VOLUNTARY SECTOR ACTIVITY AND PUBLIC SECTOR SUPPORT IN CARE IN THE COMMUNITY FOR PEOPLE WITH LONG -TERM CARE NEEDS

CORINNE THOMASON

Thesis submitted for the degree of Doctor of Philosophy
in Social Policy and Administration

University of Kent at Canterbury

December 2000

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ABSTRACT

This thesis examines the roles of voluntary sector organisations (including housing associations) in the provision of services for adults with long-term care needs. It particularly explores public sector support (financial and otherwise) for these voluntary sector activities, the assumptions behind that support and the effects of that support on voluntary agencies themselves and the work that they do.

Evidence was gathered from a number of sources, and especially from detailed work with public and voluntary sector organisations, and with service users, in four English localities. Data came from statutory bodies, service users and 27 organisations providing services for people with long-term care needs in those four areas. These data were supplemented by other collections, including local and national surveys of voluntary organisations; a case study of one hospital closure; three user (client) evaluations of mental health day services; interviews with local authority social services directors and councillors; interviews with national figures in the voluntary sector; and re-analyses of statistical and other data collected in parallel research.

Public sector bodies generally expressed a great deal of trust for voluntary organisations in the community care field. This trust was based on 'goodwill' rather than on established competence. The voluntary sector appeared to be responsive to consumer needs, and offered specialised services which were not available in the other sectors, the 'alternative' nature of which was highly valued by statutory partners. Concerns were however expressed that choice may be narrowed by the contractual links being introduced to many areas of community care in the early 1990s.

The public sector assumption that the voluntary sector is more flexible and more innovative than other sectors proved impossible to test although there was no shortage of examples of these potentials in all areas (although these were not confined to the voluntary sector alone). However, evidence about the cost-effectiveness assumption examined with data on community mental health care for former long-stay hospital residents revealed that quality of care was highest in facilities run under consortium arrangements between the NHS and voluntary organisations, and there were also suggestions in the data that user outcomes were better in these facilities. However, costs were also highest under these care arrangements, leaving purchasers with a difficult trade-off between cost and quality.

Voluntary organisations in the field of community care were found to be heavily reliant on public sources of finance. Concerns about the negative effects of funding of this magnitude on the sector were not verifiable with evidence at the time of this research, although it was clear that the new community care environment posed many new challenges for the voluntary agencies in the studies. The thesis was able to build on the work of other academics writing on the consequences of change to develop a more detailed analysis of these impacts, taking into account the heterogeneity of the sector.

The mythology around what each of the sectors did was found to be influential in the decisions which people took over funding, sometimes resulting in poor decisions about client services. The importance of values at all stages of service provision emerged as a significant variable and the 'cognitive dissonance' which arose from differing values was deemed to be a significant barrier to collaborative working, which was seen to be the key to good community care.

Corinne Thomason, December 2000.

This thesis is dedicated to the memory of my Grandmother - Alice Bateman

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PREFACE

The original work from which the idea for this thesis arose was conducted at the Personal Social Services Research Unit, University of Kent, as was subsequent work which also informed this thesis. I was employed in the PSSRU from 1984-1992 and for the first five years worked on an evaluation of the Care in the Community Demonstration Programme funded by the Department of Health to encourage good quality community care as an alternative to long-stay hospital care.

Although I had previously worked in both the health service and local government and often questioned what I saw in practice - this was particularly the case in my work with the former Regional Nurse Training Committees, which involved visits to institutions now closed as a result of re-provision programmes - the opportunity to be involved in evaluating programmes was very new and exciting.

With hindsight I realise that good researchers are not born they are made and being part of a research team working on such a wide-ranging project - there were 28 schemes spread geographically all over England - and working alongside other more experienced researchers in such a fertile environment (PSSRU) was invaluable to my development as a researcher. My thanks to all those connected with the Unit, past and present, for giving me the opportunity to learn; my thanks to Ken Judge for employing me initially and to all of my colleagues, too numerous to mention, who taught by example.

Development as a researcher does not just happen within the confines of the University of course and I owe an equally important debt to the people I worked with in the field, people who often challenged the parameters in which the research was conducted and the interpretation of what was 'found' simply by looking at the world through a different lens. At times I found the contradictions thrown up by 'different ways of knowing' difficult to reconcile and yet the challenges emerging from multiple perspectives have remained an enduring interest of mine and I thank clients, carers and providers alike for making life hard for me on occasion and forcing me to 'explain' myself.

I cannot remember the precise time when I became particularly interested in what the voluntary sector was doing in respect of community care services for people with long-term care needs. I think of it more as an increasing interest. Perhaps it was a response to the issues I saw statutory projects coping with and voluntary organisations dealing with in an 'apparently' unproblematic way. The flexibility with which the sector operated was certainly appealing and the commitment shown by project leaders was also striking even when their beliefs seemed to polarise treatment regimes at opposite ends of the spectrum. The clear vision and determination which emanated from these projects was captivating.

In 1989 Martin Knapp and I applied for, and received funding from

the ESRC to take this interest foward. The interest had also been developed via work for the Home Offfice on the extent of and rationales for support of the sector in a range of fields (Knapp, Robertson and Thomason, 1987). The ESRC funding allowed me to undertake the DHA study which is the central data source for this work and I acknowledge their support. I also draw on data from other studies, which I either conducted alongside the ESRC work - like the study of hospital closure and the user evaluations - or was involved in as an advisor or in a supervisory capacity, for example, the Camden and Canterbury and Thanet territorial studies respectively.

The research process is rarely as linear as the written up account suggests. The time lapse between the central data collection on which this thesis is based (1990/91) and the production of this thesis has posed some interesting epistemological questions for the author. I have been blessed or cursed with the space for reflection. Within this time lapse I am aware that the agencies I worked with have moved on, as indeed I have myself both intellectually and personally. Although these changes have happened post hoc it has allowed me to reflect on the changes which have happened to me as I developed from a novice researcher. You appreciate with hindsight what each interview, each period of analysis in a project, each research presentation has taught you. For the most part, unless 'forced' to reflect for a publication or a discussion about research practice, this process goes on subliminally. There may be something in a research encounter which jars or a statistical finding which doesn't sit comfortably with the situation you

witnessed in the field. Morgan (1981) argues that this is the distinction between 'knowing about' and 'knowing' raised by Frankenberg (1979). Morgan argues that 'knowing' implies the possibility of understanding and change, 'knowing about' does not. Morgan says that the distinction gelled for him when he attended a summer school on feminism and sociological research. He argues that he thought he had known about feminism but a more profound form of knowing occurred during the course because of the circumstances in which he found himself (ie. one of only two men discussing the marginalisation of women's concerns in research).

This resonates with the very powerful feeling I often had when working with clients in the Care in the Community Programme, ie. that the more I knew about mental illness the less I knew. Shakespeare et al (1993) in their edited volume of reflective accounts about the research process identify three themes which were with hindsight influential in my choice of methods.

The notion of the *self* and the research process both in terms of the part that we play in it and, related to this, reflection on the work that we have been involved in. I now teach research methods and have found that in order to teach it has been necessary to think about methods and the research endeavour itself in a less instrumental way. It has given me cause to reflect on power differentials in the research encounter, on the way in which I have used me (and others) in that encounter.

Secondly a natural progression for me from reflection and perhaps most importantly of all is their notion of ***other-awareness,*** that research is most often done to the most vulnerable and marginalised groups even though research with these groups has the potential to empower them. The importance of other-awareness is the tenets by which research will then be conducted - eg. sensitive interviewing - an empathetic approach to the interview which may involve some reciprocity so that the researcher is not only 'taking' from the interviewee; the challenging of power differentials; and a participative atmosphere which aims to give people a voice.

Finally there is an approach to research-in-practice which encourages a ***spirit of openness*** in contrast to an approach which is fixed and predictable or predetermined. Part of the process is to negotiate meanings with subjects and to allow frameworks for understanding to evolve over time

On reflection I could never have anticipated the personal intellectual growth afforded to me by the involvement in 'new paradigm' research. Neither did I expect the professional interest in the framework for consumer evaluation I was developing. The switch to a primarily teaching role, although detrimental in terms of completing the writing up and dissemination stage of the work, had some unexpected positive spin offs. I have made many new contacts in Cheshire through my continued interest in the work and have acted as a consultant to

voluntary and statutory fora alike on service development issues, in particular consumer needs.

An unexpected outcome has been the fresh perspective on the work afforded me by my career move. The change in environment and professional slant has given me a much more rounded view of the work which overall is beneficial to the study but was confusing at the outset.

ACKNOWLEDGEMENTS

My very special thanks to Professor Martin Knapp to whom I am indebted for his positive supervision, encouragement, patience and friendship. His instruction and his example have helped me to develop skills which I did not know I possessed.

Last but not least I thank Thamir, Caleb, Rhiannon and Ishbel for the time with me relinquished to the completion of this thesis.

Corinne Thomason
December, 2000.

CHAPTER 1

INTRODUCTION AND AIMS

1.1 INTRODUCTION

This thesis pulls together two of the dominant themes of social policy in the last two decades: the emphasis on mixing the economy and concerted attempts at 'de-hospitalisation'. A number of pressing policy questions arise at the interface of these themes: Who should provide which services, in what circumstances? How are those services resourced or funded? Who is provided with them and how are inter-personal choices made? Who will benefit and who will lose as a result of decisions taken in the mixed economy and regarding the locus of care? The subject of this thesis is closely linked to the heart of these concerns. Questions such as these will be addressed in one particular field by examining the roles of voluntary sector organisations in the provision of community services for adults with long-term care needs associated with learning disabilities and mental illness.

The thesis will focus specifically on public sector support for voluntary sector activity, the assumptions behind that support and the resulting implications for the working of voluntary and statutory agencies.

1.1.1 Why support the voluntary sector?

Virtually every article and book written on the voluntary sector - and

certainly every policy document or commentary, not only in recent years, but for many decades - contains a listing of the advantages enjoyed by voluntary bodies. The sector is imbued with numerous desirable characteristics. Voluntary agencies are heralded as innovative, flexible, participative, cost-effective, having the ability to enhance consumer choice and simply different. (Chapter 4 focuses in more detail on the literature related to these ascribed qualities.) But do these characteristics of voluntary-run services stand up to close scrutiny? Is there 'evidence' to support claims made on behalf of the sector? Are the qualities posited in these claims even 'measurable' in practice? Furthermore, even if these characteristics are accurate descriptions of voluntary sector bodies, do the imputed or proven qualities explain public sector encouragement?

1.2 AIMS

The overall aim of the thesis is to describe and evaluate the role of the voluntary sector in the mixed economy of care for people with long-term care needs for whom the most common form of care in previous decades would have been long-term hospital care.

The constituent aims are to provide answers to the following questions:

1. What expectations and assumptions does the public sector (local authority departments, health authorities and central government) hold about the role of the voluntary sector in care in the community for people with long-term mental health problems or learning disabilities?

2. What expectations and assumptions does the voluntary sector hold about its own role and the role of the public sector in the local system of provision and in terms of anticipated support?

3. What evidence is there concerning the activities and performance of voluntary agencies to support these expectations and assumptions?

4. What is the level of public sector support of voluntary sector activities and what forms does that support take in the provision of community care services for these client groups?

5. What effect does public sector support have on voluntary agencies and on the public sector itself?

6. What policy lessons can be learned about the mixed economy of care for people whose long-term care is now provided in the community rather than in hospital?

1.2.1 Background to this thesis

As the preface to this thesis explains this piece of work is a hybrid in more ways than one. Not only does it draw methodologically on a range of voices to address a complex question but it also represents the fruits of a developing research career, not only in terms of the ideas and connections which have been generated but also in the opportunities afforded to me for the empirical part of the work.

The research focus arose primarily from a number of projects I was working on whilst employed by PSSRU at the University of Kent. These were in chronological order, although they overlap: a DOH-funded evaluation of the Care in the Community demonstration programme (1984-1989); a Home Office funded study of public support for the voluntary sector (1986); a study of hospital closure facilitated by Liverpool Health Authority (1991); an evaluation of day care facilities in Warrington funded by Warrington Social Services Department (1991). Some of the empirical material employed to address the questions posed in this thesis was drawn from the above sources, but the main data collection in four contrasting DHAs would not have been possible without ESRC funding. In addition, involvement in a number of other ongoing projects generated essential research material: the Camden and Canterbury and Thanet parts of the Johns Hopkins Cross National Project on the Nonprofit Sector (1991), and an examination of the concept of monitoring and regulation in a local Home from Hospital service (1997).

1.2.3 Choice of client groups

Two client groups were selected as a focus for this work - adults with learning disability and adults with a mental illness. There were a number of reasons for this. First, both groups have a complex array of needs which must be met if these people are to live successfully in a community setting. As I will discuss in chapter 3, these needs include housing, support with daily living, work/education or other day time occupation, protection and guidance, and medical, social and psychological support.

In order to meet these multiple and various needs a number of services

must be available, for no one agency is going to be able to tackle them all. Suitable housing may involve anything from a council flat through a range of options including group homes, hostels, residential care homes, adult foster care (where a client is parented through 24 hour support in a group home) and more independent options where a client can access help from a support team. Provision of most of this housing support will need the skills of a specialist housing agency. Health care requires skilled health professional inputs, and so on. With such a multiplicity of needs and necessary responses, possibilities open up for voluntary sector activities (in provision, co-ordination and advocacy).

A second reason for focusing on the adult mental health and learning disability groups was that both groups represent people who are unlikely to be supported informally in the community either because time in hospital means that local connections have been severed or (in many cases) because families do not wish to provide support. Indeed some are unable to, or are hostile to care in a community setting. This means that it is more likely that all care is formally provided.

Third, both client groups have at times been described as 'cinderella groups,' so called because they have been given low priority (overtly or covertly) in terms of public funding and societal status. For these and other reasons the voluntary sector has developed considerable experience and expertise in supporting these groups, certainly in the development of community services but also in terms of their campaigning role, through older organisations such as Mencap (renamed Scope), Mind and more recently through a wider array including People First, Survivors Speak Out and SANE.

Fourth, precisely because of what has been perceived by some people as the lack of development of statutory care and its historical focus on segregation and the medicalisation of needs and services, the voluntary sector has developed a distinctive style. It has a strong reputation for care which bears a different hallmark from statutory provision, either in terms of risk taking, or in the meeting of needs or through offering care that is underpinned by a philosophy that emphasises social integration and client empowerment.

The 'alternative nature' of many voluntary sector services makes them an interesting focus given that one of the major aims of this work was to explore the impact of public sector support for the voluntary sector on both sectors and on the services which are provided. For example, does accepting money from the public sector mean that a voluntary organisation's autonomy is compromised? Will public money transform the service which is provided in such a way that choice is diminished? Or will more public support of services increase diversity and offer organisations the capacity for further innovation? There are no simple answers to questions such as these. One reason is that there is such diversity in the voluntary sector. Some agencies may provide a total package of care - they are multiple providers - while others will provide a single service. Size and age of organisations will also be important variables, and could well influence the nature of voluntary-statutory links, as could an organisation's raison d'etre, client group coverage and funding base. Information about a range of agencies would therefore be desirable in seeking to establish a greater understanding of the impact of public funding on voluntary agencies.

1.3 CONTEXT

The National Health Service and Community Care Act (1990) put great emphasis on an enabling role for the statutory sector, an enhanced role for the independent sectors, needs-led decision-making, and non-institutional care arrangements. Although the work reported in this thesis began before enactment of this legislation, the new care system that it introduces clearly added further relevance to the major themes of this thesis. However, we need to go back a little further to understand the context of this work.

1.3.1 De-hospitalisation:the context

Movement out of hospital of chronic or long-stay patients, and the whole emphasis on care in the community, is not a novel feature of health or social care systems. Care in the community has been the reality for centuries. What is different about the emphasis of recent years, arguably, is the greater effort to make a reality of good quality care in the community, and the formalisation of this aim in explicit policy documents.

The hospital psychiatric population of England and Wales peaked at 148,000 in 1954 and has gradually fallen since. Both diversion away from admission and decanting from hospital beds have reduced the numbers of long-stay hospital patients. De-hospitalisation has been an obviously salient theme of post-war legislation and action. For example, the Mental Health Act of 1959 changed the legal status of the great majority of mental hospital patients. The Hospital Plan of 1962 came hard on the heels of Enoch Powell's 1961 recommendation, when

he was Minister of Health, for the acute population of mental hospitals to be halved in fifteen years, and the chronic population to dwindle eventually to zero. The first recommendation was almost exactly realised, although the latter is taking rather longer to achieve.

In 1975 the then Department of Health and Social Security (DHSS) issued Better Services for the Mentally Ill with its strong emphasis on early recognition and prevention, and its recommendations for the integration of support from families and community services. Similar themes had been stressed in Better Services for the Mentally Handicapped, prepared by the DHSS in 1971. Ten years later Care in Action carried the clear message that hospital closure plans should be introduced, phased over a ten year period. The debate on de-hospitalisation continued into the 1980s. Numerous Government statements in that decade stressed a commitment to the policy of running down hospitals to eventual closure and building up community services to replace them. Over the same period, numerous commentaries either criticised the Government for its failure to implement this policy fast enough or for doing so too fast. In the 1980s reports from the House of Commons Social Services Committee (1985), the Audit Commission (1986), the National Audit Office (1987), the DHSS committee chaired by Joan Firth (1987), the Residential Care Review Committee chaired by Lady Gillian Wagner (1988), and The Griffiths Report (1988) clearly kept de-hospitalisation high on the policy agenda. Most of them also made recommendations as to the roles to be played in de-hospitalisation and community care by voluntary organisations.

At the end of that decade, and just as the work for this thesis was

beginning, the Caring for People White Paper (1989) and the National Health and Community Care Act (1990) - hereafter referred to in shorthand format (NHSCC) - promoted or reinforced a range of ideals which have subsequently shaped care: service pluralism, needs-related decision-making, care in 'homely' settings and value for money. These ideals have been conceptualised in a number of ways by different commentators and are discussed in more detail in Chapter 3.

The term community care refers to more than the location of care, and this much was becoming increasingly clear over the period of the 1980s. The successful reprovision of care involves finding good alternatives to admission as well as de-hospitalisation. The diverse objectives and systems of service delivery are apparent from the definition of community care in the White paper which preceded the 1990 Act.

> Community care means providing the right level of intervention and support to enable people to achieve maximum independence and control over their own lives. For this aim to become a reality, the development of a wide range of services provided in a variety of settings is essential. These services form part of a spectrum of care, ranging from domiciliary support provided for people in their own homes, strengthened by the availability of respite care and day care for those with more intensive care needs, through sheltered housing, group homes and hostels where increasing levels of care are available, to residential care and nursing homes and long-stay hospital care for those for whom other forms of care are no longer enough.
>
> (Caring for People - 1989:9)

The definition of Care in the Community outlined in this White Paper excerpt suggests an entity with several strands, resourced in different

ways and managed within different organisational systems with different objectives. The acknowledgement of the role of informal carers in the provision of community-based services is conspicuous by its absence, an omission which the feminist gaze construes as a taken-for-granted assumption that women are available and ready to care (see Finch and Groves, 1983 and Williams, 1989, Baldwin and Twigg, 1991).

Stepping backwards again in the chronology of events to the early 1980s, the Department of Health and Social Security issued its Care in the Community Circular in 1983. The Circular brought together a number of themes which ran through public policy in the health and social care fields during the post-war period, including de-hospitalisation, joint working, and cost-effectiveness. The aim of the Circular was to take forward the development of community care, as an alternative to hospital. It altered the financial relationships between district health authorities, local authorities and voluntary bodies by allowing health authorities to make financial transfers to encourage the development of community-based services for people discharged from long-stay in-patient care. The payments were to be financed from hospital savings achieved or imminently anticipated and were to be paid (virtually) in perpetuity. The 1983 Circular also launched a demonstration programme of 28 pilot projects to explore different ways of moving people and resources out of hospital and into the community. Each pilot project was funded by the DHSS for three years under various conditions, including continued funding thereafter from local resources, and joint working between health and local authorities. Together, the pilot projects set out to facilitate the move to the community of more than 900 long-stay patients. The Personal

Social Services Research Unit, University of Kent at Canterbury, was commissioned to promote, monitor and evaluate the programme.

I was part of the team working on the Care in the Community demonstration programme, with a particular interest in the role of the voluntary sector. The work I began then forms a useful starting point for examining the developing roles of the voluntary sector in community care and I discuss it further in chapter 3.

1.3.2 The Mixed Economy: the context

The 1970s and 1980s witnessed the reversal of previous (upward) public expenditure trends, the posing of penetrating questions about the role of the state, the rediscovery (or maybe the "re-ignition") of small business enterprises in areas of social services (such as private residential and nursing homes), the sale of 'untouchable' public enterprises like British Airways, British Gas and British Telecom, and the revival of old quasi-market debates about health insurance, occupational pensions, public housing and the financing of higher education.

Over the same period there were some quite fundamental changes in the roles of, and views about, the voluntary sector. These changes included: the introduction of payroll donations; the extension of tax advantages for registered charities; the importing or wider usage of transatlantic terms such as 'purchase of service contracting', 'empowerment of mediating institutions' and the 'third sector'; a greater emphasis on informal carers in some official speeches and reports at a time when research had graphically described the

intolerable burdens of care; Live Aid and mass or "popular" philanthropy; some critical Parliamentary remarks about the almost non-existent monitoring of charities by central government; and of course the sizeable increase in public sector subsidies.

These trends and events were all part of a progressive mixing of the UK economy. Less visible but no less important were government policies - both active and passive - to encourage larger roles for the voluntary and private sectors. Non-statutory agencies were assumed or argued to be able to substitute for or complement public agencies; they might act as pressure groups and consumers' representatives; they might be able to innovate and perhaps take greater risks (although many in the sector might dispute this); they might be more cost-effective in delivering some services; or through their wider provision they may contribute to improved equity or access. But voluntary and private sector bodies, removed as they are from close public sector control and accountability, are not universal panaceas for all society's ills, and an important part of the work conducted for this thesis has been to examine just what it is that the voluntary sector contributes to the mixed economy.

The mixed economy in the UK is becoming increasingly complex. The variety of producers grows, the funding sources multiply and different regulatory styles proliferate. Although it is still possible to distinguish four basic production or supply varieties - public, voluntary (non-profit), private (for-profit) and informal sectors or providers - the margins between them are blurred. Some private agencies disguise themselves as voluntary, some voluntary agencies behave in a manner that looks not unlike the maximisation of either profits or managers'

salaries, and a growing number of public agencies are developing direct labour organisations and all the trappings - but without the benefits - of a commercial enterprise. Distinctions will need to be made between the three "formal" sectors in what follows. However this thesis will address the issues of informal care services only via the input of (formal) voluntary agencies. For example, respite care services offered by voluntary organisations have been included in the empirical research but informal carers not receiving support in cash or kind from the voluntary sector have not.

Provision or service delivery needs to be distinguished from the funding or demand dimension of the mixed economy. This latter dimension is no less blurred. For didactic purposes (only) five varieties of demand are distinguished here, a classification developed in earlier work with colleagues, Martin Knapp and Eileen Robertson (1987):

Coerced collective demand, where the government acts as purchaser on behalf of citizens, mandated by the democratic or electoral process.

Non-coerced or voluntary collective demand, where voluntary organisations use voluntarily donated funds to purchase services. The choice as to precisely what goods or services to purchase, and for precisely whom, is controlled by the organisation and not (directly) by individual donors.

Corporate demand, which is interpreted here to mean demand by private sector corporations or firms.

Individual consumption, being payment for goods or services consumed by the payer.

Individual donation, which is payment for goods and services to be

consumed by someone else, payments being made directly to suppliers and not to voluntary organisations as intermediary bodies (the latter being non-coerced collective demand).

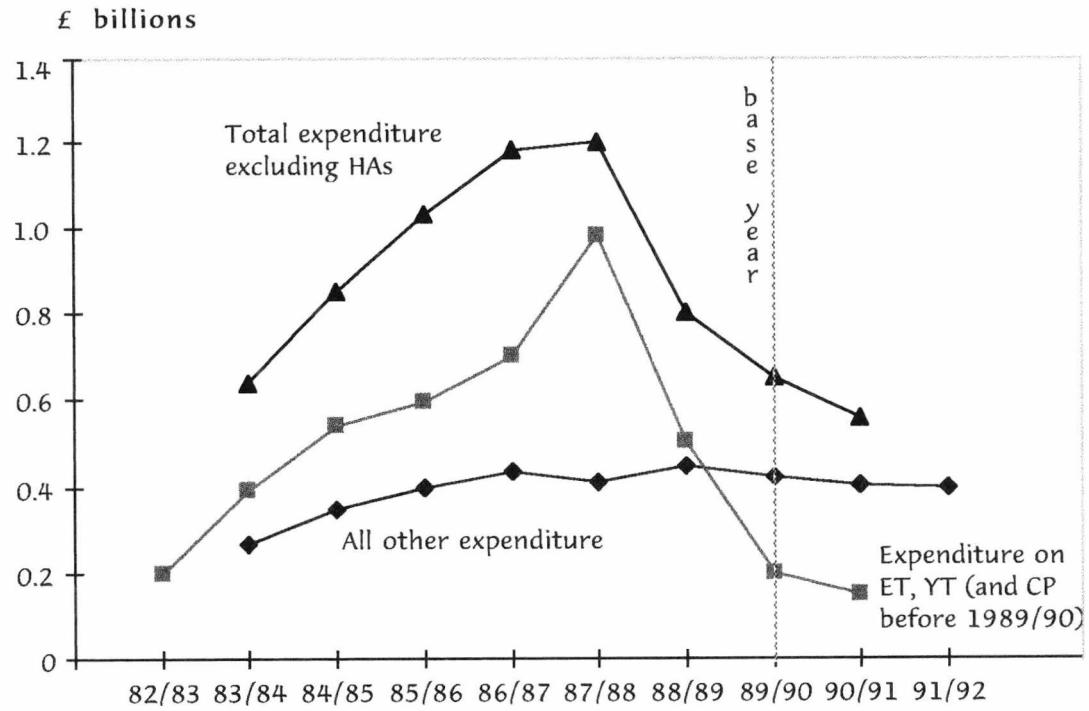
It is crucial to maintain a clear distinction between the production and funding dimensions of the mixed economy. For example, the policy assumptions behind supply-side subsidies to the voluntary sector - such as tax exemptions, non-specific grants or purchase of service contracts - are very different from the assumptions behind demand-side subsidies such as vouchers or social security allowances.

