community Care

Davies A (23 January 1987), "Parachute Regiment", New Society

Eaton L (5 March 1984), "Never the twain shall meet?", Social Work Today

Fowler N (4 April 1984), "Making the most of what we've got", Community Care, p 41-43

Hadley J (25 February 1988), "Inside the Voluntary Sector", Community Care

Hawker M (1 February 1977), "Cooperation/coordination - Professional disaster", Social Work Today

Knapp M, Roberson E, Thomason C (May 1987), "Public Money, Voluntary Action: Whose Welfare", Discussion Paper 514, University of Kent

Manser G (1974), "Further thoughts on Purchase of Service", Social Casework, no 55, p 421-474

Marshall JD (1961), "The Nottinghamshire Reformers and their contribution to the Poor Law", Economic History Review, 2nd series XIII

Mason M (25 February 1988), "Together in Perfect Harmony", Community Care

Morris P (25 February 1988), "No Flesh on the Bones", Community Care, piii

Short Clare (1983), Involve, no 28

Special Report (10 December 1987), "Hand in Hand with the Voluntaries" , Community Care, no 6

Webb A and Wistow G (22 March 1983), "Can you spare a policy?", Social Work Today, p 10-12

White K (15 January 1987), "Practical Implications of Community Care", Community Care, p24-25

White K (18 January 1987), "Why is Community Care so Popular?", Community Care p 16-18

Wilson DC, Butler RJ (September 1986), "Voluntary Organisations in Action: a strategy in the voluntary sector", Journal of Management Studies, Oxford

Woodroffe (27 September 1884), "From Charity to Social Work", Charity Organisation Reporter, p27