Kendall and Knapp (1996) in their extensive study of the scope and nature of the voluntary sector in the UK have compiled information about the relative share of voluntary sector activity in a range of industries. In particular, their analysis compares changes in the availability of funding to the sector and how this has impacted on service development. For example, total government expenditure on the sector may be falling overall and yet the proportion given to some parts of the sector may be showing a dramatic increase. A good example of this is the case of housing associations. Funding for this activity increased dramatically in the ten years after 1989/90 whereas funding for the community programme, youth training and employment training all decreased (see Figure 1.1). Other commentators like Bolton and colleagues (1994) and Russell and colleagues (1996) have demonstrated similar tendencies with the introduction of Special Transitional Grant funding for community care and the withdrawal of other monies like the Urban Programme, which they argue, resulted in the rapid growth of voluntary organisations undertaking certain activities alongside the contraction

of those specialising elsewhere. This interesting phenomenon is expanded upon in Chapter 6.

Figure 1.1

Trends in Direct Central Government funding, excluding Housing Associations, in real terms (1989/90 prices), 1983/4 to 1990/91



HA = housing association: ET = employment training:
YT = youth training: CP = community programme

Source: Kendall (1994) using data reported in Hansard, cited in Kendall and Knapp (1996:144)

In their analysis of relative market share, Kendall and Knapp (1996) focus on two fields of health and social care which are of particular relevance to this study: residential care services and mental health services. They argue that independent sector provision of residential care was marked by its exponential growth (at least until recently) and the way in which it epitomised many key aspects of the mixed economy of care. Mental health care was characterised by much slower development of the mixed economy in the sense that independent agencies have not taken over so much of the provision previously offered by the state sector.

Table 1.2 illustrates the relative market share of the different sectors in 1990 (a key year in the research reported in this thesis) which gives a broad picture of voluntary sector activity in different fields. If we focus on residential care in particular, we can see that the voluntary sector had the smallest share (15%) and yet a more detailed analysis of total funds allocated to the voluntary sector for the elderly, for example, reveals that the majority of funds went to residential care. Kendall and Knapp fixed the figure at £400 million in 1990, which they argue is 5/6ths of total income (1996:211). The table also demonstrates the dominance of the private sector in residential care which saw a dramatic growth in the 1980s as a result of increased demand, encouraged, in part, by the availability of generous and largely unregulated social security payments. This development in relative market share supports Hansmann's (1987) thesis in the United States that the private sector will increase it's market share, relative to the voluntary sector, in times of increasing demand.

Commenting on this trend Parker (1990) makes an interesting observation which is important for the work of this thesis. One way of explaining the lesser or slower supply response of the voluntary sector to the availability of new funding opportunities is the fact that this money promoted residential rather than domiciliary care, whilst the latter was perhaps more in accordance with the philosophy of care informing many voluntary organisations at the time. This point introduces two important issues: first, that the work that the respective sectors do is influenced by different factors or at least factors which are prioritised differently. Second, that if the work which the voluntary sector does is distinctive because it promotes excellence, or innovative care or care where clients want it - ie. at home - then this diversity may be lost in situations such as the one described above.

Table 1.2

Voluntary sector market shares in key fields of activity, 1990

Field and Measure	BVS	For-profit	Public	Total
Primary/secondary education[1]				
Pupil headcount (000s)	1,660	70	5,830	7,560
Market share (%)	(21.9)	(0.9)	(77.2)	(100)
Acute hospitals[2]				
No. beds x occupancy	2	4	143	149
Market share (%)	(1.6)	(2.5)	(95.9)	(100)
Nursing homes[3]				
No. of staffed residential places (000s)	12	115	155	282
Market share (%)	(4.2)	(40.8)	(55.0)	(100)
Residential homes[3]				
No. of staffed residential places (000s)	53	169	142	364
Pre-school daycare full-time[4]				
No. of places for under 5s (000s)	16	42	28	86
Market share (%)	(81.6)	(12.3)	(6.0)	(100)
All housing[5]				
No. of completions (000s)	17	156	17	190
Market share (%)	(8.9)	(82.2)	(8.8)	(100)
All housing[6]				
No. of occupants aged 16 or over (000s)	1,170	28,930	9,380	39,090
Market share (%)	(2.9)	(74.0)	(23.9)	(100)
Rented housing				
No. of occupants aged 16 or over (000s)	1,170	3.130	9,380	13,680
Market share (%)	(8.6)	(22.9)	(68.6)	(100)

Source: Kendall and Knapp (1996:128)

1 Includes primary secondary and nursery education
2 Non-psychiatric in-patient beds only.
3 For main adult client groups: Elderly people (including psychogerioatrics) and younger (16+) physically handicapped, people with mental health problems and people with learning difficulties.
4 Full-time day nurseries only.
5 As 4, plus part-time groups, including playgroups, parent and toddlers groups and under 5 groups.
6 Includes owner-occupied properties

1.3.3 The Mixed Economy of De-Hospitalisation

Concentrating specifically on the conjunction of de-hospitalisation and the mixed economy, both the context for this thesis and its relevance can be appreciated.

A good starting point is the 1983 Care in the Community circular, introduced in the last section, which explicitly encouraged promotion of a mixed economy.

> Voluntary organisations often play a key role in sustaining people in the community. If the fullest benefits of transferring patients from hospital to community care are to be realised, voluntary resources will have to be engaged at all levels, both when arrangements are being made for transfers and in the long-term provision of supporting services. These will range from informal support - such as neighbourhood care schemes, which local authorities are now increasingly assisting - to the provision of more formal services such as day and residential care, and hostels. This makes it particularly important to involve voluntary sector representatives in the planning of community care arrangements generally and, in appropriate cases, in decisions about the placement and the continuing support of individual patients. The Government has introduced an amendment into the Health and Social Services Bill to provide for additional members of joint consultative committees to be appointed by voluntary organisations (paragraph 14).

The circular continued by making the following recommendations in order to develop the mixed economy:

> Representatives of the statutory authorities should together meet representatives of local voluntary organisations to discuss a joint approach to carrying forward the Care in the Community Initiative. The authorities should jointly invite voluntary organisations they consider likely to have a contribution to make and to be interested in taking part. More generally, joint care planning teams should be

encouraged to explore the potential contribution of the voluntary sector. Authorities may wish to consider inviting representatives of the major voluntary organisations to joint care planning team meetings whenever appropriate.

As well as organisations providing social services, others, such as housing associations, often work in partnership with local authorities to provide community care and authorities should bear in mind their potential contribution. As with other aspects of community care, joint finance can be a source of funds for meeting the cost of care in accommodation provided by housing associations and/or other voluntary organisations.

Consideration should also be given to the interests of ethnic minorities, and organisations representing them should be consulted where local circumstances make it practicable and appropriate.

The underlying principles of the relationship between statutory and voluntary agencies were explored in "Working Together: Partnerships in Local Social Services". Voluntary bodies will be able to benefit from the payments available from health authorities under the new arrangements; they will also continue to be eligible for grants for the provision of relevant services under sections 64 and 65 of the Health Services and Public Health Act, 1968, from health and local authorities, respectively (paragraphs 15 -18).

Chapter 3 documents in detail how the Care in the Community pilot projects operationalised these principles and, in particular, how the voluntary sector contributed to these developments. The continuing emphasis on the major role to be played by voluntary agencies in providing services for people who might otherwise be accommodated in hospital was taken up in the 1980s by the Firth Committee (DHSS, 1987) and Wagner Committee (1988). The Griffiths' Report (1988) also stressed the important role which it envisaged for the voluntary sector.

The primary function of the public services is to design and arrange

> the provision of care and support in line with people's needs. That care and support can be provided from a variety of sources. There is value in a multiplicity of provision, not least from the consumer's point of view, because of the widening of choice, flexibility, innovation and competition it should stimulate. The proposals are therefore aimed at stimulating the further development of the 'mixed economy' of care. It is vital that social services authorities should see themselves as the arrangers and purchasers of care services - not as monopolistic providers (Griffiths, 1988, para 3.4).

At the end of the decade, as I have already noted, the White Paper Caring for People (1989) and the NHSCC Act (1990) continued to propound an expanded role for the sector.

1.3.4 The contemporary picture.

As I have argued, the rundown of hospital beds and the closure of whole hospitals started some decades ago, but there has been a particularly fast decline in the last two decades. To bring things up to date, we can examine the picture for people with mental health problems. Figures obtained from the Department of Health website make it possible to chart the number of psychiatric in-patient beds in England and the numbers of community-based beds earmarked for people with mental health problems (see Figure 1.3).

As the figures demonstrate, the number of psychiatric hospital beds fell from 83,831 in England in 1983 to 39,477 in 1996, a decline of 53%. Most of the decline has occurred because of the closure of long-stay beds (see Figure 1.4), although Department of Health statistics have only made the distinction between long-stay, short-stay (acute) and secure beds since 1991. These closures have been made possible partly through in-patient deaths, but mainly by moving people from

hospital to the community. A number of those people have been able to return to families or to live with their spouses, but the great majority have needed alternative, staffed accommodation, as was the case for most clients moved under the Care in the Community initiative. The growth in residential and nursing home provision charted in Figure 1.3 shows how rapidly this has occurred in the mental health field.

The most noticeable supply growth has been in the private sector, which provided only 764 residential care beds in 1983 but 15,211 by 1996. The private sector also delivers most of the nursing home beds, although Department of Health statistics do not allow separation of the contributions of the private and voluntary sectors to nursing home provision over the period. Total nursing home provision for people with mental health problems was almost 14 times larger in 1996 than it was in 1983 (from 1,994 beds to 27,450 beds).

Less spectacular but nevertheless important growth has been seen in the local authority and voluntary residential care sectors. Local authority provision grew from 4,173 beds in 1983 to 4,694 in 1996, a slow change which reflects, among other things, many local authorities' reluctance to stray into service areas which they saw as NHS responsibilities and, of course, the attractions of social security-subsidised private and voluntary sector provision (at least until the reimbursement arrangements changed in April 1993).

Figure 1.3: The changing balance of mental health accommodation in England.

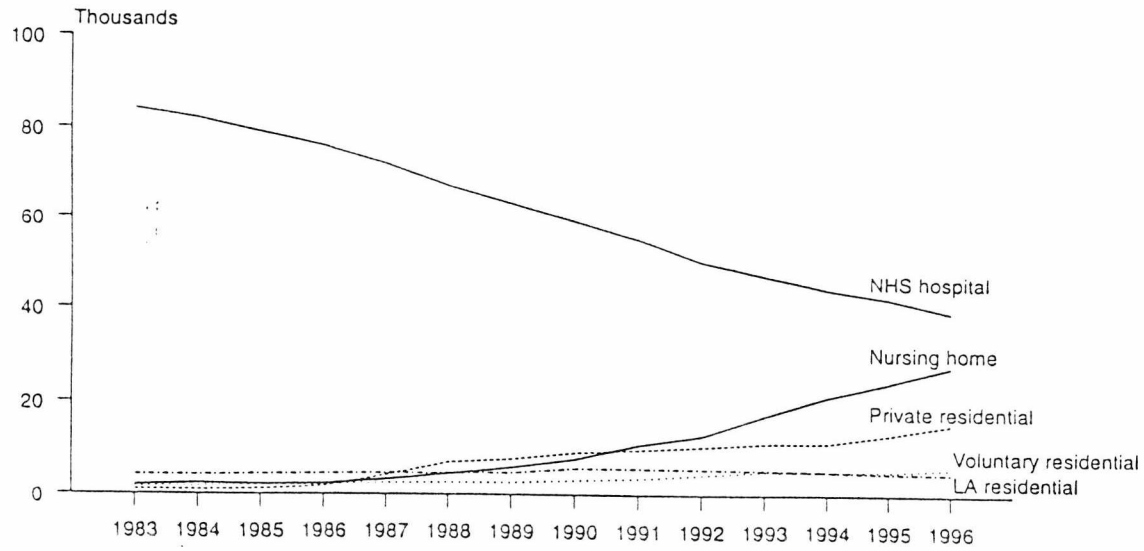
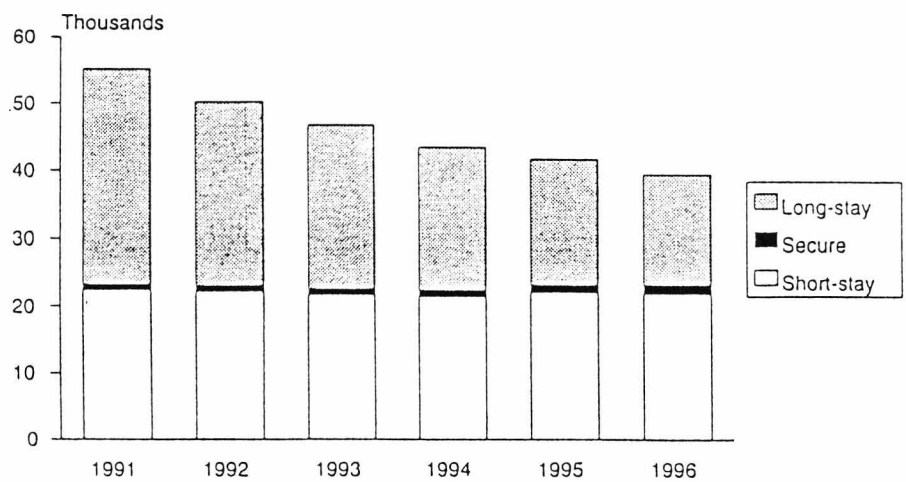


Figure 1.4: NHS Hospital accommodation composition, 1991-1996.



Source: Compiled from DOH statistics.

As I shall show in this thesis, the voluntary sector's contributions to care in the community for people with long-term mental health problems and learning disabilities are many and range far beyond the provision of residential accommodation. Nevertheless, the almost fourfold growth of residential care provision (from 1,603 beds in 1983 to 5,791 beds in 1996) and an unknown but probably similar growth in nursing home beds is indicative of an important and growing commitment to community-based support of these vulnerable and often marginalised client groups.

1.4 THE SHAPE OF THE THESIS

This chapter has examined the various contexts in which the voluntary sector is providing care for people with long-term care needs. This thesis is focused on the collection and analysis of the material which will allow us to examine these contexts in more detail. Chapter 2 outlines the study design, the methods employed and the outcomes of employing these methods.

Chapter 3 focuses on the developing roles of the sector in community care and looks in particular at the roles played by the sector in the Care in the Community demonstration programme. Chapter 4 examines the literature surrounding the claims made about the sector and chapters 5 and 6 report the empirical findings on the perspectives of agencies, evidence on their performance and financing of the sector respectively. The final chapter looks at the consequences of public funding for agencies.

CHAPTER 2

DESIGN AND METHODS

2.1 INTRODUCTION

As Chapter 1 suggests, the mixed economy of dehospitalisation generates a host of complex policy and theoretical questions which this thesis seeks to address in respect of voluntary sector care for people with long-term care needs associated with learning disabilities and mental health problems.

As we have seen from the discussion in the previous chapter, the Conservative government's views on the contributions of voluntary and private sector providers of community care were set out clearly in the 1989 White Paper, Caring for People, and encapsulated in the 1990 NHS and Community Care Act. Emphasis was placed on an enabling role for the statutory sector, an enhanced role for the independent sector, needs-led and non-institutional care. The sector's abilities to broaden choice, stimulate innovation and achieve cost effectiveness were also extolled. Although these assumptions were less enthusiastically shared by local and health authorities (Wistow et al., 1994), they nevertheless ran through many of the observed actions of these other bodies.

In reality it often seemed that local and national decisions to run down long-stay hospital provision were taken in the absence of an adequate appraisal of the likely consequences for service users, service providers or budgets, and also without learning the lessons from

similar decisions previously taken elsewhere. Encouragement of voluntary and private sector providers also often seemed to be based more on assumption than on information about what would result. As we discussed in chapter 1 the change in the locus of care and the emphasis on mixing the economy and changing the roles of the participants prompt important questions: Who should provide which services in what circumstances? Who will benefit and who will lose as a result of these decisions? Do the characteristics of voluntary-run services stand up to close scrutiny? Is there evidence to support the claims and are the claims even measurable in practice? Furthermore, do the imputed qualities explain public sector encouragement and are the assumptions behind these reasons identified or even valid?

The aim of this chapter is to outline and explain how this thesis set out to address these important questions. In section 2.2 and 2.3 I examine the research questions and some of the design issues which they generated. In section 2.4 I review the data sources used and look in detail at the methods employed and finally in section 2.5 I include some reflections on both the process and the outcomes of employing these sources. To begin, however, I further explicate the background to this collection of studies.

2.2 BACKGROUND TO THE RESEARCH

The previous chapter and the preface have outlined the background to this thesis both in terms of the projects I was working on during my research career with PSSRU (p1.3) and some of the emphases which emerged. As I explain in the preface it was here that I became aware of gaps in knowledge, practical issues which emerged that did not sit well

with existing theory, here where I started to make connections and develop questions that might be addressed with empirical research.

It is inevitable when drawing together work which has taken place over such an extended time period that the linearity of the process is not as clear as a traditional doctoral thesis but I have tried to represent accurately the way in which my ideas developed as the work I was engaged in changed over time and to be clear about the ownership of work; distinguishing between work for which I was solely responsible, work jointly produced and material from colleagues which I was able to access during its development in exchange for my contribution to other aspects of projects.

As the preface explains, the work from which the idea for this thesis arose was conducted at the Personal Social Services Research Unit, University of Kent, as was subsequent work which also informed this thesis. I was employed in the PSSRU from 1984-1992 and for the first five years worked on an evaluation of the Care in the Community Demonstration Programme funded by the Department of Health to encourage good quality community care as an alternative to long-stay hospital care. In 1989 Martin Knapp and I were awarded funding from the ESRC to take foward this interest which had also been developed via work for the Home Offfice on the extent of and rationales for support of the sector in a range of fields (Knapp, Robertson and Thomason, 1989). The ESRC funding allowed me to undertake the DHA study which is the central data source for this work. I also draw on data from other studies which I either conducted alongside the ESRC work, like the study of hospital closure and the user evaluations, or was involved in as an advisor or in a supervisory capacity, for

example, the Camden and Canterbury and Thanet territorial studies.

Some evidence was drawn from studies which had a more minor overlap with my mainstream work at PSSRU such as The North London (TAPS) Reprovision Study, The Mixed Economy of Care Project and the Comparative Non-Profit Sector Project. All of these and their exact contribution to the evidence collected for this thesis are further explicated in section 2.4.

The primary focus of this thesis is to describe and evaluate the role of the voluntary sector in the provision of care in the community for adults with long-term needs associated with learning disability and mental illness. As noted earlier, this started from my work on the Care in the Community evaluation 1984-1988. My role in that team changed over time but in the early stages was mainly data collection and project liaison. Consequently I was privileged to visit 24 of the 28 projects. With hindsight I was well placed to embrace the bigger picture of the contrasting ways in which the sectors were working together. I was also fortunate to have particular contact with a number of projects hosted by or involved with what I soon recognised to be dynamic voluntary bodies. I was struck by different arrangements, the speed of some over others (as the preface explains), the way in which some projects were stymied by practical issues and yet others found creative ways around them.

Although unaware of it at the time, this gave me a very valuable historical perspective (for the purposes of this thesis) on the role of the sectors and as I mentioned in the previous chapter, the work I undertook as part of the Care in the Community team forms a useful

starting point for examining the developing roles of the voluntary sector in community care and thus it forms an important part of the overall design. This is developed further in chapter 3.

Running alongside the latter stages of the Care in the Community project (and equally influential for the subsequent ESRC study and hence the thesis) was a study conducted for the Home Office in conjunction with Martin Knapp and Eileen Robertson examining the funding and roles of voluntary organisations. Emerging from this work were a set of possible explanations for public sector funding of the sector and a series of possible threats to the sector which we identified should public support be further formalised.

This work formed the basis of our contribution to the 1st European Conference on the Non-Profit Sector and the Modern Welfare State held in Bad Honnef, Germany in 1987. This was the first European meeting of a group of international scholars with an interest in voluntary sector or third sector activity. As Anheier and Seibel (1990) explain in their introduction to the published proceedings, the third sector was becoming recognised as performing important social, economic and political functions in western societies and in many countries had become the subject of intense interest as it was reconsidered in a new light as a possible remedy for the crisis in the welfare state. Thus theorising about the existence of the sector was broadening from the largely negative view of either market or governmental failure to new and more positive ways of conceptualising it. One such example was heterogeneity theory (James, 1987), positing a voluntary sector response to the range of needs in a society.

Involvement in this wider research community with different experiences of voluntary/statutory relations prompted us to pose a different set of questions about contemporary developments than we might otherwise have done, although both policy and practice were beginning to ask similar questions. The ESRC bid for funding therefore arose from a synthesis of these ideas and influences. Hence in order to focus the work further and impose some structure on the very broad over-arching question the constituent research questions which formed the basis of the research underpinning this thesis were formulated:-

1. What expectations and assumptions does the public sector (local authority departments, health authorities and central government) hold about the role of the voluntary sector in care in the community for these client groups?

2. What expectations and assumptions does the voluntary sector hold about its own role and the role of the public sector in the local system of provision and in terms of anticipated support?

3. What evidence is there concerning the activities and performance of voluntary agencies to support these assumptions?

4. What is the level of public sector support of voluntary sector activities and what forms does that support take in the provision of community care services for these client groups?

5. What effect does public sector support have on voluntary agencies and on the public sector itself?

6. What policy lessons can be learned about the mixed market of care for people for whom the most common form of care in previous decades would have been long-term hospitalisation?

As the previous chapter suggests, the work took place at a dynamic time in the history of public/voluntary relations and against a backdrop of debate about the fundamental nature of the shift in the balance between the sectors regarding burden of care and the reasons for this. I wanted to examine further what happend to organisations after seeing in detail how they responded in the rather 'special' environment of an initiative. The ESRC work provided the opportunity to test out the hunches resulting from what I had seen in practice in environments which were not evaluation projects, characterised by contrasting histories, politics and statutory/voluntary relationships.

2.3 DESIGN ISSUES

2.3.1 Client group focus

Although the original work looked at a wider range of client groups, two were selected for the central study and thus also for this thesis. The choice is fully explained in chapter 1 (p1.4) and is linked primarily to the range of services and particular care issues which these clients attract. There was also a methodological preference for working with people with mental health problems as I had become

interested in issues around user evaluation with this client group and wanted to take this interest further.

2.3.2 Plurality of approaches and flexibility.

In order to gather information on a range of perspectives and assumptions (Q1&2) and to look for evidence about performance (Q3) it was clear from an early stage that the design would have to cope with a plurality of perspectives and find some mechanisms for hearing many different voices on service mix and the role of different agencies. In addition perceptions and assumptions by their very nature do not lend themselves to easy measurement. The reasons behind certain funding patterns may not even be explicit.

A key research feature therefore was to build up a picture of reprovision services in a number of areas (mapping) and to collect as many perspectives on that provision as possible. From my earlier experiences with the Care in the Community projects I knew that understanding the dynamics of a project meant becoming involved in a range of ways which would be impossible to predict at the planning stage of the research. Whilst designing a 'common core' framework for the research as a whole I knew it would be important to allow for the flexibility to adapt to the particular characteristics of the different areas. It would also be helpful to take up opportunities which were available in some places and not in others; for example the hospital closure study or the day care evaluations (both described later in this chapter).

2.3.3 Rationales as a framework

Although it was important that the design be flexible enough to respond to the range of opportunities on offer in different areas and to utilise a range of methods to capture the many perspectives, all of these methods were being employed to a common end. It was important to build-in some mechanism to make the different components cohere. The previous work for the Home Office on the rationales suggested that the glue might be provided by seeking to justify or to explain public sector support of the voluntary sector. The identification of these rationales - particularly, choice and specialisation, flexibility and innovation, cost-effectiveness, participation and advocacy - was useful because some of them closely resembled assumptions held by central government at the time of my fieldwork.

These rationales structured some of the data collection processes, particularly for questions 1-3. Analyses of data collected in other studies were also undertaken in addressing question 3. To answer questions 4 and 5 I used information collected about the nature and level of public sector support for voluntary agencies, and its impact on these agencies and the services they provided. In addressing question 4 I also reviewed and collected data about funding of the sector at national, local and individual agency levels.

2.4 DATA SOURCES

Evidence was gathered from a number of sources, and especially from detailed work with public and voluntary organisations, and with service users, in four English localities. Data came from statutory

bodies, service users and 27 organisations providing services for people with long-term care needs in those four areas. These data were supplemented by other collections, including local and national surveys of voluntary organisations; a case study of one hospital closure; three user evaluations of mental health day services; interviews with local authority social services directors and councillors; interviews with national figures in the voluntary sector; and re-analyses of statistical and other data collected in parallel research.

Methods ranged from face-to-face interviews with managers of agencies in four localities; locality surveys of the voluntary health and social services sectors; a questionnaire survey of perceptions ('administrative anthropology' as Glennerster terms it, although less rigorously conducted than this more recent label may imply); interviews with local authority social services directors and elected members, and with local and some national figures in the voluntary sector; and secondary statistical analyses of user-level data on costs, quality of care and outcomes.

Each of these sources is described below, outlining the methods of data collection, the particular contributions to the overall thrust of the thesis and any relevant issues which arose whilst conducting the research. More time is given to the DHA study as this was the central core around which much of the instrumentation was developed. It is to this study which I turn first.

2.4.1 The DHA study.

A key feature of this research was an in-depth analysis of service mix in a number of parts of the country. It was felt that, in view of the resources available, this research aim could best be attained by limiting the number of study areas to four.

The aim was to examine in some depth four localities (chosen as District Health Authority areas, mainly because the starting point for many of the services being examined had been discharge from hospital) and the organisations and services within them. Relevant parts of the local authority (or authorities) and relevant parts of central government were also included in the research. The work was based in England and focused on four contrasting areas and the services within them. The districts were chosen to give some geographical spread, to give a mix of urban and rural areas (the implications for community care can be very different), to include local authorities of differing political complexions and to provide areas with contrasting histories of voluntary sector involvement. (I endeavoured to select at least one area in which the formally organised voluntary sector had conventionally played only a minor role.)

Choice of area was aided by work conducted with 28 DHAs during the previous Care in the Community evaluation (Renshaw et al 1988). Two of the study areas were selected from this sample of 28 because the areas were well known to me and access had already been assured. An additional advantage was the familiarity of the local policy contexts. I had previously collected primary data in both areas which was available for further analysis and as a basis for a more longitudinal

approach. One of these two areas was also the focus of an in-depth study of costs and outcomes to which I had access. The other two areas, Canterbury and Thanet and Medway, were conveniently placed (close to my workbase) which allowed a more thorough examination of some of the issues. In fact, where possible, in all of the four study areas I tried to fit in with an area's plans for development and make the data collection as user-friendly as possible, and tried to make the outcomes of the research practically useful to the participants.

We first built up information about the service mix in each area; and sought some perspectives on voluntary/statutory involvement in service provision, and on evidence about role expectations and assumptions. Interviews were conducted with key players and other data sources were accessed. Among other things this part of my work gathered data on 27 voluntary organisations (including some housing associations), the selection of which was influenced by their activities (delivery of care services, respite care, advocacy), scale and vintage. We included branches of nationally-based bodies (local branches of MIND, MENCAP, Leonard Cheshire, the National Schizophrenia felowship) as well as independent local organisations.

The sample achieved a spread of both new and long established agencies, and included some housing associations. While it was necessary to limit the number of voluntary organisations studied because of resource constraints, I was guided by the relevant health authority as to the key organisations offering services in any area. For parts of the research it was impossible to work with all voluntary agencies involved with the client groups which were the focus of the study. When looking at public sector expectations and support it was

not necessary to narrow down to a sample of voluntary organisations; when looking at these agencies expectations and experiences it was.

In summary, it is fair to say that several factors were crucial in the final selection process. First, the north-south dimension was attractive; second the south-east based study areas were more easily accessible and thus more attractive in terms of fieldwork, finance and logistics, and therefore better suited to exploring some dimensions of the evaluation which required intensive investigation. Third, the north-west areas were already well-known to me and access had been negotiated.

The areas themselves also had their own particular characteristics which it was felt would make them interesting subjects for comparison. For example, in Warrington mental health services were dominated by a large psychiatric hospital and a mutual aid/new entrepreneurial agency. On the other hand, Liverpool was interesting from a political and historical perspective having a strong voluntary tradition and politics which favoured the promotion of a flourishing voluntary sector. However, strained relationships between authorities and the promotion of a new not-for-profit agency to the exclusion of existing service providers was altering the balance in this area.
In Canterbury and Thanet the voluntary sector had not been encouraged as much as the private sector. The statutory sector had taken the lead in helping those leaving hospital but was heavily dependent on the services offered by the two major voluntary agencies in the area. Both services were over-subscribed and one was being encouraged to develop more than the other. The service which most closely resembled traditional services was the favoured organisation.

Finally, the Medway/Swale area had an active voluntary sector but few major service providers. One explanation for this was that the long-stay hospitals were all located out of District. The voluntary sector in this area was heavily influenced by the statutory sector which had tried to stimulate growth by seconding personnel. The result had been damage to the trustworthiness of the sector in the eyes of many, which had become a major barrier for community care planning.
New use of the sector was confined to encouraging participation.

(i)Methods

Information was gathered via semi-structured interviews with managers and elected/appointed members in both the public and voluntary sectors, with clients and their relatives or advocates, and with a limited number of people with nationwide responsibilities in either sector. Some parts of the study analysed the accounts of public authorities and voluntary bodies, others documented financial links between them. The study also included some quantitative analyses of national level data to test hypotheses involving the cost-effectiveness and specialisation rationales for encouraging the voluntary sector.

Central to the purpose of the study was a clear picture of how and why agencies in these four areas provided the services they did and therefore information was collected from both public and voluntary agencies to allow some assessment of the impact of support by the former to the latter.

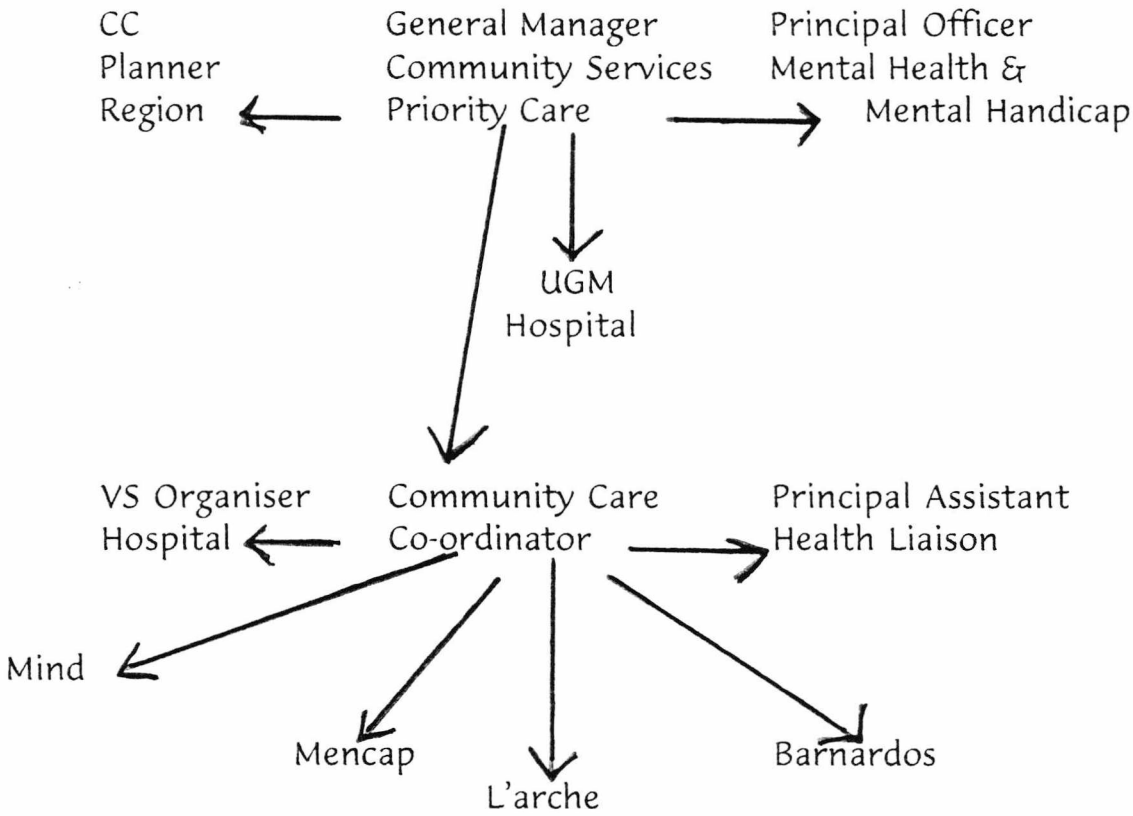
(ii) Who did the study interview?

The starting point for this process in each area was the District Health Authority (DHA). An approach was made to the designated officer in charge of planning for priority care groups and from there a range of contacts would emerge.

The pattern was different for each authority but one example might be the pattern shown in Figure 2.1 below. This one interview opened up a broad spectrum of contacts, who in turn widened the spectrum further and in many cases affirmed the roles of other key individuals already known to the researcher.

Empirical work began by conducting semi-structured interviews with key actors in statutory and voluntary agencies. This information fulfilled four functions; to map out the nature of service provision in an area; to generate other contacts who might be potential interviewees; to cross-check and verify the accounts of how and why a service appeared as it did; and to generate issues for further study. Table 2.1 gives an indication of the range of interviews conducted and the purpose of these interviews.

Figure 2.1
Example route followed for contacts in the DHA study



Interviewees therefore ranged from, chairmen of authorities, local dignitaries and local authority managers, directors of voluntary organisations (local and national), service developers and providers, service users, relatives and friends. Their pooled experience spanned the breadth of service provision and the range of professional interests.

(iii) The questionnaires

A number of interview schedules were designed. Table 2.2 shows the range of interviewees, what type of interview was conducted with them and the purpose of that interview. Where possible the interviews were structured to give some basis for comparison.

Table 2.1
Range, type and purpose of interviews in the DHA study

Interviewee	Type of Interview	Purpose
All interviewees	Standardised scheduled	To assess the other contacts perceptions about the voluntary sector of a wide range of people
Key actor vol sector	Standardised scheduled	1) Expectations and assumptions about local role of Voluntary Sector and extent of public sector support. 2) Information to define organisation type
National and co-ordinating	Standardised unstructured	1) Strengths and weaknesses 2) Level of support3) Roles4)Effect of White Paper
Key actor stat sector Local		1) What expectations and assumptions held by stat sector about role of VS
- social services	Standardised scheduled	2) Information about service mix
- health authority	Standardised unstructured	3) Recommend other interviewees
- national (civil servants)		4) Assessment about activities and performance of VS
	Participation non/participation	
Users, relative,friends	observation	
		1) Identify stakeholders
		2) Issue generation
		3) Content analysis
	Focussed group interviews and discussions	4) Perspective appreciation
		1) Used where topic complex,users suspicious/ shy /or communication difficult
	Focussed individual interviews	2) Further explore rationales
	Standardised/structured individual interviews	Consumer view of services Personal view of services but often with a more evaluative component

(iv) Standardised scheduled questionnaires

The interview schedules for voluntary organisations and statutory agencies were different, to take account of the evidence being collected about each. I wanted voluntary organisations to be more specific about what their organisation did and which organisational category they fitted into. The voluntary organisations' questionnaire was thus designed to elicit information on size and nature of organisation, funding base, any bureaucratic change or any side-effects of public funding. On the other hand, when speaking to a statutory agency my interest was largely about the function they felt that organisation provided and what it's qualities and deficits were. In contrast the statutory questionnaires were designed with the 1989 White Paper, Caring for People, in mind to capture the changing environment and to collect information about how the role of the sector was changing vis-a-vis the voluntary sector

Both questionnaires contained questions about the rationales, where appropriate. For example, when addressing the choice rationale relevant questions would include asking how choice was incorporated into service provision. Evidence of this might be supported advocacy programmes, patient councils, case review or other mechanisms.

The other side of this coin was to gather evidence about consumers' perceptions of choice in service provision. Collecting data on how participative services were or how much choice was offered was initially addressed by mapping what was available via information collected during visits to key individuals in agencies. An essential element was also to collect service recipients' perceptions of how much choice they had in service provision.

Data was collected using a number of techniques ranging from unstructured interviews, through group meetings, participant observation and non-participant observation. The approach adopted varied along a continuum depending on the appropriateness of the situation/ability of user. More will be said about user interviews in section 2.4.3.

I now discuss each questionnaire in more detail.

a) Questionnaire for health authority representatives

As was explained earlier, the health authority was the first point in my line of enquiry in each study area because the starting point for the majority of discharge services was hospital.

The questionnaire was introduced to the respondent thus:

> *This questionnaire has been designed to gather information about the organisation of services for people with long term care needs associated with mental health problems/learning difficulty in your area.*
>
> *It specifically aims to explore how agencies work together to provide services and to what extent and on what bases you work, in conjunction with voluntary agencies, to provide services.*
>
> *Please do not feel constrained by the areas covered in this schedule, they are not definitive. Additional information in the form of planning documents, strategy papers etc. are most welcome.*

This was the most loosely structured of all the interviews with representatives of agencies so as not to constrain enquiries at such an early stage in the proceedings. However, it covered areas comparable to

the SSD questionnaire (see below) and where appropriate there was the facility to draw on more detailed questions from that questionnaire. Examples are the questions which required the participant to make a judgement about respective strengths and weaknesses of the sectors.

In line with the information needs of the first aim of the study the general areas covered were: mechanisms for dehospitalisation; key actors in other agencies; which agencies provide what services; inter-agency relationships; finance; consumer participation in service delivery; assessing consumer need; relative strengths and weaknesses of different sectors; preparations for Caring for People; and information on any other research in the area.

b) Social services agencies' questionnaire

This questionnaire was introduced as follows:

> *I would like to get a general picture of services for people with mental health problems/learning difficulties in your area.*
>
> *I am therefore interested in having quite a wide-ranging discussion which might cover some or all of the following:- overall strategy, service mix, inter-agency relationships, consumer participation in service delivery, preparation for the contract culture, monitoring and regulation. More specifically I would like to hear your views on the relative strengths and weaknesses of the different sectors in service provision.*

This interview was designed to allow for a semi-structured discussion around a number of key themes with a more structured component vis-a-vis perspectives on the voluntary sector.

This interview was normally conducted with the Principal Officer-in-charge of community services for priority groups. The title by authority tended to vary, although the broad areas of responsibility of the people interviewed tended to be the same. These interviewees were often nominated by their health authority counterparts, often with a connection via joint planning machinery.

In Table 2.2 the main components of the questionnaire are listed. Next to each of these I have made explicit the type of dimensions the research was looking to cover as evidence relating to each component. For example, when looking for evidence of monitoring and evaluation of the voluntary sector I would be particularly looking for information concerning quality assurance.

The questions, although based around a number of themes, were fairly broad and therefore did not restrict discussion but ensured at least minimum coverage of a number of areas. The questions fulfilled a number of aims: straightfoward information gathering, policy interpretation and professional assessment. The interviewee was often requested to make judgements based on experience. As a result, it was anticipated that answers would inevitably be subjective. However, as this was felt to be the essence of the research, it was not considered antithetical to the research objectives.

TABLE 2.2

Schema for social services' questionnaire in the DHA study

Components	Dimensions Under Examination
Strategy	Overall service plan, key elements, issues. Under review?
White Paper	What preparations, issues, reactions effect on key players
Consultation	Arrangements for consultation with all players
Purchasing, contracting and budgeting	Extent of mixed market, experience of contracting and lending, financial information
Monitoring and evaluation	Quality assurance arrangements, criteria, effect on stat/vol sectors
Perspectives on the voluntary sector	What do they provide, quality, encouragement, resources, what do they do best! Comparative information

c) Voluntary organisations' questionnaire

This questionnaire for voluntary organisations carried the following note to the interviewee:

> *This questionnaire has been designed to gather a wide range of information about your organisation and what it does. It specifically aims to explore the ways in which you contribute to the mix of community services for people with long-term care needs in your area and uncover to what extent and on what bases you work in conjunction with statutory agencies to provide services. Please do not feel constrained by the areas covered in this schedule, they are not definitive.*

Additional information in the form of planning documents, strategy papers or any other information you feel is of relevance are most welcome.

Because of the diversity of organisation types and functions within the voluntary sector, the questionnaire was modular in design. It had 12 sections, each complete in its own right, and could either be used in its full form, if appropriate and time allowed, or by selecting different modules.

It was anticipated that not all sections would be appropriate for some organisations. For example, a service-providing agency might not have a membership (Section C) as such or might not use volunteers. The questionnaire was broadly-based enough to be sensitive to the different characteristics of a diverse set of organisations, but where a line of questioning was clearly inappropriate to that organisation, the interviewer could proceed to another section quite easily.

The areas covered by the questionnaire are listed in Table 2.3 below and annotated in the right-hand column to further clarify the evidence which was being targeted in each section. For example, in order to collect information about organisation type I would ask questions about the type of activities which the organisation might be involved in and ask them to categorise themselves using a number of classifications eg. service provider, campaigning organisation, mutual aid organisation.

TABLE 2.3
Schema for voluntary organisations questionnaire in the DHA study

Components	Dimensions Under Examination
Organisation type	Service providing, mutual aid or advocacy
Activities	What activities is the agency involved in - look for diversity, growth, specialisation
Membership	How big? Who are members, examine composition now and over time
Staffing	How many? Professional background. Change over time. Conditions of service and unionisation - use of volunteers
Structure	Test for Participation in governance structures and decision-making procedures. Which skills are represented. How devolved is day to day management
Information	How professionalised is operation and has this changed over time
Links with other agencies	What are the strengths and weaknesses, nature of relationship. Use of intermediary bodies, influence on statutory agencies and vice versa.
Finance	Where does money come from, general grants, POSC, trust funds, support in kind. How has composition changed
Effectiveness	What are the outcomes for agency, funders, clients. How successful in own terms.
Policy formation	Who influences it and to what extent?
Response to White Paper	Involvement in discussion, what are implication for agency
Role reflection	View of role in past, present

It was possible to obtain a great deal of valuable information from participatory organisations. Nevertheless some difficulties arose. There was, for example, variation in the ways voluntary organisations

kept financial and other data (sometimes there was also year-on-year variation within the same organisation). Another difficulty was that I was often posing questions couched in different terms and contexts from those in which these organisations themselves operated. Third, the national policy context was changing during the course of the fieldwork. In particular, the 1989 White Paper was published shortly before our ESRC funded research commenced, and implementation of the 1990 NHSCC Act followed soon after it. As far as possible I adjusted the approaches to improve the validity and relevance of the information I was seeking.

2.4.2 Perceptions Checklist

The Perceptions checklist questionnaire gathered attitudinal information from various stakeholders in the four areas. It was distributed randomly to potential respondents involved in the support of people with long-term care needs and to users themselves. The checklist is included in an appendix to this thesis and covered consumerism , advocacy, sources of finance, use of volunteers, type of service commitment, bureaucratisation, participation, regulation, accountability, and roles in local service mix. The effective sample was 97 respondents including 14 users, spread across four areas. Data from users were collected via in-depth studies in three day care settings for mentally ill people, alongside other data.

The checklist was designed for use with a range of people to examine views about the contribution made by the voluntary sector to community services for people with long-term care needs. The questionnaire was distributed to those I met in connection with the research in each of the study areas. Some of those people interviewed

were people who I met along the way and expressed an interest and others were passed on by colleagues or other clients. The sampling was therefore clearly not systematic, although useful evidence was nonetheless obtained from use of this instrument.

The checklist aimed for an overall impression rather than lengthy responses and therefore it was deliberately compiled in a manner which was quick and easy to complete (each interviewee was instructed that it should take no longer than five minutes). The idea for the questionnaire arose because I became aware of the range of conflicting views about voluntary agencies and the services they provided. It therefore seemed appropriate to try to test this in some way, firstly to see what these views were, and secondly to see if there was any relationship between characteristics of respondents and beliefs.

In chapter 5 I will report checklist responses by sub-population and rationale. Each study area generated exactly 25% of the total responses. Fourteen users were represented in the total sample and the age profile of respondents varied, the majority (72%) being between the ages of 30 and 49.

2.4.3 Day care evaluations

User data was collected via in-depth studies of three day care settings for people with mental health problems, which included interviews with users. Although data was drawn from all three settings the evaluation appended at Appendix A was the most comprehensive. Forty service users took part in the evaluation although the descriptive information is based on a smaller sample of 18. The profile of

participants is described in Table AA.2, appendix A (p.AA.18). The Canterbury evaluation involved interviews with 20 clients and the pilot study in Cheshire 10 clients. The questionnaires used in this study are appended to this thesis.

The descriptions of the interviews with agency personnel reveal how part of the information was collected to test consumer-related rationales for funding. Another important aspect was to gather evidence about consumers' perceptions of choice, participation, and specialisation in service provision. This was initially addressed by mapping what was available. Information collected during visits to key individuals in agencies was another useful source.

In practice however, service recipients' perceptions of how much choice they had in service provision was essential. One reason was because of how people experience services. Another was how they perceive them. In line with von Abendorff's (1990) findings it was anticipated that the views of service providers and users would conflict.

In terms of questionnaire design a number of factors had to be acknowledged and dealt with. The aims of the research were such that eliciting consumer views was paramount. However, there are a number of problems associated with collecting data from clients with mental health problems and learning difficulties which have been well-documented.

Previous experience with these client groups and also a review of methodologies used by others (see Simons, 1989; Atkinson, 1988; Wyngaarden, 1981; Walker, 1989; Simons, Booth and Booth, 1989), suggests that poor quality information is often obtained when working with service users for a number of reasons. First, there may be response problems from people who often do not comply or comply in a restricted sense, either for reasons of suspicion, or an inability to understand or an inability to communicate. Second, methods which fall at the more 'scientific' end of the spectrum are often inappropriate for people who have often been through the system and either have a set reaction to being questioned in terms of letting the interviewer know what they 'feel' they want to hear or have taken a decision not to comply.

Leedham (1989) refers to the work of Lowe and de Pava who found that Yes/No questions produced high rates of response and although their validity was of doubtful significance their inclusion was valuable in opening up discussion. They also found that clients were encouraged by easier questions to attempt answers to more complex questions. Other researchers such as Wyngaarden (1981) have also found that simply-phrased open-ended questions, and scope to rephrase questions while maintaining original intent, tend to spark a response.

Similarly to Wyngaarden (1981), Lowe and de Pava found that freedom to change slightly the format of questions, whilst retaining their original intent, was useful and aided clients' comprehension of what information was being requested. In addition they found that the use of the prompt, "anything else?" as suggested by Sigelman et al

(1981), was of value in eliciting fuller responses.

Many of the national advocacy agencies are now assisting with evaluations of services, particularly because of the problems of getting people to speak honestly about their needs (Knapp et al, 1992).

There is now a growing appreciation that good quality information and high response rates are closely correlated with sensitive questionnaire design (Wyngaarden, 1991; Leedham, 1989). Sensitive questionnaire design involves the following components. First, the instrument should be sensitive to the experiences and abilities of the interviewees i.e. informal interviews with clients before the questionnaires are designed to elicit key issues that those in receipt of services are ideally placed to know (Allen et al, 1992). Second, instruments should be sensitive to the preferred style of evaluation. Third, it is important to make sure the research is useful to those you hope will participate. People are much more likely to respond if they feel there could be direct benefits for them and so the researcher needs to discuss ways in which the work could improve services in an area.

In line with these guidelines for sensitive research I spent time with staff and clients to get a feel for topics of interest to them, key issues and level of ability of clients. Time was also spent explaining what the research was about and exploring ways of producing work which would also be of use to the participants. These activities resulted in several presentations of research ideas and final results in the day centres concerned and user friendly research publications to honour feedback commitments.

This information then informed the questionnaire design where a questionnaire was felt to be appropriate. The key issues and domains of people's lives were looked at in the light of client-related rationales and appropriate questions designed. Each question therefore had an intent. Many of the clients were contacted via day centres. Where this was the case this service was used as a focal point for collecting information about their experience and opinions of services. However, the questionnaire went wider than the service through which they were contacted. It was designed to elicit views about the range of services in an area and about their own needs and the needs of the client group in general.

Therefore data was collected using a number of qualitative techniques ranging from unstructured interviews through group meetings and participant and non-participant observation. The approach varied along a continuum depending on the appropriateness of the situation/willingness and choice of user. A number of instruments were designed to suit a range of people with different preferences, circumstances and abilities. In Table 2.4 two versions of the questionnaire are compared .

The questionnaires focus mainly on clients' needs as a mental health user, their experience of the particular service in question and other services in general. They were also designed to uncover the interface between the two and collect information on specialisation, participation, consumerism, and self-determination.

Version 1 of the questionnaire was more structured and explicitly covered a number of topics. Version 2 had a looser structure and it

was anticipated would raise the same areas but because of its more unstructured format be less constraining to the respondent.

The two questionnaires were quite different. Version 2 was much shorter and was mainly concerned with needs, services and if the two coincide. In this case the respondent would be much freer to voice their own opinions without too much structure. This lack of bias was a fundamental characteristic of the research, aimed as it was at eliciting a genuine consumer viewpoint untainted by pre-imposed categorizations. Such a questionnaire would be difficult for some people to complete however, hence version 1 had a mix of open-ended, unstructured questions along with some multiple-choice type items which some clients prefer.

Collecting data for people with learning difficulties raises rather different issues. Clients have differing degrees of expressive or receptive languages and therefore questionnaires were designed using language, symbols and pictures following other studies (Booth, 1983; Cambridge, 1991). The data collection was planned for the hospital closure study (see below) but because of the upheaval for clients that the move caused and the particular difficulties involved with asking complex questions of this client group, - for example, to make judgements about aspects of different services - it was decided not to proceed. This aspect of the study was therefore quite heavily dependent on carer views and interpretations.

Table 2.4
Content comparison of two versions of user questionnaires from day centre studies

Components	Version 1	Version 2
Personal details	Not essential but help to identify:- name age, gender	Where do you live What type of support Main problems wishes Characteristics/ professional involvement What like most/least Improvements?
You and the Centre	Attendance, how long, what's good about it, who referred	
What the centre offer	Who is it for, comment on range of things, other day time activities, what offer:	Much reduced version
How the Centre is organised	Participation, choice, roles, confidentiality	Much reduced version
Help	To what extent is Centre source of help?	Much reduced version
Alternatives	Choices? and what prevents it	Much reduced version
Your situation	Consumer groups? Needs, to what extent being met - could centre help?	What do you need?
Additional optional information	Characteristic of consumer - hospital admission - type of accommodation - medication - work	

2.4.4 A study of hospital closure

I was fortunate to have the previously unplanned opportunity to look more closely at a fast-tracked hospital closure in one of the study areas. Interviews were conducted with 13 key stakeholders from the health authority local authority and voluntary organisations. Two brainstorming days, not so different from focus groups but involving larger groups of people, allowed discussion and debate about key aspects of the closure process. Several factors made this an interesting focus for a case study. Not only did the strategy being evaluated close a hospital, but it also used a single agency to achieve this end. The area was characterised by a strong voluntary tradition and poor relationships between the local and health authorities. The health authority in question had also prided itself as 'being in partnership' with a plethora of managing agencies.

The case study examined how practice reconciled service principles, policy change and political expediency, the weights attached to different and often conflicting factors when decisions were being made, and how reconciliation was achieved between the needs of users, organisations, staff, finances and type of service. It also looked at the impact of external factors, for example, regional and national policy directions and externally set timetables.

In practice when major themes in social policy - in this case, de-hospitalisation and mixing the economy - conjoin in a strategy for service development. Which factors are influential in service design for example? It also allowed me to speculate about the extent of knowledge concerning what the voluntary sector provides, on what

basis beliefs are held and to what extent these beliefs influence service design.

2.4.5 Locality surveys of voluntary organisations.

Two territorial surveys of the nature and scope of the voluntary sector in the UK provided useful data on a range of organisations working locally in the health and welfare field. The surveys were conducted in Camden and Canterbury and Thanet, and were both part of work being conducted by the PSSRU as part of the Johns Hopkins Cross-National project which provided the first systematic attempt to map the UK voluntary sector comprehensively (see Kendall and Knapp, 1996). The broad study adopted a modular approach to map the sector which interrogated a range of sources: government statistics, work of umbrella bodies, secondary analyses of data to fit their categorisation, territorial surveys to cross-validate and inform, and original collections where there was no prior information.

The locality surveys were two of the in-depth studies designed to give a clearer view of the accuracy of national mapping in the knowledge that many organisations may not be picked up in the other broader collections.

The study in each locality consisted of a postal survey of voluntary organisations in 1992 thought to be providing or supporting provision of personal social services. Questionnaires were posted to 342 organisations in Canterbury and Thanet (questionnaire appended to this thesis). The sample was drawn form the Council for Voluntary Service listings. From this initial sample 57 responses were received.

After adjusting for organisations which were defunct and those which did not or were no longer working in the field of social welfare, the final sample was 44 - a response rate of 16%. In Camden, questionnaires were sent to 162 organisations. From the initial sample, 41 responses were received and after adjustments there were 31 valid responses - a rate of 27%.

The disappointing response rates may be attributable to four factors: First, there was no way of knowing whether the remaining questionnaires had reached their target. Organisations may have ceased to exist or addresses may have changed. Second, the questionnaire itself was fairly lengthy and required a range of information which may have taken some time to compile. Third, the locality study by its very nature was targeting small local organisations perhaps with no paid staff but heavy workloads which preclude this type of additional task (completing questionnaires). Finally, it is possible that some organisations might prefer not to reveal detailed information about their organisations which until now had remained in the private domain. This is particularly likely to be the case in an environment where grants to the voluntary sector are being cut.

Data from both sites has been combined for the purposes of this evaluation, although it is worth noting that there were marked differences between the main features of the sector in London and Kent. Figures 5.10-5.19 in Chapter 5 offer descriptive information about the sample.

A related territorial study by Shore and colleagues (1994) in Liverpool

is drawn upon in Chapter 6 when funding of the sector at local level is examined. The Liverpool work was conducted in 1990 and had 298 respondents (a 28.3% response rate).

2.4.6 The Mixed Economy of Care (MEOC) Project

This thesis was able to draw on interviews conducted for the Mixed Econonomy of Care (MEOC) project managed jointly by the PSSRU and the Nufffield Institute, and funded by the Department of Health. The MEOC project sampled 25 representative English social services authorities, interviewing directors and elected chairs of social services in late 1990/early 1991. Quantitative data were also collected on expenditure patterns, including contracting out. Interviews focused on how local authorities had responded to the 1989 White Paper and the 1990 NHSCC Act, and how they were planning to promote and manage the local mixed economy of care as the Act required them to do. The material drawn upon in this thesis, using the MEOC interview transcripts from 1990/91, concerned local authority perspectives on voluntary organisation services and roles.

2.4.7 The North London Reprovision Study

The thesis was also able to draw on the findings of the North London Reprovision study (often called the TAPS study, after the Team for the Assessment of Psychiatric Services that carried out the study) of the closure of Friern and Claybury hospitals. Claybury hosapital was one of the sites for the Care in the Community pilot programme, so that there was a chance to use complementray evidence. The North London Reprovision study was drawn upon to look for evidence of activities and performance (Q3). A re-analysis of the data also contributed to

the evidence on cost-effectiveness. The PSSRU conducted a regional health authority-funded study of the economics of community reprovision for former long-stay residents of Friern and Claybury Hospitals in North London. It collected detailed service use and costs data alongside clinical data and social data collected by the Team for the Assessment of Psychiatric services (Leff, 1997). The PSSRU component of this study was commissioned to examine the costs of community care to compare them with hospital costs and to explore their links with outcomes and needs. These data then permitted comparisons between the provider sectors of outcomes, quality of care, user characteristics and costs (Knapp et al.,1999).

2.4.8 A study of a home from hospital service.

A small study of a British Red Cross Home from Hospital Service (Thomason and Mitchell, 1987) provided more recent data about the reality of organising care at the health/social care interface. The work examined the meaning of the concept of 'monitoring' in practice and the impact that statutory requests to monitor client care have on the work that people do. The first part of the work was an exploration of the notion of monitoring with volunteers.

The questionnaire used in this particular component study is appended to this thesis. Because of the preliminary, although interesting, nature of this work, the results are used in an illustrative way throughout the thesis where they illuminate discussion of particular issues rather than in tabular form.

2.4.9 The Care in the Community Evaluation

As I noted earlier, the 'springboard' for the work reported in this thesis was my experience during the PSSRU evaluation and dissemination of the 28 pilot projects of the 1983 Care in the Community evaluation. This programme of activity will inform a number of aspects of this thesis. In particular I will draw upon it in chapter 3 when I look in detail at the shape of the voluntary sector in community care. The Care in the Community data is re-analysed to answer a number of questions: for example, what is, and what accounts for the role of the voluntary sector in community care? To answer this question I will be addressing the related questions of: a) what accounts for the shape of the sector? and b) what accounts for how we care for people with long-term care needs?

2.4.10 Financing the sector - Compilation of data from a range of studies.

As I mentioned earlier in section 2.4.1, costs data was particularly difficult to collect in the DHA study because of the way in which organisations stored their records and the way they kept their accounts. It was often difficult to access the information, and even harder to draw meaningful comparisons between organisations because of the differential formats. In Chapter 6, which focuses on public funding, it was therefore necessary to draw on a range of work which looked at funding from a number of perspectives.

One particular source was the work of Kendall and Knapp (1996) who mapped the sector as part of the Johns Hopkins Comparative Non-Profit Sector Project (Salamon and Anheier, 1993). The full study

sought to map the relative scale and composition of the sector in 13 countries. The broad figures on the UK offer some interesting baseline information in terms of broad trends in funding and market share. The figures are particularly useful in identifying changes in funding which have accompanied shifts in policy, including the encouragement of housing associations in the 1980s and some of the perverse incentives offered by generous board and lodgings payments in the late 1980s resulting in the dramatic growth of independent sector care homes, and private sector homes in particular.

The NCVO survey of local authority support for the voluntary sector (Bolton et al, 1994) was also a useful resource, helping meto track and understand the way in which this source of public sector support was changing over time. The donation of individual time in the form of volunteering is a vital resource for many organisations and Knapp et al (1996) examined the scale of this source of support across the sector. These data will also be drawn upon. Schneider's (1996) work on national and local mental health organisations is also informative. In addition the work of Russell et al (1996) on a small sample of voluntary organisations in the north of England is most helpful in its analysis of recent trends in support for the sector.

National overviews of funding patterns are interesting and help us to appreciate the relative scale of the sector compared to other sectors, as well as the relative nature of public support. The national picture however is not sensitive enough to provide an in-depth view of the extent and impact of public support on agencies. A national picture cannot help us to discriminate finely enough between organisations with different activities, ages or size. It is also in danger of hiding

from view many of the very small and localised services which sustain people withlong-term care needs. This is why I decided to draw most heavily on data from a number of local studies.

2.5 CONCLUDING REFLECTIONS

The aim of this chapter has been to describe the strategy employed to answer the central questions of this thesis, the methods used and the data sources drawn upon.

A particular strength of the work was the access which I was able to gain to a wide range of data. As a result of this I was able to gather a greater cross-section of views and collect a fuller range of evidence about the achievements or otherwise of the puported attributes than I might otherwise have done. On reflection this advantage probably encouraged me to be 'over' optimistic about what it was possible to achieve and prevented me from pinning down the research questions more tightly.

For some parts of the research one might argue that the result was breadth at the expense of depth. However, I would argue that this was more than counter-balanced by the contributions made by the focused work with users and the hospital closure case study.

In addition the user-based work made a particular contribution at the time it was conducted to our understanding not only of what users feel they ***need*** and value but also how that information can be accessed.

As I mentioned earlier, the data was collected at a time of great

upheaval for organisations and this posed several problems. First, agencies were often over-burdened with additional demands emanating form changes to their funding base; second, there was sometimes more suspicion about participation in research in what was increasingly being viewed as a competitive, evaluative market; and third, the huge variety in organisation type and structure and how much change organisations had undergone to their funding base, posed particular problems for uniformity in data collection. This was particularly the case for funding information, the end result of which was a change of plan for the funding part of the data collection (see Chapter 6).

In chapter 3 I examine the developing roles of the sector in community care. Two questions will be particularly important in this examination: what accounts for the shape of the sector in community care services?; and what accounts for the way in which we care for people with chronic needs? The role of the sector in the demonstration programme is analysed to examine what it contributed in particular to care and how this relates to the theoretical rationales outlined in chapter 4.

CHAPTER 3

DEVELOPING ROLES OF THE VOLUNTARY SECTOR IN COMMUNITY CARE

3.1 INTRODUCTION

Chapter 1 examined the broad context for this work and chapter 2 has looked in some depth at the design and detail of the methodology employed. The principal aim of this chapter is to begin a more focused explication of the contexts which were referred to in Chapter 1. Section 3.1.2 looks in detail at the outline of this chapter but I begin rather unconventionally with an illustrative example of voluntary sector roles to explain the need for this deeper focus.

3.1.1 Contextualising the role of the voluntary sector

One cannot fully understand the role of the voluntary sector or the concept and practice of community care without locating both notions within the context in which they have developed. For example, in contemporary terms, an analysis of the policy of community care would be incomplete without an acknowledgement of the burden this places on informal carers, largely women, and the impact this will have on 'cared for' and carer alike. (See amongst others the work of Ungerson, 1987, Graham, 1983, Finch and Groves, 1983.) In addition, one would also need to find a way to explain the apparently contradictory nature of employment strategies which are taking more and more women out of the home alongside a policy of community

care which seems to assume their location within the private sphere. Debates about these issues have been conducted widely and much of the academic literature can be found in discussions of the ideology of caring, the sexual division of labour, and the nature/nurture debate.

Likewise, a contemporary analysis of the role of the voluntary sector would need to employ analytical tools which help us to analyse not only what the voluntary sector does and why but also the impact of growth on what it does and what it is claimed to do well. For example, what impact does an enhanced role have on governance structures within organisations? How does a change in the balance of provision between the sectors affect the respective legitimacy of each? Concepts, constraints and objectives such as bureaucratisation, participation, cost-effectivness, flexibility and responsiveness, and ideas about the ethos of voluntarism and the changing voluntary/statutory divide would all aid our understanding of the way in which the many factors currently impacting on the sector interact to affect it.

None of these interlocking issues would be apparent if an analysis purely focused on legislation. Decisions on the role adopted by the sector are a result of a complex interplay between prevailing ideas about what constitutes a 'good' society and how society should best organise itself. These ideas manifest themselves in competing theories of welfare which are underpinned by different assumptions, identify varying degrees of state intervention and are catalysed by other factors such as the state of the economy and the political priorities of competing groups.

By inference then, the analysis of the conjunction of the role of the

voluntary sector and the policy of community care will inevitably reveal a complex association of these factors which an appreciation of the ideological, political and economic context can only illuminate.

By way of illustration, the policy of community care is about more than practice decisions about where care should be located. Factors underpinning policy change are multiple and when a number of factors come together, for example dwindling resources, concern over dependency and lack of responsiveness, they can combine in different ways to produce different outcomes. In different models different factors assume more priority than others. Taylor-Gooby and Lawson (1993) argue for example, that a wish to facilitate consumerism can be embodied in a participatory democracy as well as in a market economy. An appreciation of who has the power to conduct that prioritisation is crucial to our understanding.

We can explore these tensions further by applying them to a thought experiment (a fantasy of mine). It occurred to me that if I could transplant a contemporary voluntary sector manager into a voluntary organisation of 100 years ago it would be interesting to think what sense s/he would make of voluntary effort in this rather different context. Would their experiences inevitably be so completely different that they had nothing in common or would there be some commonality - an essence of voluntarism - which would allow them to 'speak the same language' and share the same concerns? Furthermore, what would this tell us about the developing role of the sector and the relative importance of the factors which have shaped that development?

My example from the past is documented by Miller (1988) in his analysis of the lives of the poor in Victorian Liverpool. The Central Relief Society (CRS) of Liverpool was established in 1863

"to provide the necessaries of life for deserving families who through sickness on the part of the breadwiner, lack of work or unavoidable misfortune of any kind, were in need of help"

(quoted in Miller p.30)

My contemporary example is cited in Hadley and Clough (1996) and focuses on an organisation (established early 1980s) whose principal aim is to facilitate ordinary living for people with learning disabilities. What values and assumptions were these organisations built upon?

As Miller argues, the CRS was not interested in anyone whose condition was due to "improvidence or thriftlessness". Indeed he argues that charitable institutions of 100 years ago were based on two assumptions; first, that poverty was not a result of the social and economic system but something which could be avoided, and second that philanthropy could adequately deal with the extent of poverty.

The Director of the organisation in the contemporary example argued that the organisation was driven by a commitment to the model of normalisation by those dissatisfied with hospital-based services. Commitment to this model was based on several beliefs; that long-term hospital-based institutional care was not in the best interests of people with learning disabilities; that access to a 'normal' lifestyle would be in the best interest of clients, would not be institutional and was realisable.

The manager in the historical example operated in a context which stressed self help and independence. Poverty was a cause for concern and yet the root of the problem was not yet located in the social and economic context of people's lives rather with the notion of individual moral failure. The rich were encouraged to express their obligation to the poor via philanthropic effort and yet there was a concern about the effects of "indiscriminate charity". This led to ideas of 'deserving' and 'undeserving' cases. Much of the effort of a CRS administrator, who incidently was likely to be a member of the elite, would be taken up with judging the worthiness of the many potential clients, with the result that most of those in need were passed over. Intervention by the state was a measure of last resort and there was no entitlement to services as of right and no choice for those in need between a variety of providers. The aim of the service was to enable those who were felt to be deserving of help to 'improve themselves'.

In the contemporary example the organisation's raison d'etre is to offer a better service to clients than they currently receive. The origin of the service is therefore deeply rooted in a critique of the status quo. Eligibility is not a problem as such, although if a client is too expensive (because of their staffing needs) or too disruptive they might not be accommodated in the scheme because of "average funding" levels imposed by purchasers. Current preoccupations of the manager are with erosion of trust and threats to quality of service, both seen to be the result of the contracting process. The manager is a highly skilled and trained professional who is operating in a competitive market with other providers of similar services. The manager would argue that services are purchased by people who have no expertise in the area of care they are purchasing (Hadley and

Clough 1996:129).

So what can we learn from this comparison? Would the managers experience any commonality? Both were clearly subject to constraints imposed by the environment of the day. An analysis of the issues which currently concern each manager most would reveal prevailing ideas of the day ie. ideas of competition and choice in the latter and morality and desert in the former.

Kendall and Knapp (1996) point to the importance of this rich texture of economic and social life in determining what the voluntary sector does. In the historical example central beliefs about non-intervention rested uneasily alongside fears about the stability of society at a time when it was experiencing unprecedented upheaval. The result was to individualise misfortune and locate the 'blame' with the individual, whose last resort was charity. Religious doctrine and the fear of instability were also influential factors affecting beliefs, and different commentators prioritised different explanations according to their own partialities.

In the contemporary example commitment to the new economic order, financial austerity and a critique of the achievements of post war welfare policies, as well as changing notions of the 'proper' place to care for people with chronic needs, combine to allow the voluntary sector a major role.

It is the interaction of the twin themes of dehospitalisation and the mixed economy of care which accounts for the environment in which the contemporary manager is functioning. As we have suggested

earlier and will return to later in this chapter, forces for change can combine in a number of ways. Taylor-Gooby and Lawson (1993) argued that the new order in welfare in the 1980s and early 1990s - the period in which this thesis work is located - particularly expressed conservative ideology. The context in which change happens is therefore crucially important and needs to be understood. It is therefore instructive to trace what factors have shaped the voluntary sector in community care today.

3.1.2 The aim and contribution of this chapter

A large part of this thesis is concerned with examining the contemporary role of the voluntary sector in community care. Indeed in order to answer the central questions of this thesis (p 1.2) it is necessary to look in detail at the work, funding arrangements, characteristics,and changing role of a range of voluntary organisations working with people with long-term care needs associated with learning disability and mental health problems.

These data give us valuable information about the status quo. They allow for comparison of the performance of different types of organisations and an examination of the impact of their changing role vis-a-vis the other sectors. In addition, they allow an exploration of what happens in practice at the interface of the twin themes of dehospitalisation and mixed economy.

Chapter 1 focused on the contexts in which the voluntary sector is providing care for people with long-term care needs, concentrating primarily on the legislative contexts of de-hospitalisation, mixed

economy and the mixed economy of de-hospitalisation. By examining policy intent in this way we can build up a picture of the way in which the sectors are enabled or disabled. For example, under the Care in the Community Initiative, financial transfer was enabled to bring people out of hospital in a way which encouraged agencies to work together. But merely facilitating change doesn't always mean that change will follow or have the anticipated outcome (*throwing money at a problem does not make it go away).* For example, will organisations respond and if they do, can they deliver what is prized about their service or will it be affected by the changes that will have to be made in order to deliver? This is the practice element of this thesis. However, as my thought experiment reveals, the context in which change happens is crucially important and needs to be explicated to understand more fully the role of the voluntary sector.

The aim of this chapter then is to add this contextual dimension. The diverse and important roles played by the voluntary sector in the organisation and delivery of community care services are explored. The complexities of the backdrop against which decisions are taken to fund non-statutory services and the expectations of current policy regarding the independent sector are discussed. It will also be helpful to discuss the context in which re-discovery of the sector has occurred: an emphasis on the broad range of social and economic attributes of the sector, allowing politicians to support those parts or aspects of the sector which seem to support their interpretation of the welfare state in crisis.

The chapter addresses several important questions: What accounts for the role of the voluntary sector in community care today? To address

this question I will be addressing the related questions of: a) what accounts for the shape of the sector? and b) what accounts for how we care for people with long-term care needs? It then moves on to look in detail at the shape of the voluntary sector in community care today. This analysis draws on work I did as part of the evaluation team working on the Care in the Community Initiative 1984-1988.
Finally the chapter examines what this information tells us about the sector's contemporary role and we consider whether and with what purpose the government will fund it.

Before doing any of these things however, it would be remiss of me not to further clarify exactly what is meant by the term 'voluntary sector' in this thesis.

3.2 WHAT IS THE VOLUNTARY SECTOR?

Conceptualising the voluntary sector is problematic. As I argue below, the sector's heterogeneity and the confusion around the precise meaning of the term as well as related but different concepts such as 'volunteer,' 'voluntary work' and voluntarism, often used in the vernacular, add to these difficulties.

I do not intend here to engage in a lengthy discourse about the intricacies of definition (that is another thesis!) but as I am operating in an area 'fraught with ambiguity' (Marshall,1996) it is important to delineate for the purposes of this work the meaning of 'voluntary sector' and what it comprises. In reaching this end, I engage in a brief but not exhaustive review of why definition is so problematic and go on to discuss the types of definition and classifications which can be

found in the literature. The issues around definition are instructive in themselves as they are similar to many of the issues which I faced in conducting this work. Discussion of the typologies which exist additionally offers the opportunity to explain where my data sets can be located and clarifies which 'voluntary sector' I am discussing.

Kendall and Knapp (1995) have described the voluntary sector as 'a "loose and baggy monster," characterised by a multeity of structures, activities and orientations' (p 133). Marshall (1996) suggests there are four or more voluntary sectors therefore accounting 'for its apparent incoherence and lack of clarity' (p52). He argues that there is a multiplicity of voluntary sectors and names the following broad forms: informal action, community action, religiously motivated action, philanthropic action.

When we talk about the voluntary sector what, then, do we mean? Marshall (1997) argues that it is a term often used without precise definition and confused with similar sounding but materially different activities, such as 'voluntary work' and 'volunteering.' Elsewhere, Marshall (1996) employs a set of common conceptions (see box 3.1 below) about the voluntary sector, not unlike those which form the basis of the 'perceptions checklist' used in the DHA study to illustrate the mythology and confusion which plagues understanding of the sector.

He reminds us that part of the need for definition arises from the existence of 'other' sectors and that in less complex societies 'voluntary activity is nothing more than everyday life'. The study of voluntarism may have advanced apace and allowed us to distinguish in quite

BOX 3.1

MARSHALL'S COMMON CONCEPTIONS OF THE VOLUNTRY SECTOR.

1. Voluntary organisations are about volunteering.
2. The voluntary sector is more personalised, closer to the community: the statutory sector is bureaucratic.
3. The statutory sector serves consensus values: the voluntary sector is able to respond to minority values.
4. The private sector serves private good: the statutory and voluntary sectors serve the collective good.
5. The voluntary sector is primarily concerned with the disadvantaged.
6. Control in the voluntary sector lies with the community, not with investors (private sector) or the government (statutory).
7. The voluntary sector has a strong relationship with moral values.
8. The voluntary sector is creative, innovative, flexible and quick to respond.

Compiled from Marshall (1996:p48-51)

sophisticated ways between the sectors, as Marshall's work demonstrates. However, I would suggest that this argument can still be applied to popular perceptions of the voluntary sector, many of us still perceiving many voluntary activities as everyday life, as women's work, or the work of the retired, and most certainly as unpaid and unskilled. The picture is more complex than this of course, as Davis-Smith (1996) and others argue, with many organisations employing paid staff and highly skilled volunteers.

This long standing mythology which surrounds the sector hinders precision and partially accounts for definitions of the sector which rely on what it is not - for example, through the rise of terms such as 'not-for-profit' - or definitions that regard it in relational terms and assign it a more residual role, for example 'the third sector'.Marshall argues that the problem with regarding it as if it is somehow deficient - for example, when the market cannot provide for some reason, or that which is not 'private for-profit' and not 'statutory' or 'public ' - is that it fails to recognise that it stands for something positive and "cannot be adequately conceptualised as some kind of polyfilla" (1996:46).

Others have employed a range of ways of classifying the sector. Not surprisingly the taxonomies which result are often linked to the motivation (interests) of the people who design (and sometimes fund) the classification. For example, those taxonomies based on subject matter or the work of government departments have been popular, particularly because of their association with the allocation of money. In chapter 6 of this thesis, when I look at financing the sector, these data will be seen to have been useful for deciding which organisations were relevant for my area of study.

Marshall also notes that other characteristics have been used in classifications, such as the distinction between service provision and campaigning (Knight, 1993) and those differentiated by their tendency towards informality or bureaucracy (Billis 1989)

Kendall and Knapp (1996:133) also examine issues of definition in their thorough work on the voluntary sector, part of which I was

associated with and have drawn upon in this thesis (see section 2.4.5). They argue that typologies have become more complex as investigation of the sector has advanced and they cite the work of Wolfenden (1978), Brenton's (1985) discussion of core functions such as service provision, mutual support, campaigning and advocacy, the work of Handy (1988), and that of Nathan (1990) who added resource coordination to the classification.

Inevitably taxonomies have their limitations. Marshall argues that they are artificial if you want to capture variation in role and relationship to society (p 47). Kendall and Knapp (1996) also point to the problems with classifying voluntary activity. They argue that uni-dimensional classification schemes can focus attention on service provision functions at the expense of mutual aid, campaigning and advocacy roles, but more recent classifications have been two-dimensional, focusing on both industry (area of provision) and societal function. They employ similar functional distinctions to Wolfenden (1978) Brenton (1985) and Nathan (1990), ie. service provision, self help and mutual aid, individual advocacy, community development, policy advocacy and campaigning, grant-making, and liaison and representation.

Marshall adds a quite new dimension to classificatory systems - the different implications for social change associated with each sector. Marshall argues that the 'potential for social change' is what differentiates the sectors. He examines six sectors of organised action: private, statutory, religious, philanthropic, community and informal. His analysis distinguishes between the sectors by identifying for each sector where the locus of control lies; by what criteria action is

allocated to the sector; and what contribution the sector makes to social change.

Lipsky and Smith (1989) in their work with non-profit welfare agencies in the United States classified agencies into three main types for the purpose of their analysis: traditional social service agencies, new agencies responsive to government, and community based organisations. Table 3.1 shows the characteristics of each agency type as described by the authors.

In terms of their relationship to government Lipsky and Smith argue that these different agency types can be seen as a continuum, with community-based organisations at the one end - which I have referred to as mutual aid agencies - and at the other end 'new' entrepreneurial bodies which are more recently founded often in response to the availability of government funds. Their contention is that different types of agency "are affected by government funding priorities in different ways. The most pronounced shifts and the greatest conflicts with government occur amongst those agencies that initially resemble government least" (p.630).

In a paper with a colleague (Mocroft and Thomason, 1993) we employed this typology to look at its utility in the English context. Still relevant today, Kendall (2000) also employs this typology in his recent examination of the voluntary sector's contribution to a range of care for older people. He further extends the typology by adding two new categories to keep pace with the changes which have happened in the 1990's, in particular national specialists and providers created as not-for-profit trusts formed as a direct response to the 1990 Act (p10).

These taxonomies have influenced the data collection for this thesis to some extent, although in the DHA study in particular, organisations were left the freedom to define themselves using other criteria if they so wished. In Chapter 5, Figures 5.1 - 5.9 illustrate the characteristics of the 27 organisations in the DHA study and Figures 5.10-5.18 describe the 85 agencies in the locality studies. Because dehospitalisation was one of the key themes of this work it inevitably means that most of the voluntary agencies belong to the more formal end of the voluntary spectrum, for it was necessarily formally-constituted and formally-run bodies that were best placed to secure the funding to run community-based care services. Looking at Marshall's categorization they are unlikely to fit into his informal or community action categories, although this is not to say that some of the groups involved would not have had these elements at some time in their history. Section 3.3.2 applies some of these ideas to the agencies involved in the Care in the Community initiative to build up a profile of voluntary involvement.

Table 3.1

Lipsky and Smith's typology of voluntary organisations

Traditional	Entrepreneurial	Mutual Aid
* founded by affluent civic leaders	* direct response to funds available	* response to unmet local needs
* Well established	* more recently established	* or unmet needs of less popular cases
* funded mainly by endowments	* most revenue from government sources or poorly paid workers	* often started and staffed by volunteers
* less dependent on government funds	* often established by social activists	* workers show strong personal commitment
* diversity of provision - less dependent on demand for single services	* intention to achieve social reform * rulebound & concerned with consistency * highly responsive to priorities of government	* shoestring operations built on shaky financial grounds * act most like volunteer organisations * non-bureaucratic * held together by freely given commitment

Compiled from Lipsky & Smith (1989)

3.3 THE VOLUNTARY SECTOR IN COMMUNITY CARE IN HISTORICAL CONTEXT

3.3.1 How can we account for the size and shape of the voluntary sector in this country?

Contemporary scholars (Salamon and Anheier 1996a), evaluating competing explanations for the size and role of the voluntary sector in cross-national studies, stress the value of a theoretical approach which sees the sector as a product of a "constellation" of social, political and economic forces. They cite Seibel (1990) who refers to the way in which the voluntary sector is embedded in the prevailing social, political and economic structures. Their work commends the value of the "social origins approach" and they usefully extend the notion of welfare state regime types advanced by Esping Andersen (1990) to analyse which factors can be associated with which model of voluntary sector development. (This is expanded upon in the next chapter.)

This approach acknowledges that the voluntary sector is a product of its environment rather than an 'isolated phenomenon floating freely in social space' (Seibel 1990:40).

So where does this leave us in respect of understanding the voluntary sector in the UK? As I have already argued, any understanding will require the analyst to locate developments in time and space. Taylor and Kendall (in Kendall and Knapp 1996), in their useful review of the history of the sector, argue that the voluntary tradition has a strong pedigree in British culture dating back as far as the 12th and 13th centuries. They document what is known of voluntary action since the middle ages until the mid-1970s and interpret this in the light of

other important events which were happening at the time. This exercise unearths myriad explanations for the development of the sector - including the impact of moralization during the industrial revolution; concerns about social stability in the late 1600s; and increasing state intervention this century.

However in considering which factors have been conducive to the strong tradition of voluntary action in the UK, they argue that certain characteristics have been consistently relevant. First, the importance of a comparatively stable society with the absence of recent civil war (excepting Northern Ireland) and a legal system which has protected charitable assets have both facilitated a diverse and broad sector. Second, the predominance of liberal values which have been tolerant of free association and democratisation and have spawned traditions of mutuality and altruism, and third the British preoccupation with status - philanthropy being a classic manifestation of the fact that "one had arrived" (p59). This final factor forms a central argument in the Marxist critque of capitalism which argues that voluntarism legitimises the status quo comprising the 'social cement' which holds the system together.

Many of the issues which are at the heart of this thesis spring from the changing nature of voluntary/statutory relations. It is important to realise that it is only comparatively recently that the state has had a significant role in the provision of health and social care. Prior to the development of the post-war welfare state the voluntary sector had dominated centuries of organised health care and welfare provision. Similarly the rhetoric of community care belies the fact that for many people with long-term care needs their home has always been 'the

community.'

The primary goal of social theory is to understand how societies organise themselves and why a certain model predominates. Of particular interest is the role which the state is assigned and to what extent it mediates between other actors in society. This is examined in more detail in the next chapter. Many commentators have traced the development of the sector and the notion of voluntarism in the UK (Brenton, 1985; Gladstone, 1979; Prochaska 1988). As I have mentioned Taylor and Kendall trace the origins of the sector as far back as the 13th century but in discerning influential factors which have shaped the sector, accounts of the origins of the sector tend to attribute importance to notions of philanthropy and charity engendered in the Victorian era. This period has been described as the 'golden age of philanthropy.'

Accounts go on to document how the sector has fared as changes in society have impacted upon it. Commentators tend to emphasise the following changes as being influential. One has been sporadic state interventions and the social concern of the late nineteenth century in the form of Poor Law provision and reform of the Civil Service. During the first part of this century the granting of working mens' suffrage and the social surveys of Booth and Rowntree, in combination with the inequities in society uncovered by two world wars, led inexorably to the implementation of Beveridge's vision of comprehensive statutory welfare provision. Indeed Brenton argues that Beveridge was a supporter of the voluntary principle in contrast to the Labour administration of the time who did not see it as a suitable instrument for its social programmes. In contrast, their vision of the future

involved the state in organising services along "rational" lines - an ability which was not attributed to the sector by the government of the day. In addition, as Taylor and Kendall argue, voluntary effort was associated with middle class patronage and where the political goal was a more egalitarian society their presence was seen as socially divisive. Survival was therefore dependent on the development of a new image.

These accounts demonstrate an important aspect of voluntary sector development - its ability to adapt to changed circumstances. This 'chameleon-like' quality of the voluntary sector, referred to by Beveridge as the "secret of success, its singular strength", has undoubtedly helped it to survive.

Hence, although the creation of the welfare state weakened the voluntary tradition, it did not lead to the demise that was anticipated in some quarters. Need continued to be met by a range of public and private institutions providing formal and quasi-formal service (Brenton, 1985 and Kendall and Knapp, 1996). Indeed, some commentators argue that the sector has helped the Welfare State to remain intact in an era dogged by lack of resources. Caulcott (1985) suggests that it has 'mitigated the cold climate' for personal social services by dealing with increased demand which the statutory sector had insufficient resources to meet.

As Taylor and Kendall argue, this period of adaptation in the late 1940s and early 1950s was relatively short lived. Dissatisfaction with the results of welfare statism - including the stigmatising nature of services, the power of professionals, inflexibility of services and the

rise of participatory democracy in the form of the various civil rights movements - spawned the development of a significantly different voluntary sector in the late 1960s and early 1970s. New organisations in the self help, mutual aid and pressure group categories such as Womens Aid, Shelter, CPAG, Friends of the Earth, Volunteer Bureaux, all seeking to influence statutory welfare provision, illustrate this change. The notion of charity - so central to philanthropic endeavour - had been replaced by the notion of rights.

What followed were policy initiatives which reflected this change in the nature of voluntarism eg. in the style of the urban programme. Community development, educational priority areas and services such as play groups, toy libraries, advice and law centres - which reflected the new voluntarism - abounded.

It is doubtful whether the sector would have thrived without official interest and encouragement of voluntary action. An analysis of official documents reveals growing interest from the late 1960s onwards. Voluntary action was strongly recommended in the Seebohm Report (1968), and Aves (1969) recommended the setting up of the machinery to encourage the development of the sector in the form of the Voluntary Services Unit and the Volunteer Centre. The Barclay Report (1982) made clear statements about the respective roles of the state and voluntary care when it stressed a residual role for the state, favouring family and local networks as the primary source of care, underpinned by the notion that too much state provision undermines "both their capacity and their moral resolution to care for their own."

A key feature of the voluntary sector is its diversity, a characteristic

which Taylor (1991) suggests has enabled it to adapt in the past and will help it survive in the future, insulating it when policy direction has marginalised its role or excluded it altogether. One could argue that this was particularly noticeable in the health field where private practice and voluntary hospitals were largely swept away when the NHS was established in 1948. But this 'chameleon-like' quality is both a source of strength and weakness, and has led to the sector being perceived as an antidote by people on all sides of the political spectrum. For example, Deakin (1991) argued that it is interesting to note that the efficiency argument, once used by advocates of collectivism by promoting the use of large organisations designed on scientific, rational principles, is now being used by advocates of voluntarism to promote its use, claiming that some services can be provided more efficiently by the voluntary sector. However, definitional problems with the concept and its confusion with cheapness leave many people unsure about the worth of these arguments. The cost-effectiveness literature seems to indicate that there is little proven evidence in favour of either sector, although the data presented by Knapp and colleagues (1997) suggests that the cheapest services for mental health clients are provided by private sector facilities, although in terms of health and quality of life outcomes, clients did not fare as well as those in consortium facilities. In other words lower cost sectors achieve poorer outcomes.

Deakin (1991) takes this further when he argues that this "chameleon-like" quality enables public policy to define the voluntary sector in terms which best fit general policy objectives. In other words the sector is deemed to have the power to bring about fundamental changes in society. He argues that it is precisely because 'the sector

contains such an array of activities, organisational forms, beliefs, and personalities that it is relatively easy to latch on to an aspect of the sector to demonstrate desirable traits such as efficiency, flexibility, good management and organisational skills.' He goes on to argue that the logic of this is at best suspect, at worst tautologous. A central problem is that when individual examples, representative of only certain aspects of the sector are generalised in this way, false assumptions may be made about capabilities and capacity.

Brenton (1985) argues that the voluntary sector we have is the result of two key considerations: ideological assumptions about the role and responsibilities of the state versus non-state; and practical concerns about the achievements of the statist position. Both themes are themselves part of this much broader debate concerning the proper role of the state in society which has raged since the late 1970s. The debate itself is multi-factorial and different elements, notably economic forces, political ideology and societal values, vie for superiority within it. It would therefore be naive to review these themes without some understanding of this backdrop which has undoubtedly been influential in terms of policy direction and speed and nature of implementation.

An appreciation of this is vital for two reasons: first, the mixed economy of dehospitalisation is operating in what Brenton refers to as a 'changed reality'. This is predominantly shaped by fiscal constraint, but the effect is to alter the way in which services are delivered. It immediately suggests prioritisation and this in turn suggests winners and losers. It would help us, for example, to understand why the principle of "normal living" has been compromised in favour of

maximum benefit receipt. This is the 'perverse incentives' argument advanced by the Audit Commission (1986).

Second, as Deakin suggests (1991), the contribution which the voluntary sector makes to community care is the stuff of legend: bolstered by beliefs but short on evidence. But those beliefs, whether supported by evidence or not, have grown up in a rather different context where voluntary organisations have not been constrained by accountability requirements and conditions attached to funding have been minimal. So not only do we have a system ostensibly designed around suspect attributes, those attributes were assigned to different organisations functioning in a different climate. In addition the only information we have about the consequences of an enhanced role is drawn from the US (Knapp and Thomason, 1987, 1990; Gutch, 1992, and others for review). Commentators in this country are now challenging the relevance of the US experience when applied to the UK (Taylor, 1993; Deakin, 1992).

3.3.2 How can we account for the way in which we care for people with long-term care needs?

It can be argued that the care we afford the most vulnerable members of our society is a reflection of the values which underpin that same society (Hadley and Clough 1996). This idea can help us to understand the way in which we care for people with long-term needs and to uncover the role which ideology plays in shaping 'welfare.'

Community care is not a new endeavour and most vulnerable people have been and continue to be cared for by family and friends in the community; albeit that care has variously been described as informal,

neighbourhood, voluntary, befriending and 'good neighbouring'. This perhaps belies the crucial role that community care has played in supporting people. However, the famed gap between rhetoric and reality has meant that progress has been sporadic and patchy. Wistow et al (1994) suggest that it is only now, in the shape of the 1990 NHSCC Act, that community care has well-defined expectations such as planned and tailored packages of services delivered to people with assessed needs, in cognisance of people's preferences, funded with these needs and preferences in mind, complete with built-in resource monitoring and quality assurance. This move reflects a number of factors: concern over the delapidated condition of the old asylums and the cost of renewal, humanitarian concerns about the effects that 'institutional' living can have on people and a reaction to the various 'scandals' which came to light in the 1970s; the influence of the various 'rights' movements which began to emerge also in the 1970s; and changing notions of difference which has led to more tolerance of variance in the human condition.

The old asylums grew up in a period when there was rapid change in society and fear of difference. Coupled with a belief in philanthropic endeavour and a paternalistic approach to vulnerability, this resulted in the large scale building of institutions to segregate what some people viewed as the consequence of rapid change.

The intention to provide care in a community context rather than in large institutions has been a discernible feature of government policy since the 1960s. (The links are summarised here but are documented more fully in the first book published by the Care in the Community research team, of which I was a member : Renshaw et al 1988).

As was discussed in chapter 1, the hospital population of England and Wales peaked at 148,000 in 1954 and has gradually fallen since. Both diversion and decanting have reduced the numbers of long-stay patients in the hospital population and de-hospitalisation has been a salient theme of post-war legislation and action. Individual pieces of legislation have built one upon another to facilitate hospital closure and transfer patients to community settings.

For example, the Mental Health Act of 1959 changed the legal status of the great majority of mental hospital patients. The Hospital Plan of 1962 came hard on the heels of Enoch Powell's 1961 recommendation, when he was Minister of Health, for the acute population of mental hospitals to be halved in fifteen years, and the chronic population to dwindle eventually to zero. The first recommendation was almost exactly realised, although the latter is taking rather longer to achieve.

In 1975 the DHSS issued Better Services for the Mentally Ill with its strong emphasis on early recognition and prevention, and its recommendations for the integration of support from families and community services. Similar themes had been stressed in Better Services for the Mentally Handicapped, prepared by the DHSS in 1971. Ten years later Care in Action carried the clear message that hospital closure plans should be introduced, phased over a ten year period. The debate on de-hospitalisation clearly continued into the 1980s.

Government statements stressed commitment to the policy of running down hospitals to eventual closure and building up community services to replace them, and numerous commentaries have either

criticised the Government for its failure to implement this policy fast enough or for doing so too fast. In the 1980's reports from the House of Commons Social Services Committee (1985), the Audit Commission (1986), the National Audit Office (1987), the DHSS committee chaired by Joan Firth (1987), the Residential Care Review Committee chaired by Lady Gillian Wagner (1988), and Sir Roy Griffiths (1988) kept de-hospitalisation high on the policy agenda. Each also made recommendations as to the roles to be played by voluntary organisations.

Contemporary policy is underpinned by the values inherent in market liberalism. This view of the world prioritises notions of self help and freedom and emphasises the central importance of the "family" as a cornerstone of a "good' society. State intervention is viewed as wasteful of resources, a constraining factor on people's lives and a deterrent to self help. The idea of welfare is not opposed but market liberals believe that the introduction of competition between providers will ensure more choice and more efficient services for consumers than a state-run monopoly can offer.

In the 1990s the NHS and Community Care Act (1990), with one of its central concerns being the creation of social markets to eventually make a reality of community care, consolidated much of what had gone before. Perhaps for the first time 'community care' was an identifiable concept or process, acknowledging the range of actors who were involved in care, the focus of political debate, legislation, purposive funding, professional training and research inquiry (Knapp et al, 1992).

Analysts differ in how they conceptualise and account for policy change depending on the perspective from which they view developments, for example from a broad policy viewpoint or through the eyes of providers or users. Elsewhere in earlier work (Knapp et al 1992:14-25), I and others have argued that it is possible to trace a number of recurring themes in the development of community care policy - *hospital closure* - a hospital rundown programme pre-dating current community care policy and influenced by a range of factors which Korman and Glennerster (1990:11) distil as 'part medical preference, part public opinion and part hard political economy'; *community care* - or at least the rhetoric surrounding the notion of community care that it is a 'good thing', but little strategic action to ensure that it happened; *joint working* - the realisation that people with long-term care needs required a range of services which needed to be co-ordinated in some way and yet few concomitant financial incentives to make joint working a reality; *the value for money imperative* - the drive in public service to ensure economy, effectiveness and efficiency were just as powerful an influence in community care developments as in other sectors of central and local government; the belief in *pluralism in service delivery* in order to realise other related aims of service diversity and efficiency pressures; *user choice* - the belief that people with long-term care needs have the right to be consulted about the type of services they receive.

Beecham et al (1995) argue that one account would be to see the changes as 'the logical culmination of social, clinical and economic trends' (p.41). They are an extension of the notion of marketisation into the fields of health and social care; a response to the rising cost of community care and to concerns about the neglect of clients.

Wistow et al (1994 and 1996) identify four dimensions of policy change which they argue capture the complexities of the 1990 Act reforms and embrace the essential differences between the 'old' and 'new' styles of service provision for people with long-term care needs. First, was a move from *institutional to community-based care,* representing not only the change in location in which care is delivered but also the principles governing that care. Second, there was a move from *supply-led to needs-led care,* namely a switch from provider-dominated to purchaser-dominated care. Third, was a shift away from *public sector towards independent sector provision,* or in other words the move towards service pluralism rather than public sector monoploy. Finally, the Act sought to make progress from *care under the auspices of the NHS to care under the auspices of local government.* This final dimension represents not only an organisational switch in terms of moving the lead role towards local government but also a philosophical one against the biomedical model in favour of a more holistic approach. The complexity of the changes is compounded, they argue, by the contradictions inherent in the changes and the issue of the relative weighting attached to each of these trends.

This conceptualisation of the reforms is helpful at the macro level but may appear rather abstract to those who are experiencing service change. What do these changes mean in reality for service users and those implementing them? Hadley and Clough (1996) also focus on some of the fundamental contradictions inherent in the reforms but this conceptualisation differs from the afore-mentioned as it is derived

from the accounts of service providers. They identify nine contradictions at the heart of the reforms which they argue account for the confusion and alienation of the personnel who are charged with implementing them. These contradictions are interconnected and can therefore, for the purposes of this discussion, be considered under four headings. One heading is *values issues* - market versus public service values - which Hadley and Clough argue involves the denigration of public service and those who provide it in terms of devaluing of skills and poor working conditions. The paradox is that in the face of diminishing resources and increased demand the very thing which is devalued is invoked to sustain the service ie. the notion of 'commitment' which the ideology of 'public service ' is supposed to have instilled. In addition the dichotomous nature of the twin notions of co-operation and competition, which seem hard to sustain given the fragmentation of services which a competitive market requires, leads to a lack of openess and trust which undermines collaboration.

Second, Hadley and Clough distinguish *resource issues* and the contradictory nature of increased demand versus fixed supply and needs-led versus budget-determined services. They argue that the core issue of scarce resources still remains to thwart the reforms. Demographic trends, the promotion of client rights and the increasing responsiveness of services have all combined to push demand up. However, in an overall context of retrenchment the market cannot respond by increasing supply and so when resources are used up rationing is introduced. In addition it is purchasers who decide which services will be met, not users of service, but the rhetoric of choice and consultation disguises the core issue of recource insufficiency.

Third, they identify *organisational issues* and the problem of change versus capacity, 'industrialised' versus responsive organisations and defensiveness versus learning within organisations. The contradictions apparent on the organisational side of the changes, argue Hadley and Clough, are to do with the requirement for local authorities to make substantial changes to what they do within the context of restricted budgets which do not allow them the capacity to establish an infrastructure to faciliatate that change. In addition they argue that the type of organisation and product which fits the market model is not the same as one which can respond flexibly and deliver the type of service which the rhetoric promises. There are some important aspects of high quality service which cannot be specified precisely or which at best can only be guestimates. They also argue, and this is one of the central themes of their work, that the entrepreneurial culture restricts the willingness of people to speak up about deficits in the system, because of the insecurities it generates.

Finally, Hadley and Clough distinguish *service issues*, treatment versus prevention and better services versus poorer working conditions. The reforms encourage the targeting of priority needs which leaves the future of preventative services in the balance and encourages a 'fire-fighting' mentality rather than a more holistic approach to health and social care needs. It leaves in a particularly vulnerable position services for people with substantial but chronic needs: the British Red Cross Home from Hospital scheme discussed later in this work is a prime example of this. Another important service issue is the expectation of and demand for better services in an environment which devalues the work which is involved both ideologically and economically. A related and crucially important point

is that these trends are likely to impact differentially upon certain sections of the community and in the case of both informal and formal caring, women are likely to be the hardest hit.

Taylor Gooby and Lawson (1993) looked at changes in the delivery of services across a range of sectors. They identify a number of themes inherent in the new paradigm in welfare: managerialism, consumerism, opposition to professional power, suspicion of large bureaucracy, enthusiasm for markets, and a determination to improve cost efficiency. They argue that the particular issues which emerge from the operationalisation of these themes are *first* in terms of the emphasis on cost efficiency - the valorisation of economy to the detriment of quality - which they argue means that a cheaper option is likely to attract public support before a quality option. In the light of the findings of Knapp and colleagues (1997) that cheaper service options are associated with poorer client outcomes, this is a matter of concern.

Secondly, Taylor-Gooby and Lawson argue that in practice the notion of responding to consumer need by offering more choice is problematic because the transaction costs of competing in a market often act as an entry barrier for smaller providers which in theory could narrow plurality, and that in practice information asymmetries exist which prevent 'consumers' from making informed choices. For example, what do performance indicators really measure - quality of care or dimensions of service? A classic example is the performance of schools. Is performance in test results a good enough indicator of the quality of the school or does it just tell you that those particular students were inherently good? *Third*, and closely related to the first

point about valorising economy, the authors argue that the innovative potential of local authorities will now be channelled into the field of economy which will prevent the direct expression of this trait in service provision. *Finally* they express concern that the most costly services and individuals will be residualised in a service which stresses economy.

The chapter now turns to the activities and roles of voluntary organisations in community care for people with learning disabilities and mental health problems.

3.4 WHAT DOES THE VOLUNTARY SECTOR LOOK LIKE IN COMMUNITY CARE TODAY?

In 1983 the Personal Social Services Research Unit at the University of Kent at Canterbury was commissioned by the then Department of Health and Social Security, to promote, monitor, and evaluate the Care in the Community demonstration programme. £15 million (£25 million at todays prices) had been allocated by central governemnt to "pump-prime" a programme of pilot projects which would help long stay hospital residents to resettle in the community. I was part of the research team working with the programme and took particular interest in and responsibility for research on the voluntary sector. What follows is an analysis of the roles adopted by the sector in the programme. This part of the thesis draws on but also extends work conducted by the author and published with colleagues (Knapp et al, 1992).

The 1981 Care in the Community consultative document referred to the value of a multiplicity of provision, and the 1983 Circular

explicitly encouraged a mixed economy (DHSS, 1981, 1983).

> If the fullest benefits of transferring patients from hospital to community care are to be realised, voluntary resources will have to be engaged at all levels, both when arrangements are being made for transfers and in the long-term provision of supporting services
>
> (DHSS 1983, para. 14).

The linked imperative of good liaison was also recognised. The demonstration programme encouraged not only joint working between health and social services authorities, but also between the statutory and non-statutory sectors. The pilot programme was in some ways a mid-1980s 'experiment' in the mixed economy of care. Project plans anticipated a dominant or prominent role for voluntary organisations in five cases, but elsewhere their expected involvement was only vaguely specified: "the project will make full use of the voluntary sector' and 'housing associations will be used' were typical objectives.

3.4.1 What activities did the voluntary sector perform in the projects?

Voluntary sector contributions to the programme were diverse. Table 3.2 documents the range of activities performed by all projects where there was voluntary sector involvement. Among the voluntary organisations heavily involved in strategic planning, management and/or provision were Mind in Waltham Forest, Mencap in Warwickshire, the Parkview Society in Torbay, Making Space in Warrington and Age Concern in Camberwell. Private (for-profit) sector care provision was limited to placements in residential homes, almost exclusively in the Maidstone and Kidderminster projects, although

privately rented accommodation and home care placements were more widely used.

Projects which specifically set out to mix the economy of welfare hoped to challenge the preconceptions of statutory agencies, by demonstrating that multi-disciplinary forums could work (Waltham Forest), or that housing associations could usefully link with public authorities to develop ordinary housing (Liverpool), or that cost-effective and efficient management was not the preserve of the public sector (Warwick and Warrington).

To what extent could we argue that there was partnership with the statutory sector within the programme? The extent to which the voluntary sector was integrated into project planning, service organisation and operational management in each of the 28 projects gave us some indication. In some areas the sector was in no position to make a contribution, and in some others its potential to supplement or substitute was overlooked. For example, despite the emphasis placed on consultation with the voluntary sector, the first priority for most statutory agencies contemplating applying for pilot project funding under the programme was to submit plans to meet the short application deadline, and this usually meant delaying formal consultation with the voluntary sector until after funds had been secured.

A common criticism of the pilot programme from the voluntary sector was therefore the lack of consultation at this planning stage. Although strong inter-sectoral links were often established at a later stage,

Table 3.2

Involvement of the Voluntary Sector in the Care in the Community Pilot Programme - a simplified representation as at mid-1988

	Managed	Staffed	Represented on		Housing	Advocacy service	Day Care provision	Employment Opportunities	Leisure activities	Volunteers	Transport	Other services
			Planning Body	Management gp.								
BOLTON			Through CHC representative		25% in housing association accommodation			Services of Mencap Pathway employment officer	Volunteers helping with normal use of community activities	Volunteers		
BRENT			Housing Associations, Black Mental Health Project	Yes	Provided by Carr Gomm, Mental Health After-Care Ass'n and others						Brent Community Transport	Second hand furniture store and workshop facilities
BUCKS			Yes		Guidepost Trust bedsit development		Social/ recreation day/ placement opportunities		Friendship circles / TocH			
CALDERDALE			Yes	Yes					Clubs and centres	Volunteers bureau finding befrienders		
CAMBERWELL	Age Concern											
CAMBS			Yes							Befrienders		

Table 3.2 continued

	Managed	Staffed	Represented on		Housing	Advocacy service	Day Care provision	Employment Opportunities	Leisure activities	Volunteers	Transport	Other services
			Planning Body	Management gp.								
CAMDEN	Managed by CSMH	Linc / CSMH	Yes	Yes	Some provided with housing and support service of CSMH	Yes						
CHICHESTER				Local management committee	Housing developed by Stonham HA		Link (Mind club) volunteers in activity centre			Trying to mobilise friends of activity centre		
COVENTRY									Befrienders	Escorts SSD voluntary organiser	Tuck	shop trolley
DARLINGTON				Re-roof	5% of housing provoded by HAs		Lunch club		Outings, Xmas shopping, church activities	Paid volunteers, MSC task force, decorating, etc	Escorts	Laundry service, specific servicers for individuals meals on wheals
DERBY			Mencap Homes Foundation HA	Mencap	Over 50% provided by HA and Mencap Homes Foundation					Volunteers help in clubs and befriend clients	Volunteers escort people to pubs	

Table 3.2 continued

	Managed	Staffed	Represented on		Housing	Advocacy service	Day Care provision	Employment Opportunities	Leisure activities	Volunteers	Transport	Other services
			Planning Body	Management gp.								
GLOSSOP					Managed by N. counties HA				1 client pursuing hobby with vol. group		Provided by volunteer bureau	
GREENWICH				Mind National Schizophrenia Fellowship	Maintained by Hyde, and London & Quadrant HAs		Mind day centre available			Mind befriending scheme available		
HILLINGDON												
ISLINGTON							The Peter Bedford Trust		Use of Local fecilities, including the church	Propose to recruit volunteers	Will be using Bridge-in and Link	
KIDDERMINSTER					Partnership arrangements with Mencap, Mind.	Hereford & Worcester Citizen Advocacy Scheme	Mencap, Where Next					
LIVERPOOL	Managed by Mencap	Staffed by Mencap	Yes	Yes	Liverpool Housing Trust							
MAIDSTONE					Managed by HA	Self-Advocacy group		To be developed		Volunteers		
SOMERSET			Yes	Yes	Mencap	Advocacy group, belongs to People First	Through church, FE, work experience		Single volunteers, use of FE courses	Volunteers	Yeovil CS, local small buses. volunteers	

Table 3.2 continued

	Managed	Staffed	Represented on		Housing	Advocacy service	Day Care provision	Employment Opportunities	Leisure activities	Volunteers	Transport	Other services
			Planning Body	Management gp.								
ST HELENS										Volunteers		
TORBAY	Managed and staff employed by Parview Society				Devon & Cornwall HA				Gateway club,theatre workshop	Yes		
WALTH'M FOREST	Managed and staffed by Waltham Forest Mind - a company limited by guarantee				E.London HA: Mind managed		Mind facility and care	Limited	Mind facility	Proposed to recruit volunteers	Volunteers as required	Generic services as requred
WARRINGTON	Managed and staffed by Warrington Community Care - a consortium				Grosvenor HA		Yes		Yes			
WARWICK	Mencap	Mencap	Yes	Yes	Core & Cluster - managed by Mencap		Mencap	Pathway Scheme	Normal use of community facilities		Volunteer driver	
W. BERKSHIRE			Yes	Yes	1 client in Guidepost Trust Hotel		Maidenhead Association for Mental Health					
WEST CUMBRIA						Yes, 1 resident			Tea dances and other local facilities	Relatives		Fundraising
W.LANCASHIRE			Yes, Richmond Fellowship	Yes, NW Fellowship, advocacy by families	Richmond Fellowship Hostel		Skelmersdale day centre			Befriending in co-operation with W. Lancs Vol. Bureau	W.Lancs Volunteer Bureau	Decorating WLVB & Task Force. Relatives/carers support group
WINCHESTER		Hants HA manages staff	Hampshire HA	Hampshire HA	Andover Scheme: Hants Vol. HA		Exercise and craft sessions		Brownies, Red Cross, Library & outings		Volunteer drivers, relatives and friends	Meals on Wheels

Source: Knapp et al (1992) pp246-249

success was almost a lottery, dependent mainly on the voluntary sector's access to information, its energies, its contacts and therefore inevitably its key perspectives. An important lesson to emerge from the programme was the inadequacy of the then existing joint planning machinery for the task of constructing workable and agreed plans, involving district health authorities, family health services authorities, housing departments, housing associations, other voluntary organisations, consumer groups and private sector suppliers, as the projects discovered. This was still an area of concern some years later when the Ritchie Report highlighted the serious problems of lack of information sharing between agencies as being a central and enduring factor in the events which led up to Christopher Clunis fatally wounding Jonathon Zito.

Collaboration and partnership between the statutory and voluntary sectors within the programme often led to the latter sharing responsibility for service management, although Table 3.2 shows that six projects with voluntary sector inputs had no representation at the planning or management levels. The implications of this were various and impacted on organisations in different ways. The invisibility of essential elements of projects is interesting in itself and often meant that decisions were taken at steering group level which may have benefitted from voluntary sector input. In other cases voluntary organisations were more than happy not to be involved in time-consuming meetings and preferred to restrict their input to the activities in which they specialised. A recent example of this has emerged as an central issue in work currently in progress with the Red Cross "Home from Hospital Scheme" (Thomason and Mitchell, 1997).

In this case the voluntary organisation resisted strongly the local social services department's wish that they alter the work they normally did to monitor clients on their behalf. The funding for the project currently allows them to resist this and their desire for independence means that it suits them not to be part of the formal planning machinery.

Client advocacy and consumerism made great strides during the 1980s and a few projects developed links with voluntary-led advocacy schemes which paralleled the establishment of national organisations such as Advocacy Alliance, People First and Survivors Speak Out. However, the increasing importance attached to organised citizen- and self-advocacy outside case management did not develop until midway through the demonstration programme, and hence the number of projects drawing on the voluntary sector in this way does not really reflect the importance that this role has subsequently assumed as social services departments have sought to implement the consultation and consumerism recommendations of the 1990 Act.

While common use was made of volunteers across the programme as a whole, in four projects this was the *only* input from the voluntary sector. Volunteers were mainly used as befrienders, helping with leisure activities or escorting, a function which was of crucial importance to some projects where staff shortages threatened quality of life enhancers such as trips out. Direct care or support from volunteers was generally felt to be inappropriate, and difficult to manage.

The most common form of involvement was housing or residential

provision: eighteen projects worked with housing associations, ten under management agreements, and twelve projects worked exclusively with the voluntary sector for residential provision. The Maidstone project established its own housing association in response to a local need for flexible housing resources. In some situations it was clearly considered necessary not just to stimulate the mixed economy but to create it. This was also the case in the hospital closure programme documented in Appendix B.

The specialised role of housing associations was pivotal to the demonstration programme. In an environment where there was a scarcity of suitable public sector housing the Housing Corporation outlined its role thus:

> "The Corporation will continue to provide capital finance for schemes for elderly, mentally ill and mentally handicapped people, which may include people returning to the community ... Health authorities may fund up to 100 per cent of the capital cost of a housing scheme. They can fund housing associations directly, and under these circumstances, the Corporation will have no involvement.... In principle, schemes under the Care in the Community Initiative may be funded using a mixture of Corporation and health authority finance."
>
> (Housing Corporation, 1984, para. 3.1).

Housing association involvement in the programme included all such arrangements. It also illustrated the potential financial and managerial complexities which can result and which certainly require clarification through joint working and community care planning procedures. Voluntary housing input was actively sought by projects, not simply because it offered additional financing, but because it

improved the chances of securing flexible needs-led services which were almost immediately available. In fact, 18 projects worked jointly with housing associations, in some cases relying on them as sole providers (including the hostel in Warrington, the supported flats in Glossop, the core and cluster houses in Chichester, the staffed group homes in Liverpool, and the residential accommodation in Torbay). Eight projects illustrated the complexities of the arrangements put in place. Included in this analysis is a project ranking of achievement in relation to 12 commonly - specified objectives for community care (see Table 3.3 below).

It is interesting to note the central importance of a small set of objectives to these projects, namely securing appropriate housing, moving targetted clients, adhering to principles and philosophies of care and developing both successful joint working and a team to operationalise the projects. Whilst these concerns to some extent reflected the practical difficulties which projects faced in making a reality of their objectives, it is interesting to note that although projects were designed around a core set of policy priorities - such as consumerism, dehospitalisation, cost-effectiveness and service pluralism - the project perspective on 'success' does not necessarily coincide with the 'official' line. For example, the cost- effectiveness imperative is not prioritised by any of the projects mentioned above or indeed by any of the full sample of projects, although two projects, both services for elderly people, ranked this objective third.

The *Cambridge* project was designed to provide support for three adolescents with multiple disabilities who moved from Ida Darwin Hospital. A house was rented from Cambridge City Council housing

department by Cambridgeshire County Council social services department, and managed by King Street Housing Association. The social services department managed the staff. Capital funding of £10,000 from the demonstration programme covered the set-up costs of furniture and special equipment. When asked to rank the broad achievements of the project, adherence to principles and philosophies, successfully moving targetted clients, adequate housing provision and changing attitudes in the wider community were all prioritised.

The project for people with mental health problems in *Chichester* worked in partnership with Stonham Housing Association to develop community-based housing in Bognor Regis. Although not clearly specified at the outset, by 1986 management responsibility for the accommodation was firmly written into the project design:

> "The core and cluster houses will be managed by Stonham Housing Association.... In order to manage the houses on a day-to-day basis a local management committee will be established which will become a local branch of Stonham Housing Association.'

It was envisaged that committee members would be drawn both from senior staff at Graylingwell Hospital and lay members of the community. The health authority was responsible for purchase, with capital and upgrading costs met from project funds. This was a cooperative venture, with Stonham Housing Association owning and managing the houses and employing a 'housekeeper', and peripatetic rehabilitation nursing input provided by the health authority. In terms of the project's own evaluation of achievements, successfully moving targeted clients, adequate housing provision, appropriate day

care provision, and successful development of staff team were prioritised.

Table 3.3

Ranking of broad project achievements by project.

Project	Areas of achievement[1, 2]											
	A	B	C	D	E	F	G	H	I	J	K	L
Calderdale	3	8	4	5	7	9	2	6	1	12	11	10
Camden	2	5	3	8	4	10	9	1	6	12	11	7
Derby	3	10	7	12	6	11	1	5	4	8	9	2
Islington	1	10	7	4	6	12	9	2	8	11	5	3
Kidderminster	2	10	1	6	7	12	3	8	5	9	11	4
Liverpool	4	10	8	1	7	6	3	2	12	11	9	5
Maidstone	5	6	8	3	2	9	4	1	10	12	11	7
Somerset	4	2	7	8	3	10	6	1	9	12	11	5
Torbay	8	7	11	6	10	11	2	3	1	5	4	9
Warwick	3	6	5	4	10	11	9	2	1	12	8	7
Cambridge	3	5	11	5	7	9	8	1	2	12	10	4
Glossop	4	6	5	7	3	11	12	2	1	10	8	9
Brent	3	5	4	5	7	10	9	2	1	11	8	12
Bucks	3	2	6	7	8	4	5	9	10	12	1	11
Chichester	2	6	3	4	7	9	10	8	1	12	4	11
Greenwich	2	8	10	5	11	12	3	3	1	7	6	9
Waltham Forest	1	7	5	1	4	9	9	8	1	11	6	12
Warrington	2	5	8	3	7	12	6	11	1	9	4	10
West Lancs	1	1	1	1	1	1	1	1	1	12	11	10
Coventry	5	6	6	6	6	6	4	2	1	6	3	6
Darlington	11	12	9	10	8	7	1	6	5	3	2	4
Winchester	1	6	4	2	2	3	5	1	2	3	1	8
Hillingdon	12	8	11	2	4	7	6	5	1	10	3	9
St Helens	5	10	19	5	1	9	5	1	1	12	4	8
West Cumbria	12	9	8	4	1	6	2	3	11	5	10	7

[1] The letters represent the following

- A: Adequate housing provision
- B: Development of suitable rehabilitation facilities
- C: Provision of appropriate day support services
- D: Successful operational development of staff team
- E: Application of appropriate assessments/reviews
- F: Mainstreaming of project with other services
- G: Demonstrating innovative service models
- H: Adherence to principles and philosophies
- I: Successfully moving target clients into community
- J: Providing more cost effective services than hospitals
- K: Achieving successful joint working
- L: Changing attitudes in the wider community

[2] The ranks are: 1 = most important: 12 = least important.

The *Glossop* scheme was developed in April 1985 after discussions with a physically disabled man living in Withington Hospital. By May 1987 three people had moved to community accommodation (four self-contained purpose-built flats, one for staff) designed by the Northern Counties Housing Association in conjunction with the local housing department, who owned the land and property. The housing association took over management responsibility, with ongoing maintenance costs met from social security allowances, and worked closely with residents to tailor accommodation to their needs. The Glossop team prioritised successfully moving targeted clients, adhering to principles and philosophies, applying appropriate assessments, and adequate housing provision.

The accommodation in *Liverpool* comprised three ordinary houses, each occupied by four people with learning difficulties who had moved from Olive Mount Hospital. Care and support was available 24 hours a day. Two of the houses opened in August 1984 and the third in May 1985, having been purchased by Liverpool Housing Trust using Housing Corporation loan facilities. The Trust converted the houses with maintenance met from rent and service charges from the DSS and housing benefits to individual residents. The project aimed to show that housing associations could usefully work in conjunction with statutory agencies to provide ordinary housing for people with a learning difficulty. There was no major capital outlay from central funds (apart from £6,000 for furniture). The project was a collaborative effort involving a housing association (Liverpool Housing Trust), a voluntary body (Liverpool Mencap), Liverpool Health Authority and Liverpool social services department. Mencap and Liverpool Housing Trust assumed leadership of the project in April

1987, when central funding finished. Formally, the project was managed by a joint general management group incorporating representatives from the four agencies, although each organisation remained responsible for employing its own staff. In reviewing their achievements the Liverpool team emphasised development of the staff team, adherence to philosophies and principles, demonstrating innovative service models and adequate housing provision.

Part of the *Warwickshire* project used a similar approach: Mencap running a hostel in Rugby which was built as a new facility alongside an existing hostel, and other local Mencap groups developing and managing units across the county, using capital allocated from central funds. The Nuneaton hostel was purchased from central funds with the Coventry Churches Housing Association responsible for administration, adaptation and renovation. The Warwickshire team stressed successfully moving targeted clients, adherence to philosophies and principles, adequate housing provision and team development as indicators of their achievement.

The *Torbay* project, funded from April 1984 to March 1987, was designed to provide flexible, family-type living within a caring environment where residents with learning difficulties could develop according to their individual abilities. A ten-place residential home was opened in Newton Abbot in June 1985, managed by the Parkview Society. (The Society already managed a successful group home for mentally ill people.) The property was purchased for £110,000, 90 per cent of which came from the demonstration programme grant. A top-up grant of £25,000 from the health authority financed the necessary renovation. Revenue costs were met from residents' social security

benefits. Achievements stressed by the Torbay project were successfully moving targeted clients, demonstrating innovative service models, adherence to principles and philosophies and achieving successful joint working.

The staffed hostel in *Warrington,* which was converted from a nurses' home, offered 24-hour cover for 16 people from Winwick Psychiatric Hospital. Ownership was transferred to the Grosvenor Housing Association and management to Warrington Community Care, a consortium and company limited by guarantee. The hostel opened in November 1985. Central funding provided the initial capital with revenue from residents' board and lodging allowances. The *Registered Homes Act* 1984 had a marked effect on the development and management of the scheme; after discussions between Warrington Community Care and the registration officer, changes were made, including the installation of a warden call system. Conditions of registration included flame-retardant furniture and dietary record sheets. The pilot project became a catalyst for subsequent service developments funded by the health authority and managed by Grosvenor Housing Association. The Warrington project stressed successfully moving targeted clients, adequate housing provision, team development and achieving successful joint working as their key achievements.

Places in the two specialised sheltered housing schemes used by the *Winchester* project were provided by Winchester City Council and the Hampshire Voluntary Housing Society in Andover. Both housing units originally allocated five places to clients. The Andover element was separately managed by a multi-agency steering group convened by the

Housing Society. While the scheme as a whole was designed to extend norms of provision and test the viability of supporting very dependent elderly people (with dependency levels normally associated with long-stay geriatric admission wards), it also provided opportunities to test new cooperative management arrangements. This project had difficulty prioritising its achievements but ranked three objectives in joint first place: adherence to principles and philosophies, adequate housing provision, and successful joint working; team development, application of appropriate reviews, and successfully moving targeted clients were ranked joint second.

Housing management arrangements varied from - those projects tightly steered by a small group in a housing association - to those based on committees of users, professional workers and individuals from different agencies (councillors and community representatives, as well as from the housing association itself).

Local experience and successful ventures obviously influenced plans: for example, the impetus for the Torbay project came from the Parkview Society's success with a hostel for people with mental health problems, and the Stonham Housing Association's specialised experience in working jointly with public service agencies contributed significantly to the Chichester project. There are clear advantages in building community services on local experience. Some housing associations are particularly geared to providing special needs housing, and are perhaps skilled at obtaining the necessary capital financing. As one interviewee remarked:

"To make special needs housing work you need to be an

> expert in your field. It is a political area and you must be hard-nosed about it. You have to be in the driving seat. Care in the community used to be flavour of the month and there was plenty of money around, but this is no longer the case. It is impossible to plan ahead but we have managed by 'fixing' deals with the Housing Corporation and the health authority so that both promise to contribute half the money each to schemes."

Securing funds for capital development proved problematic for many projects. Anticipated reliance on housing associations to secure capital funds from the Housing Corporation proved not always to be justified. For example, the original plan for the West Lancs project was to use vacant public housing stock in Skelmersdale. When this proved inappropriate, local housing associations were approached to apply for Housing Corporation finance. But this funding was restricted to localities with 'stressed area' status and the Ormskirk area was ineligible. With additional and diverted funds, the project was eventually able to finance a hostel in conjunction with the Richmond Fellowship. These difficulties can be contrasted with Chichester's experience, where a capital component in the original application for Care in the Community funding allowed housing to be purchased and ownership transferred to the Stonham Housing Association. Liverpool and Torbay also bought properties outright from central funds, with management then passing to housing associations. Some projects were fortunate (or far-sighted) in securing ad hoc housing resources, for example where a health authority donated a property eg. the Warrington hostel which was an ex nurses home.

3.4.2 What functions did the voluntary sector perform in the projects?

The previous subsection examined the activities which the sector undertook in the Care in the Community programme, but which **functions** did the sector perform?

The earlier account of how the voluntary sector has waxed and waned and adapted to the vaccilations and partialities of political and economic systems accounts, in part, for the range of organisations which populate the sector. As I mentioned earlier, Kendall and Knapp have described its many forms as a "loose and baggy monster" (Kendall and Knapp 1996:133). I also described how a number of commentators have developed typologies of voluntary activity. The sector contains an array of organisational forms and activities, and classifications have become increasingly more complex as investigation of the sector has advanced. As I argued earlier, core functions identified by a range of analysts include service provision, mutual support and campaigning and advocacy (Wolfenden 1978, Brenton 1985). To these core functions others have added resource coordination (Handy 1988, Nathan 1990). To recap, Kendall and Knapp (1996) argue that uni-dimensional classification schemes can focus attention on service provision functions at the expense of mutual aid and campaigning and advocacy roles, but more recent classifications have been two dimensional, focusing on both industry (area of provision) and societal function.

Drawing on these categories I offer the following observations about the Care in the Community Programme. As we can see from Table 3.2

the principal form of involvement in the programme by voluntary organisations was as service providers. We need to bear in mind of course that the programme was principally about reprovision of services and because of this it is more unlikely that this sample would contain a full range of voluntary sector functions. However, notwithstanding this bias, a closer examination of organisations reveals a different picture. For example, there may be a difference between a categorisation imposed from without and how an organisation sees itself. In addition the functions performed by the sector may be invisible, as suggested above. Furthermore, vital functions may not be deemed to be significant by the project even though the services of a specialist organisation or the networking abilities of another have been used to great effect. Informal use of the sector via contacts and planning forums may also be another source of unreported usage - although interviews with key actors in the programme often revealed the importance of this source of influence.

In addition, the nature of voluntary organisations is that they often perform more than one function or are linked to a host organisation which performs other functions. It may therefore be difficult to divorce one function from another; for example, in MIND service provision, individual and political advocacy are inextricably linked. When the results of the empirical work with agencies is reported later in chapters 5 and 6, this particular issue will be illustrated by the apparent difficulty agencies experience in specifying what it is they do. By far the majority of respondents in the studies which are examined cite more than one activity as their key focus.

As we can see from the earlier account of the ways in which the voluntary sector was or became involved in the programme, use was often expedient, either where there was a gap in provision, eg day care in Chichester, or where a project was constrained by inflexibility or regulations or had run out of money.

It is interesting to ponder whether the projects could have existed without voluntary sector involvement. The evidence seems to suggest that services provided by the voluntary sector were often pivotal to the success of that project. The sector often offered the flexibility and the co-ordination which are essential to good quality care. The voluntary sector was often seen to be invaluable because it was particularly strong at networking, which project managers soon realised was an essential skill when trying to co-ordinate care packages. The differing philosophies of care which formed the raison d'etre of many organisations in the sector was also a primary reason for involvement in many projects, for example, where the aim was to deliver more individualised care. Faster decision making procedures because of less bureaucracy also often got people out of sticky positions where resources were unavailable or had dried up.

As interesting as this account is, how representative is it of the voluntary sector's contemporary role? What sense can we make of this account and how can it inform our general examination of the developing roles of the sector? In some ways the experiences encountered in the demonstration programme are quite specific to the programme itself - the focus on service provision and the lack of involvement of voluntary agencies on planning bodies, for example.

However, one could also argue that the programme was an experiment in pluralism and as a consequence there are important lessons to be learned about the operation of the mixed economy of care for people with long-term care needs. Does the programme, for example, suggest roles for the sector which the Government would be likely to fund?

3.5 SO WILL THE GOVERNMENT FUND IT?

A strong theme of this chapter has been the idea that the role assigned to the voluntary sector at any one time will be a consequence of a complex interplay between a range of ideas about how society should be organised and context specific factors such as the economy, political dominance, religion and a variety of social factors. It is also, in part, what the voluntary sector chooses to be (given the constraints that impact upon it). Later in this thesis the differential progress made by organisations in the sector will be examined. In chapter 4, I examine in more detail the longevity of interest in voluntarism as a central theme in the ideas of influential scholars like Hobbes, Locke, Weber and Marx. A focus on how the voluntary sector has been conceptualised by the academy is instructive as we search for some theoretical underpinning to the institutional choices that purchasers make.

The finale to this review of roles attempts to draw together the activities which the sector undertook in the programme and the factors driving policy development. This task will enable us to make connections between, for example, the important role the sector played in the form of housing and any theoretical rationales which emerge from the literature - in this case the specialisation rationale.

It is clear that ideas about how and where we should care for people with long-term care needs have changed over time. Dominant ideas now argue for offering people care in as 'normal' a life setting as possible, bolstered by a belief that a large part of this normality means offering care in the community where most people live. The four dimensions of change introduced by the 1990 Act, as identified by Wistow et al (1996) and referred to earlier, are illustrative of this important context, and the voluntary sector is seen as the vehicle whereby some of these fundamental changes will occur.

At the beginning of this chapter I proposed a thought experiment. I argued that fundamental values in society at any one time influence the scope and nature of the voluntary sector. Back in the late 19th century notions of charity and self help were influential. In the late 20th and early 21st century a belief in needs-led rather than service-driven care for vulnerable people exists alongside priorities such as value for money, efficiency, effectiveness, choice and marketisation. Some of these values are in conflict and account, in part, for the concerns of the contemporary voluntary sector manager who was preoccupied with the impact of a market- based system on the quality of the service her organisation could offer.

As an example of innovation I have documented in some detail evidence from the government-funded pilot projects. The projects are not only illustrative of this particular reason for support but also touch on other reasons, most notably co-ordination of public agencies, flexibility, choice and access and expertise.

Although the voluntary sector in most cases was only making a contribution to care, I would argue that the nature of what it offered was distinctive. In some cases that distinctiveness was hard to quantify and seemed to be to do with the ethos or spirit of the organisation which appeared to propel change foward at a faster rate than in statutory-run schemes. This is my observation, but I will return to it later in chapter 7 when I look in detail at the spirit of voluntarism and its impact on the management of organisations, the process of delivery and the nature of provision. At other times it was far more tangible where flexible solutions to some of the intractable problems of transition from hospital to community could be clearly discerned.

Amongst the pilot projects were prime examples of how the statutory sector will sponsor voluntary groups to try new things. The schemes, although intended to be jointly planned and administered by local authorities, health services and the voluntary sector, emerged more or less dominated by certain sectors. Of the 19 projects for people with mental health problems or learning difficulties, 5 were voluntary sector run and 8 others had considerable voluntary sector input. Projects which were led by the voluntary sector on the whole appeared to have translated their plans into practice far more quickly than other projects. They tended to find ways around rules and regulations which held statutory-led projects up for months. As a frequent visitor to these projects in my role as evaluator, they gave the impression that they happened almost effortlessly, according to plan, whereas other projects seemed to be endlessly tied up with red tape, for example, union disagreement over job titles.

The provision of special needs housing was pivotal to the success of the programme and was the most frequent contribution made by the sector to the demonstration programme. The demonstration programme reflected a trend in statutory /voluntary relations which has been strengthened since the 1980s and is commonplace in the 1990s. Kendall and Knapp argue that we can partly understand the growth of the voluntary housing movement as a reaction to "the failures and limitations of other rental sectors" (1996: 142).

The state has positively encouraged the voluntary sector to take a lead in the latter, and legislation regarding the Housing Association movement, such as the charter outlined in the 1974 Housing Act bears witness to this. Statutory support of voluntary housing associations is substantial and currently runs at 13.1% of total income. In terms of housing for these client groups living in the community it is difficult to get hold of any comprehensive figures which record what is available and who it is provided by. A study commissioned by the Department of the Environment, which reported in 1983, surveyed authorities in England and Wales to identify existing housing schemes. Out of a total of 1048 schemes, 56% were run by housing departments, 28% by housing associations and 6% by voluntary organisations. The study concluded that there was a particular need for a greater supply of housing for these groups, particularly from housing associations. It also recommended that greater resources should be devoted to support services such as day care, education and employment. The importance of an adequately funded, comprehensive, co-ordinated service to the successful implementation of community care, cannot be stressed enough.

It was in exactly this area that many Care in the Community pilot projects took advantage of the flexibility of the voluntary sector. If we accept the National Association of Health Authorities' interpretation of Care in the Community as providing a 'comprehensive, coherent, co-ordinated and continuous service allowing people to live as normal a life as possible' (1986:22), we realise the importance of round-the-clock care and a range of day care and employment interventions. This level of care, although available in hospital, is difficult to replicate in a comprehensive and co-ordinated way in the community. Many people need support in the evenings and at weekends. Some pilot projects found that public services were not flexible enough to provide the comprehensive support that clients needed and so projects drew on the help and assistance of the voluntary sector to provide a range of essential services; such as housing, domiciliary and day care services, social clubs, and educational classes.

As I have argued, the move towards care in a community rather than a hospital setting is not new but implementation has been problematic. In the early days, despite joint finance arrangements, there was confusion and argument about where NHS responsibility ended and local authority responsibility began. This does not seem to have been resolved in the developing mixed economy of care even though clarifying roles was a central aim of the 1990 legislation (Thomason and Mitchell, 1997). The ability to cut through inter-agency squabbles where authorities are having trouble agreeing on who should provide what, can often break the stalemate. For example, in terms of special needs housing the voluntary sector has often taken the lead in providing homes for minority groups or those with special requirements, or those with needs where there may not be political

consensus to give assistance. The growing role of housing associations for minority groups is a case in point.

A key strength of the voluntary sector is the political muscle it has provided on behalf of clients. The political lobbying of groups such as MIND, MENCAP, the National Schizophrenia Fellowship and Age Concern has been particularly influential. They have raised the profile of clients and given consumers a voice. Government departments also depend on the sector for expert advice and for 'intelligence' about the size and nature of the client group they are representing. It would be difficult for the statutory sector to replicate this function, as strategically the information would be problematic to collect.

A service run by the voluntary sector may be favoured by clients who place a premium on the 'credentials' of a provider. In some cases expertise and mutuality are of prime importance eg. the case of mental illness where clients have experienced statutory care, often medically-driven, which has not addressed their needs. For some illnesses, sufferers would argue that the support needed can only be offered by another person with experience of the same problem. It is suggested that the mutuality of the problem often leads to a very different model of provision; for example, the differing attitudes and solutions to schizophrenia formerly propounded by the National Schizophrenia Fellowship and MIND, although they may not be so distinctive today.

The sector is a vehicle for welfare entrepreneurship either directly by staff moving into the sector or (by proxy) by statutory staff forming strong links with the sector in order to utilise its innovative potential

where they wanted to develop services in a new direction. Part of the Care in the Community demonstration programme involved bi-annual conferences where project representatives came together to share experiences and learn from one another. It was during the interchanges at these conferences that the extent to which some projects were spearheading service developments in their localities became apparent. The different standpoints encompassed in the term voluntary sector was also manifested eg the two mental health projects which differed the most in terms of structure and philosophy were both voluntary-sector managed.

An interesting characteristic of voluntary-led care is the extent to which services will engage in risk-taking. Examples of this are controversial decisions about clients' lives, often to do with the extent to which vulnerable people should be self-determining - allowing people who are vulnerable to take their own decisions - even perhaps to become parents. These two examples contradict the conventional wisdom of preventing someone who is deemed to be 'ill' from taking action by hospitalising them. In a similar vein, in placing the client at the centre of care some projects have acted in the interests of clients against the wishes of relatives. Issues such as these may prove problematic as the boundaries between the sectors shift and accountability/regulatory mechanisms are operationalised. The demonstration programme encompassed such examples where a statutory sector curtailed the activities of lead voluntary agencies where clients were deemed to be a danger to themselves or to the public at large.

For example, a project for mental health clients which adhered

passionately to the principle of normal living for its clients was called to account by representatives of the health and local authorities because of concerns about the clients' vulnerability (repeated pregnancies of one of the clients and reports of disruptive behaviour including destruction of property). The argument that it is normal to want a child and that it should be any woman's right to do this and that if someone damages property they should be dealt with in the normal way were viewed differently by services which saw some of these freedoms as negligence instead of risk-taking. These are very interesting dilemmas and are at the heart of the debate about values issues which arises when we examine how the sectors interface with one another (see Paton, 1996; and Thomason and Mitchell, 1997).

Risk-taking behaviour is often associated with the 'welfare entrepreneurs' mentioned above. It is interesting to consider to what extent the ability of voluntary agencies to operationalise projects faster and to take risks are linked to the presence of these entrepreneurial characters.

The 1990 NHS and Community Care reforms offer voluntary organisations the opportunity to prove what they can do, to expand, and to enter new forms of service delivery where the consumer can have more control. On the one hand they offer the opportunity for voluntary organisations to be treated as equal rather than marginal in provision and resource allocation. On the other hand, the new relationship with the state sector is unclear: the terrain between the public and private sectors has changed, and the variations in the voluntary sector which are emerging in the shape of management and employee buy-outs, trusts and not-for-profit organisations, are

unknown quantities.

The likely impact of growth on voluntary organisations themselves in terms of their mission, services, staff, and of course clients are also unknown quantities (Mocroft and Thomason, 1993). Concerns focus around three areas: the effects on the organisation, the impact of new regulatory practices and the implications of contractual funding. In relation to the first their small size, lack of expertise, and lack of experience in legal and financial areas leaves many organisations ill-equipped to compete in a commercial setting. This makes it particularly difficult for marginalised services such as those for ethnic groups to compete for a share of the cake. One possible solution is the consortia approach or 'piggy backing' where a large organisation can offer a back-up service to a small organisation so that they can be funded.

In relation to regulation and accountability, there can be a number of undesired side effects which threaten the independence of the sector and the nature of the service and as a result inflate costs, to which I return in later chapters. Diversifying may bring increased bureaucratization and professionalisation of staff which prevents the sector from responding flexibly to the needs of users. Growth may therefore limit the flexibility of the sector. Thirdly, contractual funding and financial scrutiny may have pernicious effects: the ear-marking of funds for certain activities will only discourage more unusual types of development and reduce diversity. This may lead to monopoly in service specification and so conformity may actually limit client choice. The expectations of other organisations may divert voluntary organisations from their original objectives. Workers may

decide that the new direction is not what they entered the organisation to support.

These are just some of the consequences of enhanced funding which may affect the voluntary sector and impact on its ability to do what it is currently doing or might do in the future. The experiences of the organisations which provided data for this thesis will help us to make sense of some of these claims and I will return to them in later Chapters.

These concerns reflect the tensions alluded to earlier between the various factors which drive policy eg. quality versus reduced burden on the state, normal living versus value for money. In the next chapter I look to theory to help understand the roots of disagreement about the grounds upon which the reforms are predicated. It is here that we see the longevity of interest in the role of the state, the individual and voluntary association and the different explanations which have emerged to account for the existence of the voluntary sector. I will also demonstrate how these different conceptualisations of the sector are played out in current analyses of its role.

CHAPTER 4

THE RATIONALES

4.1 INTRODUCTION

The previous chapter illustrated the diverse and important roles played by the voluntary sector in the organisation and delivery of community care services, using the Care in the Community pilot projects as a case study. It also documented the complexities of the backdrop against which decisions are taken to fund non-statutory services and articulated the expectations of recent policy regarding the independent sectors.

It is clear that views about the respective roles of the sectors have changed and that there is broad-based support from all sides of the political spectrum for a greater mixing of the service economy. But why is this the case? Can the voluntary sector deliver what is expected of it? What is different about the organisation, funding and delivery of community care which make former concerns about the voluntary sector as major service provider no longer as cogent?

Chapter 3 also examined the context in which re-discovery of the sector had occurred, emphasising the broad range of social and economic attributes which exist under its aegis, allowing politicians to champion those parts or aspects of the sector which seem to support

their interpretation of the welfare state in crisis or their solutions to it. These different agenda represent a key tension between arguments about better quality services versus reduced burden on the state.

The conflicting perspectives which underpin support for the sector reflect underlying motives which are important because they prioritise different outcomes. This tension is addressed by Kramer (1990) in his follow up study of voluntary welfare agencies in Italy, the Netherlands and the UK, when he notes that the real reason for the observed growth in the funding of the voluntary sector was the desire to shrink government, whereas the good reason was the ideology of voluntarism.

The discussion in the previous chapter also indicated that at the time of data collection the reforms in the funding and provision of health and welfare services encapsulated in the NHSCC Act (1990) were beginning to impact on the sector. In policy terms there was disagreement among commentators about the grounds on which the reforms were predicated and the impact the reforms would have on users, providers and purchasers.

Hadley and Clough (1996), for example, suggest that the belief that the reforms would work 'owed more to ideology than reason' (p 17). They argue, in contrast to other policy commentators who have referred to the evolutionary nature of social policy change (Hall et al, 1975), that the 1990 Act changes were revolutionary precisely because of their magnitude and the fact that they are untested.

As I discussed in Chapter 1, a central aim of this thesis is to clarify

some of these contested debates and evaluate the impact on voluntary organisations. Numerous and pressing policy questions are raised by the conjunction of the two central themes of this thesis - dehospitalisation and mixing the economy of health and social care. Answers to these are questions which could seriously affect the outcome of policy intent. Is the sector willing and able to fulfill its newly ascribed roles and what effect will this have on the structure and character of the sector? How well equipped is the statutory sector to make informed judgements about what the voluntary sector can or might do well and in which circumstances? How will the statutory sector regulate the voluntary sector and what effects will increased accountability have on the sector itself and the nature of services it provides? Will funds be available to stimulate the sector and how successful will the new modus operandi be in respect of achieving the principal aims of the reforms: needs-related services, choice, and service diversity ?

The voluntary sector is assumed, for example, to be inherently cost-effective in comparison to its statutory sector counterparts, and the benefits of competition are expected to include cost-reduction, quality improvement, and the enhancement of choice. However, there is little or no evidence to support these assumptions and even less evidence or discussion of the likely effects of the "new mixed economy of care" introduced by the 1990 Act on statutory and non-statutory providers, or on service users. To begin to evaluate the rationales for public sector funding of the voluntary sector, it is helpful to review how scholars have conceptualised the sector.

4.2 THEORIES TO EXPLAIN THE EXISTENCE OF THE VOLUNTARY SECTOR

4.2.1 The work of traditional theorists

Academic interest in voluntary action is not a new enterprise. Classical theorists trying to make sense of society and the 'human condition' have had an erstwhile interest in why and how people associate together. In David Coates' contribution to Anderson and Ricci's edited volume Society and Social Science (1990:239-290) he suggests, when analysing the rise of traditions of thought, that by the mid 1700s the earlier Hobbesian notion of the 'individual' driven by totally selfish and self-regarding motives was less apparent in liberal philosophy and the idea of 'altruism' as a basic individual characteristic was central to the work of influential writers such as John Locke (1642-1704), David Hume (1711-1776) and Adam Smith (1723-1790).

Van Til (1988: Chapter 4) reviews theoretical perspectives on voluntary action and society. He points to the centrality of voluntary action in a number of dominant perspectives in social science, in particular the work of influential social theorists such as de Tocqueville, Durkheim, Weber, Marx, Michels and more recently Parsons. He identifies five key concerns in voluntary action research which he argues still pose challenges for contemporary researchers and traces the ideas to the classical theorists.

First, in respect of de Tocqueville and Durkheim, he identifies their concern over maintaining consensus and reveals that they saw the solution to be intermediate associations to counteract the tyranny of

unbridled individualism and a despotic state (p.59). Contemporary theorists are still prioritising this important role. If we transport this idea and compare it to the work of contemporary writers we see that Marshall (1996:59) argues that the 'voluntary sector provides the adhesive which holds them (states) together and the solvent which allows them to change.' Taylor (1993) suggests that the diversity embraced by the sector is both a strength and a weakness - allowing the sector to adapt and survive and yet also being all things to all people. Harris and Billis (1996: 244) argue that this often leaves them responding to the agendas of others, and in so doing 'they can become the instruments through which other sectors achieve *their* goals....'

Second, Van Til points to Weber's and Michels' interests, both focused on the structure of organisations in society rather than broader society itself. At the heart of Michel's work lay a question about the internal workings of voluntary organisations - *is oligarchy inevitable?* Specifying the conditions under which oligarchy emerges and the extent to which Michel's proposition is applicable to the voluntary sector remains an important issue for applied behavioural scientists. Recent work on leadership style includes writers such as the prolific Charles Handy (1988), Hosking and Morley (1988 and 1993) and Kay (1992, 1994).

Van Til's **third** point revolves around Weber's concern with the increasing bureaucratisation of organisations. Van Til articulates the 'Weber problem' by posing the question: Can the perils of bureaucarcy be avoided by the voluntary sector? Many contemporary theorists are interested in this exact area. Van Til (p62) cites Kramer (1985:388) who suggests that goal deflection will result from the twin pressures

of entrepreneurialism and vendorism as governmental income declines. He also cites Kirsten Gronbjerg (1982) who has focused on the increasing similarity between voluntary organisations and their statutory counterparts. In addition Taylor (1996:22) has focussed on the myriad influences on the sector and looked at the resistance which organisations offer by retaining 'a strong value tradition which can help them to resist incorporation by other forces.'

Fourthly, Van Til argues that from a Marxist perspective the intermediate space between labour and capital was not deserving of analysis. He argues that it is now urgent that a marxist theory of voluntarism is developed to explain the inter-relations between the three sectors. An important question, he argues, *is how does voluntarism restrain critical thought and decisive action?* He uses Dreier (1980) as an example of a marxist optimistic about the role of voluntary organisations in facilitating change. He is optimistic about the positive participatory aspects of worker-based organisations which he argues constitute 'socialist incubators' which can further the socialist struggle.

Finally, Van Til points to the work of Parsons, the influential twentieth century consensus theorist, who adopted a macro perspective to the study of society and sought to explain society by isolating the functions it performed and the institutions which undertook these functions. At the centre of his analysis lay the inter-relatedness of institutions in society, and although classic functionalism has been overtaken in contemporary thought, many theorists still view the concept of inter-relation as important in understanding the relationship between the state, the economy and

association. Gronbjerg's (1987) work suggests that inter-institutional relationships are increasing and that the sectoral boundaries are more blurred, core institutions being increasingly difficult to discern.

Employing and building upon the work of Van Til my intention has been to stress the longevity of many of the ideas which are still crucial to our understanding of the sector and the inter-disciplinary nature of the concepts which offer explanatory power. The enduring nature of central ideas is one thing, but a coherent and distinct body of knowledge which we can argue forms a theory of voluntary action is another and it is to this that I now turn.

4.2.2 More recent developments

Although scholars from a range of disciplines have subjected voluntary action to analysis for many years what we have not seen until recently is a coherent research community working methodically towards the development of a theory of voluntary action. Since the mid 1970s, diverse theoretical and empirical research bases have been developed. This diversity embraces not only different theoretical perspectives, but also contributions from different countries. Many of the better known academic breakthroughs of the 1970s and 1980s were made in the US but in the last ten years a palpable development in the portfolio has been the cross national/comparative dimension. This development has undoubtedly been facilitated by the trend towards mixing the economy and rolling back the state in many countries. This development has spawned international research forums and journals such as the Association for Research on Nonprofit Organisations and Voluntary Action (ARNOVA.) the

International Society for Third sector Research (ISTR); the Journal of Voluntary Action Research and more recently VOLUNTAS.

Another significant development is the wider acknowledgement of and growing policy attention to the complex interdependencies between the public and the independent sectors in all industrialised countries. This is leading to a more measured analysis of the strengths and weaknesses of both sectors. Anheier and Seibel affirm this trend when they argue that "research on the voluntary sector has overcome many of the normative statements which characterised .....discussions by highlighting a number of inherent deficiencies of voluntary organisations which contribute to a more realistic view of organisational behaviour "(1990:379).

The advantage of articulating these deficiences of organisations in the sector is that they allow us to pose relevant questions about the implications of a changed role for the statutory and voluntary sectors and of the private, for-profit sector, with the aim of clarifying what the benefits and disbenefits of such a move are in reality. It is to the work of this group of scholars that I now turn for a broad overview of theoretical frameworks.

Anheier and Seibel (1990) brought together a volume of papers presented in 1987 at a European conference on the non-profit sector and the modern welfare state. This and subsequent conferences have led to the emergence of a body of theory on voluntary action with contributions from a range of disciplines. What follows is a sketch of this terrain followed by a more detailed analysis of the justifications for funding which can be drawn from this body of theory.

Economic theorists have made a major contribution to our understanding of voluntary action. Weisbrod (1975, 1977) conceptualised the voluntary sector as a response to market or governmental failure in the delivery of quasi-public goods. For him the government is seen either as not providing enough of certain quasi-public goods, or not offering the right quality of output, thereby creating a demand for services produced by non-profit agencies. Individuals have an incentive to join together to produce more or different outputs, and free-riding and high transaction costs make it more likely that voluntary rather than private (for-profit) firms will be established.

Douglas (1980, 1983) developed Weisbrod's demand model from a political science perspective and suggested that governments are subject to a series of constraints which limit their ability to provide certain tasks and as a consequence voluntary organisations may then be funded to undertake these tasks on behalf of statutory agencies.

Supply-side theories offer hypotheses about the characteristics of voluntary organisations, their founders and their supporters (James, 1987; James and Rose-Ackerman, 1986). Estelle James (1987) treats unsatisfied demand (the Weisbrod thesis) as a necessary but not sufficient condition to explain variations in the development of the sector. She isolates a second necessary condition as the presence of social entrepreneurs. She argues that such people are most likely to emerge under specific circumstances and she cites religious, cultural, linguistic, and ethnic heterogeneity as societal characteristics which are likely to increase the occurrence of social entrepreneurs. This

body of knowledge is also called heterogeneity theory.

Hansmann (1980) explains voluntary action as a response to contract rather than market failure. Failure arises as a result of information asymmetries where consumers/purchasers lack the information to make informed choices. This may occur where consumption is divorced from purchase in time or space, for example purchase of insurance or gifts to the third world. Another example is where a service is complex or a consumer is unable to make a judgement about what is best for him/her, for example in the case of mental instability where reasoning may be impaired. Hansmann argues that the fact that voluntary organisations do not distribute profits to any "owners" - the non-distribution constraint - is a signal to the consumer or donor about the motives and behaviour of the voluntary sector and as a result the sector will be viewed as more trustworthy than the private (for-profit) sector.

This group of theories is called contract failure or trust theory. The contract failure perspective of Hansmann (1980, 1987) and the transaction cost perspective of Krashinsky (1986) supplement and to some extent link these demand and supply theories. They describe the circumstances under which a government agency, having already decided to subsidise but not produce a service, chooses to support voluntary rather than private sector agencies. They may also offer a selective subsidy to the voluntary sector because of the relative difficulties it faces in raising venture capital. (See also, Ben Ner and Gui (1993), and Ben Ner and Van Hoomissen (1993) on stakeholder theory.)

Kendall and Knapp (1996:13-15), in analysing theoretical approaches to the voluntary sector, argue that four major themes can be identified in respect of sociological and political theory; two concern the sector's interface with the state and two with the structure of society itself. The first challenges an assumption made by economic theorists about the relationship between voluntary organisations and the state; that is that it is characterised by competition rather than co-operation. This theoretical approach argues that the relationship is one of mutual dependence - both parties potentially benefit from the arrangement.

However, the reasons for government support for the voluntary sector are not all positive. In contrast to economic theorists who conceptualise the existence of voluntary organisations as a response to governmental or market failure, Salamon (1987) advanced the idea of voluntary failure - that is, state intervention in the market as a response to voluntary failure in cases where the sector fails to supply a service (or enough of it) or where the service is too specialised or deemed to be deficient in some other respect. Salamon argues that one can see clear reasons for government subsidies or payments in the event of what he calls philanthropic insufficiency (not enough non-public money to survive, provided that the service is worth subsidising in the first place), philanthropic amateurism (low competence in the voluntary sector), philanthropic particularism (lack of choice) and philanthropic paternalism (government money can counterbalance wealthy philanthropists and their excessive influence).

The second theme discussed by Kendall and Knapp (1996) focuses on the relationship between the voluntary sector and the state. They point to the work of Seibel and Anheier (1990:14) by way of example. These

authors conceive of the voluntary sector as a "buffer zone between the state and society mitigating social tensions and conflicts." Seibel (1990) describes it as a 'shunting yard' for society's unsolvable social problems so that the rationale for statutory funding of the voluntary sector in this instance would not be efficiency but some desire by the government to create an impression that something is being done about intractable issues. For example, Seibel employs a functional analysis to argue that shifting insoluble problems such as poverty alleviation and re-integration of handicapped people onto voluntary organisations allows governments to partly abrogate their responsibility for issues which are politically sensitive or risky.

The other two bodies of ideas discussed by Kendall and Knapp concern work which has focused on the structure of society itself. The **third** theme in their classification is the approach which asks about the circumstances in which a society is likely to develop a strong voluntary sector. They cite Salamon and Anheier (1994) who argue that there are three factors which are conducive to the development of a strong voluntary sector: an educated urban middle class, a common as opposed to a civil law system, and a decentralised political framework. These factors combine, it is argued, to provide the social space in which a sector can develop and thrive.

The **fourth** identified approach focuses on the role of philanthropy and is consistent with marxist theorising about the role of the sector, as outlined earlier. It poses the question: *Is philanthropy a form of social control?* This line of argument derives from the underlying assumption that the voluntary sector mirrors the interests of elites in that they may be overly represented on governing bodies and paper

over the cracks preventing people from challenging the system.

There also exists a growing body of organisational literature about the sector. Billlis and Harris (1996:238-245) in their edited volume of discourses on organisational and management issues in the sector, argue that four central themes emerge from recent work which encompass a number of challenges for the sector. The first is the need to develop organisational knowlege about the sector. They suggest that in order to understand the dynamism and flexibility characteristic of the sector and how these traits fare in response to the changing environment we will need to develop a repertoire of theoretical tools which allow us to capture the "special' nature of the sector. They cite the work of Deakin (1996) who uses the established concepts of consumerism and citizenship as tools to evaluate the impact of contracts. The need to develop further intelligence on the sector is also prioritised.

The second theme discussed by Billis and Harris is the acknowledgement that the sector does have distinctive features. Inter alia, this means that theory and methods applicable to, or developed and tested for the for-profit sector do not necessarily suit voluntary sector analysis. Examples are accountability discussed by Diana Leat in her contribution to the Billis and Harris volume, governance and the range of stakeholders, the challenges of leadership (discussed by Richard Kay in his contribution) and the importance of values and value conflict (by Rob Paton in the same volume).

A third theme which they articulate is the impact of contracting and how this may transmogrify the sector. For example, there are

pressures to adopt a "commercial culture" which espouse notions of competition rather than co-operation. They cite the work of David Wilson (in this same volume) who has focused on how voluntary organisations manage change.

Finally, there is the important consideration of how the sector can resist transformation and retain its distinctive features. Billis and Harris argue that a key challenge for practitioners and researchers is the constant reconsideration of what constitutes the 'essence' or the 'authentic core' of voluntary agencies. It is this activity which will help the sector to negotiate trends which threaten its identity. They identify these trends as: threats to valued features of voluntary agencies, pressure to take on the agenda of other sectors, uncertain sectoral boundaries, and increasing diversity within the sector (p244).

Salamon and Anheier (1996) pick up on Billis and Harris' remark about the lack of 'intelligence' about the sector when they argue that until recently it has been difficult to test any of the theories of voluntary action which have emerged because of the lack of information. Writing about the Johns Hopkins Comparative Non-profit Sector Project they argue that information collected as part of this multi-country study has allowed them for the first time to "subject existing nonprofit sector theories to more serious testing and to determine..... what the preconditions for a 'vital' non-profit sector really are.' (p1). They identify six theories which have been advanced to explain the existence and nature of the sector - four developed in the field of voluntary sector research and two developed elsewhere but with "potential" explanatory power.

The task was to develop hypotheses and tests for each of the six explanations: heterogeneity theory (Weisbrod, 1977) testing the link between diversity of population and the size of the voluntary sector: supply side theory (James, 1987), testing the premise that the voluntary sector will be most highly developed where religious "competition" (for example) is most intense; trust theories (Hansmann, 1980, 1987) testing the premise that the size of the voluntary sector will vary inversely with the level of trust in the for-profit sector of society; welfare state theory (Titmuss, 1974; Offe, 1984; Mishra, 1984) testing the link between economic success and a residual role for the voluntary sector; interdependence theory (Salamon, 1987 and 1995) testing the expectation that because of partnership between the statutory and voluntary sectors high welfare spending will indicate a larger voluntary sector; and finally, social origins theory (Esping-Andersen, 1990) which aims to capture the complexity of third sector development by linking welfare spending and the size of the voluntary sector to welfare state regime.

Salamon and Anheier broadly conclude that "although theories are useful as heuristic devices they are too sweeping and one-dimensional to take account of the way in which the sector is embedded in the broader social, political and economic processes" (p.40). They cast doubt on single factor explanations and emerge in favour of Esping-Andersen social origins theory.

Partly due to the way in which social policy has developed as a discipline in this country - first as a largely descriptive body of work as the term social administration suggests, but latterly as a more analytical field of study (Titmuss, 1974) - it is only in recent years

that a coherent body of critical theory has emerged. This partly explains the paucity of material alluded to by Salamon and Anheier in their discussion of welfare state theory (1996:16).

However some interesting work is emerging from policy analysts such as Bob Holman (1993) and Hadley and Clough (1996), utilising the ideas of anthropologists such as Ruth Benedict (1973). Their work is essentially a response to the status quo, an alternative to the delivery of welfare along the lines of marketisation and scientific management. In a sense it connects with earlier discusions about how classical theorists tried to make sense of society. *Are we all just individuals trying to maximise our own good or are we social animals who define society by the relationships and interactions we have with one another?* Hence it is in our nature to be altruistic, this is what makes life meaningful to us. The concepts used in this case involve the idea of 'mutuality', in the case of Holman, as a value around which we could organise ourselves and the notion of synergystic societies (Benedict) where contributing to the common good also allows people to maximise their individual good because of the high personal satisfaction that the act of giving bestows.

4.3 WHAT ARE THE MAIN RATIONALES FOR FUNDING THE SECTOR ?

The previous section has summarised some broad theoretical explanations which not only help us to understand why voluntary organisations are formed in the first place, and why they survive in mixed capitalist economies, but can also cast light on some of the

rationales for goverment funding. I now want to identify these rationales, drawing on work that was conducted with Martin Knapp and Eileen Robertson initially for the Home Office, and which has been published in Anheier and Seibel ed (1990) and Knapp and Thomason (1987).

There is no shortage of suggestions as to the contributory role of voluntary organisations within British society. Numerous articles, books and certainly every policy document or commentary contains a listing of the advantages enjoyed by voluntary bodies. They are heralded as innovative, flexible, participative, cost-effective, exemplary and (simply) different. Sidney and Beatrice Webb (1912) rejected the 'parallel bars' view of voluntary bodies, in which they were seen as providing services alongside the state but for a different clientele, in favour of the 'extension ladder'. Voluntary bodies were superior to the government sector 'in invention and initiative, in their ability to lavish unstinted care on particular cases, and in the intensity and variety of the religious influences that they can bring to bear on personal character' (ibid., p.240). They were, the Webbs argued, better at complementing the state sector than substituting for it: 'carrying onward the work of the Public Authorities to far finer shades of physical, moral and spiritual perfection' (p.252).

Many subsequent enquiries have reinforced or restated the Webb's views of voluntary bodies. Gradually a comprehensive, not to say imaginative, compendium of attributes has developed. (See Deakin, 1991). However most such statements of these attributes are based on conjecture. It is rarely the case that one can detect either an empirical or a conceptual basis for the listings of the desirable features of

voluntary organisations vis-a-vis other agencies and sectors.

This collection of ideas about the sector and public sector support for it can be detected in the literature of a range of disciplines, as illustrated above. It is from a review of these emerging literatures (Knapp & Thomason 1987) that the list of assumptions about the strengths and weaknesses of voluntary agencies which provide the framework for this thesis have been developed. The rationales for government funding are consumer choice, specialisation, cost-effectiveness, flexibility, innovation, advocacy and participation. Each is now discussed in turn.

It should first be noted that many voluntary sector activities attract support 'because they are there' (Judge and Smith, 1983; Leat, 1985). The transaction costs of doing otherwise, such as moving all production to the public sector, may just be too great. Salamon's (1987) approach obviously stresses tradition - 'historical accident' - as an explanation for government involvement, but not a reasoned exposition for large areas of continued funding. 'Where existing institutions are already performing a function, government can frequently carry out its purposes more simply and with less cost by enlisting them in the government programme, thereby avoiding the need to create wholly new organisational structures or specialised staffs' (Salamon, 1987, p.110). Another reason for public support is the power wielded by large and long-established voluntary bodies which may perhaps be used to increase or extend public support. Traditional supply may thus offer an 'irrational' explanation for government funding. It is not itself a rationale; 'traditional' suppliers may continue to be supported by governments for other reasons -

specialisation, choice and cost-effectiveness are obvious examples - and I shall therefore not separately examine tradition as a rationale. As Ferris and Graddy (1986) argue, tradition is often just a shorthand term for the historical importance of differentiated demand in shaping the balance of provision between the sectors. It is misleading to elevate it to a position of equivalence with the rationales listed above.

4.3.1 Consumer choice.

A key aim of the 1990 Health and Community Care Reforms was to extend the range of providers in order to offer consumers more choice. A key concern for those trying to implement the reforms was to operationalise this aim in the face of a number of pressures which threatened to thwart it. In particular this was a concern for the voluntary sector whose fear was that contractual funding and financial scrutiny might have pernicious effects on what they did; that the ear-marking of funds for certain activities would only discourage more unusual types of development and reduce diversity. This might lead to monopoly in service specification and ultimately the limiting of client choice. There was also the fear that the expectations of other organisations might also divert voluntary organisations from their original objectives. Billis and Harris suggest this is a key threat which the voluntary sector needs to resist (1996:244).

The voluntary sector has the opportunity to produce slightly different services in response to slightly different consumer tastes, fashioned perhaps by religious, cultural, ethnic, political or linguistic differences. As was suggested earlier, James and others have suggested an

hypothesised link between population heterogeneity and voluntary sector provision (James, 1987). Services may be distinguished by religion (Salvation Army), culture or ethnicity (Black Mental Health Group), ideology (Socialist Health Group), industry or employment (Railcare), treatment preference (complementary therapy or National Childbirth Trust classes instead of standard NHS ante-natal training for example; or they may be attractive simply because they are not statutory services (particularly if the state is associated with compulsory treatment, such as under the Mental Health Act).

Applying this idea to the Care in the Community programme it was clear that this form of choice was particularly important to many of the clients, particularly those who had experienced mental health services. For these people an important attribute of the non-statutory sector is its ***wealth of expertise and understanding***. For some illnesses, sufferers would argue that the support needed can only be offered by another with experience of the same problem. This is equally the case for groups who are ***marginal*** to society or do not fit societal norms. Because of this many services are initiated by people with shared problems. The ***mutuality*** of a problem can often result in a very ***different model of provision*** which goes against the grain in the light of conventional wisdom. For example, this can be seen historically in the differing attitude and solutions to schizophrenia propounded by the National Schizophrenia Fellowship as opposed to the approach of MIND, although these two major national bodies are perhaps less different today than previously in ideology and approach. The *Warrington* project had at its core the needs of sufferers and their families and was therefore able to provide a service tailored to the needs of these clients rather than the

stereotypical mentally ill person.

It is also likely that centralisation will encourage voluntary provision. The smaller the unit of government, the greater the likelihood of citizens' diverse demands being met by public provision, because of the geographical concentration of religious, ethnic, cultural and other groupings which may express different demands for quasi-public goods. In fact wide differences between the levels and quantities of services provided by British local authorities, reflecting differences in citizens' preferences, help to explain the unequal distribution of voluntary organisations and services across the country.

The theoretical rationales for, or explanations of, output heterogeneity suggest two slightly different reasons for government funding. Governments can encourage pluralism via demand-side or supply-side subsidies in the belief that choice confers benefits on service users. In addition, the government may promote a specialist role for the voluntary sector when it is itself the purchaser of the good or service. I use the term "choice" to refer to situations in which citizens purchase services (perhaps heavily subsidised on the demand side by government, but nevertheless at least semi-autonomous), and specialisation to refer to purchases by public agencies, on behalf of citizens.

In respect of the health and community care reforms these two rationales were not as distinct from one another as the literature might suggest, largely because in many cases it is arguable who the purchaser is and also because in many areas there may not be a sector to stimulate. In addition it is often small organisations who offer the

most diverse services and yet these organisations may find it particularly difficult to compete in the contract culture. This is an important issue which I will revisit in due course.

If consumer choice is valued in its own right, but the market cannot be left to its own devices, governments must seek to regulate non-public providers. Even if the quasi-public nature of the service or other factors rule out private, for-profit production, government intervention may be justified. Consumers may benefit from a choice between a publicly-provided and voluntary sector service, or from the opportunity to choose from a number of suppliers within the voluntary sector. Because voluntary sector provision will not be even across the country, or not sufficient for certain groups, or because it is subject to particularly marked economies of scale, governments may subsidise it in an effort to preserve choice. Even the most vociferous supporters of pluralism have conceded a major role for government (Gladstone, 1979; Hadley and Hatch, 1980). Governments may fund consumer choice through grant-aid, tax exemptions and production subsidies on the supply side, and through consumer subsidies (vouchers and the like) on the demand side.

Often, however, government funding will be contingent upon satisfaction of certain standards and conformity with government policies. 'Coercive isomorphism', in DiMaggio and Powell's (1983) terminology, may follow from the public subsidy. Isomorphism obviously narrows the choice that is available to either public sector or individual patrons, and is therefore to be guarded against if choice is the primary rationale for fiscal support. However, many forms of subsidy are not primarily concerned with preserving choices, and may

even demand for their realisation a greater degree of similarity rather than variety. This is a matter of concern raised by Billis and Harris to which I will be returning later.

4.3.2 Specialisation

Closely allied to consumer choice is specialisation. I distinguish them here by separating purchases by citizens (for their own or an associate's consumption) and purchases by public agencies. Specialisation, the latter of these, will be supported partly by tax exemptions, but mainly via purchase of service contracting ("contracting out"). Specialised voluntary sector provision may be publicly supported not only because it satisfies differentiated demands or needs, but also because it is seen to be more cost-effective. Responsibility for many services rests with local authorities which are often too small to provide an economical service to meet unusual or rare needs. It is more cost-effective for these authorities to contract out. Activities with effects only in the very long term are among the specialised outputs of the voluntary sector, as are innovative provision and advocacy.

There is no shortage of examples of the specialist role of the voluntary sector. Kramer reports how 'English voluntary agencies extend the range of some rationed statutory services for constituencies that may have low visibility or low priority within the broad scope of the local authority, such as paraplegics, the deaf, alcoholics, autistic children, or persons with multiple sclerosis, muscular dystrophy, or cerebral palsy' (1981: 242-3). Hatch, in his study of voluntary agencies in three English towns, found voluntary provision of residential

accommodation for 'vagrants or those requiring short-stay accommodation in an emergency; others like alcoholics, drug addicts, ex-mental patients and ex-offenders need a supportive environment over a long period. A further category are the homeless families, including battered wives and their children.' In his three areas, 'voluntary agencies were both pioneers and sole providers' (Hatch, 1980: 102). Later he cites other supplementing activities - the Red Cross, Hospital Friends, the National Childbirth Trust - which, if they receive public money, must be competitors for funds (substitutes) though they are complements in service terms. The ability to organise and deliver services on a national basis, drawing clients from the whole country, is an obvious form of specialisation falling naturally to the voluntary sector when public sector responsibilities fall to local authorities.

Special needs housing is a very important way in which the voluntary sector has contributed to the support of people with long-term care needs. As early as 1912, the Webbs singled out two areas where provision outside the state was preferable - advice and information and special needs housing. The state has positively encouraged the voluntary sector to take a lead in the latter and legislation regarding the Housing Association movement, such as the charter outlined in 1974 Housing Act bears witness to this. The analysis of the activities undertaken by the voluntary sector in the Care in the Community demonstration programme outlined in the previous chapter illustrates the importance of the sector's specialist housing role.

As with the choice rationale, public funding has its drawbacks. When

the purchase of voluntary services is the responsibility of public authorities, the contracting arrangement may engender dependency in both agent and principal, again generating input, process or output isomorphism. I will return to this in Chapter 7.

4.3.3 Cost effectiveness.

The supply theories mentioned earlier suggest that voluntary organisations may enjoy a cost advantage (committed supporters of an organisation's ideology will offer their services or make donations to further the cause) and have a captive audience (eventually this is a differentiated demand consideration). Over time the large and well-established organisations may extract a premium from government agencies. It is also often claimed that services are produced more cost-effectively in the voluntary sector because of the style of governance, a less bureaucratic administration, a ready supply of volunteer labour, or fewer constraints from trade unions. It is also hypothesised to be easier for voluntary organisations to charge for quasi-public goods, and a cost-effectiveness advantage may arise from a variety of 'multiplier effects': public purchases subsidised from charitable donations.

These claims do not always stand up to close scrutiny. A number of empirical investigations have been undertaken. The most sensible generalisation to make about the evidence is that it is impossible to generalise about the presence or direction of any cost-effectiveness difference between the sectors (Knapp, 1988; Knapp et al.,1997). Conclusions reached for one industry or country are not transportable to other industries or countries, and often cost-effectiveness or

efficiency differences are markedly greater within sectors than between them. I will be returning to these issues in later chapters as I consider the cost effectiveness claim in detail.

When a cost-effectiveness advantage is found for the voluntary sector (or merely assumed), government funding - particularly through specific grant aid and purchase of service contracting - is likely to increase. Knapp, Baines and Fenyo (1988) found that the contracting-out of residential child care by local authorities was responsive to differences in the ratio of voluntary sector fees to public sector costs. But the very process of contracting-out, or public funding more generally, can reduce or even remove the cost-effectiveness differential. Public subsidies have been found to inflate voluntary sector costs through a number of channels. The administrative burden of 'grantsmanship' and contracting raises overhead costs. Higher wages are paid to staff, sometimes as a condition of contracting, in some cases because government subsidies erect protective barriers around agencies, increasing the influence of organised labour in the voluntary sector, and in some cases because management now has the facility to pay more to retain high quality employees. Further, because the cost-effectiveness difference encourages a substitutability relationship between the sectors, governments have an incentive to continue to contract-out until the difference disappears, other things being equal. The relative positions of the sectors may change if the balance of provision shifts, and public subsidies based on the assumption that efficiency is greater in the voluntary sector must respond flexibly to changing circumstances.

4.3.4 Flexibility

It is often suggested that voluntary organisations are more flexible than statutory organisations. As I mentioned earlier, Douglas (1983) argues that governments face a series of constraining factors, two of which - bureaucratic constraint and the size constraint - may explain why the statutory sector finds it more difficult to be responsive and flexible when faced with changes in need and demand. Flexibility offers an improved service, responding to differences and changes in need in a way that bureaucracies cannot or will not do. Flexibility, then, allows the voluntary sector to match services to the expressed wants and perceived needs of citizens; bureaucratic public agencies can only squeeze citizens into the rigidly structured services of the public sector. For these reasons, it is rationalised, public sector departments should contract with, or otherwise subsidise, the voluntary sector in order to offer an improved service, more efficiently produced and more efficiently targeted on the needs of the population. The flexibility which the voluntary sector offered mental health clients in the Care in the Community programme in terms of round-the-clock services was essential to the success of some projects (Knapp and Thomason, 1987).

It is very difficult to find evidence of the relative rigidities or inflexibilities of the two sectors. Kramer (1987: 241) argues that beliefs about the sectors are based on 'invidious organisational stereotypes whereby government is perceived as intrinsically rigid, riddled with bureaupathology, and offering mass standardised services that are dehumanising'. These beliefs, according to Brodkin and Young (1986:50), may be 'untestable empirically', but may well be

'empirically irrefutable ... that is ... not readily vulnerable to data'. The beliefs are not invalid, merely hard to validate except by recourse to the experiences of public and voluntary sector managers themselves, whose views are, of course, caught up in the beliefs they inherited in the first place. Generally, it would be perverse to maintain that voluntary agencies with unelected management committees must necessarily be more responsive to the views of users and citizens than are elected public sector policy makers.

There are two broad limitations that must be placed on the flexibility rationale for public support of the voluntary sector. First, flexibility often carries unacceptable associated characteristics, such as inconsistency and lack of accountability. Second, public funding may itself impair the flexibility of voluntary agencies, and this may occur even if the public sector chooses to ignore these associated characteristics. Leat et al (1986) found some evidence of a positive relationship between the level of grant aid and expressed feelings of a loss of independence. Furthermore, government funding, whether through purchase-of-service arrangements, grant aid or tax advantages, will have the effect of raising 'entry barriers' into the industry, deterring other voluntary organisations (with fewer production subsidies) and private (for-profit) producers (with fewer still). This protection will not encourage existing agencies to respond to changes in demand. Thus, even without added administrative burdens, public support can reduce the sector's flexibility.

At the end of the day there is limited evidence of the inherent flexibility of voluntary organisations. If they remain small or federated, if they can withstand or efficiently accommodate the public

sector's demands for accountability and conformity, if they can suitably balance responsiveness against fadishness, and if they can gather the necessary information to be responsive in the first place, then flexibility should certainly offer a supportable rationale for public funding.

4.3.5 Innovation

An obvious corollary to flexibility is innovative potential. This hypothesised attribute also follows from Douglas' (1983) categorical constraint and from the argument that an innovative organisation might develop in response to differentiated demands. If it is the case that the voluntary sector is more flexibly organised than the public, then the potential is there for greater innovative development and experimentation. The pioneering characteristic of voluntary organisations has been cited so frequently as to become legendary. But like all the best legends the truth has sometimes been colourfully embellished to make a better story.

There is, in fact, no real shortage of evidence to suggest that the voluntary sector has been innovative in the past, is still innovative today and is likely to continue to be innovative well into the future. More pertinent, however, are questions about the differences in innovative potential between public and voluntary sectors, and the willingness and ability of public sector providers to build on the experimental evidence offered by the voluntary agencies they are supporting. In fact, it could be argued that a multiplicity of agencies and energetic managers maximises the potential for innovation. Thus even if the voluntary sector was no more innovative than the public,

the continued existence of voluntary producers alongside statutory agencies would enhance innovative activity. Provided those innovations could be built upon in subsequent delivery systems, public subsidies would be worthwhile.

A number of researchers have argued that the public sector is at least as innovative as the voluntary (Beck, 1970; Rodgers, 1976; Kramer, 1981; Moore and Green, 1985; Morgan, 1984; Brenton, 1985). Of course, any such comparison must bear in mind the very different scales of enterprise to be found in the two sectors and the ticklish problem of how to measure innovative activity in the first place. Schorr went a little further, arguing that 'most significant attempts at pioneering in the social services during the 1960s ... were largely inspired and set in motion by government. Thus the decade's major examples of pioneering have marginal connections with voluntary (or proprietary) social services or owe it nothing.' (1970: 431). Schorr's point has relevance today, though it is also the case that some 'innovatory forces within the statutory sector' are more easily channelled through voluntary agencies (Brenton, 1985). The voluntary sector becomes the 'creative arm' of the public sector. Many of the innovative practices of voluntary agencies uncovered by Kramer (1981) in his four country study were initiated from within the public sector. If a public agency 'wishes to avoid being locked into long-term delivery' (Judge and Smith, 1983, p.218), arms-length innovation or experimentation may be ideal.

Unfortunately, evidence from one British study suggests that short-term government funding may incline voluntary agencies 'to pursue more traditional and reliable projects than to risk scarce resources on

new and ambitious projects' (Jackson, 1983, p.53). With long-term funding, on the other hand, the security of income may remove the necessity and impetus to innovate. Funding, that is, may encourage complacency and lassitude.

The Care in the Community programme itself of course was an innovation. An important way in which the voluntary sector contributed to the programme was to resolve stalemates over responsibility for care. Where confusion and argument existed about whose responsibility care should become, the voluntary sector often cut through inter-agency squabbles. Homes for minority groups is a key example of this (Knapp and Thomason, 1987)

4.3.6 Advocacy

Fundamental to almost all discussions of the role of the voluntary sector today is advocacy. Kramer (1981) writes of 'the quintessential function' of the sector, and that advocacy and service provision - 'case and cause' - is a good description of a large proportion of voluntary sector activity. Advocacy is particularly relevant at a personal level: giving advice to individuals, setting up self-help groups, offering counselling and befriending services and, at a public level, campaigning for and speaking on behalf of clients or communities. These are the citizen advocacy and policy advocacy roles of the voluntary sector. Groups such as MIND, MENCAP, SANE, Disability Alliance, People First, Survivors Speak Out have been able to provide political muscle for clients by raising the profile of clients and giving consumers a voice.

Citizen advocacy is offered by organisations such as Citizen's Advice Bureaux, Law Centres, Legal Advice Centres, specialist bodies such as Shelter, Disability Alliance, Unemployment Alliance, Youthaid, the Ramblers Association, the National Council for One-Parent Families, and Child Poverty Action Group. Johnson (1981: 96-105) offers an account of their activities, policies and problems in Britain. Citizen advocacy will receive public sector funding, although recent history would suggest that advocacy programmes are often the first to disappear when public budgets are cut. One reason for public support is that advocacy is often directly complementary to the work of public agencies, particularly when organisations are advocating higher quality services. A second explanation for public support is the multi-layered nature of government. Many local authorities either employ staff, or fund voluntary agencies to employ staff, whose principal task is (legally) to exploit the services offered by central government.

Policy (or public or social) advocacy is the campaigning role of voluntary bodies. The success of policy advocacy is well documented in a number of areas, 'success' being defined variously but usually with a degree of validity. Thus, for example, Mellor (1985) reports successful pressure group activities in the social services area, as did Johnson (1981, ch.4) and Kramer (1981, ch.11) before him, and Forsythe (1980) describes human rights advocacy and its effects on US foreign policy. Policy advocacy groups have been criticised for being 'far more effective in raising issues and shaping the political agenda than in developing solutions and forcing compromises' (Jenkins, 1987: 312), but then many would claim that they are in no position to do any more than this. In this activity it is obviously only an agency independent of government which can unrestrictedly criticise it. So

why might public funding be offered?

Pressure on the public sector to mend its ways will often attract public sector funding again because of multi-tiered governments and because the public sector recognises its own constraints. It is the knowledge and size constraints facing governments which lead them to offer inadequate quality services, poorly targeted on needy populations and unresponsive to the wishes of users (Douglas, 1983). With the best will in the world, no government agency can be omniscient, nor sufficiently accessible and hospitable to the enquiries or complaints of citizens. They may have few incentives to actively solicit those enquiries or complaints, and anyway they are unlikely to have much success with some rightly suspicious users. The voluntary sector can add to the government's stock of knowledge, can bring a different perspective to bear on policy issues, can represent the reluctant critic, and can campaign for change. In each of these activities independence from government is a desirable attribute. In addition, public support, direct or indirect, overt or covert, may be necessary to make a cause financially viable, 'and if some groups are wealthier, more vociferous or more politically skilful than the majority, then they may succeed in attracting more than a fair share of resources to their cause or to the client group they represent' (Johnson, 1981: 63). These are examples, to use Salamon's terminology, of philanthropic insufficiency and particularism (1987).

The greatest danger of public funding is that the policy advocacy groups cease to be independent of government. Kramer (1979, 1981) could find no evidence to suggest that governments pull the rug out from underneath embarrassing or irritating policy advocacy groups in

the voluntary sector. Nor did his study bear out the familiar concern that the administrative burdens generated by the requirements of fund-raising and accountability to government divert voluntary bodies from what they do best. Johnson (1981) and Brenton (1985) reached the opposite conclusion. This is a vital issue which will be addressed in later chapters.

4.3.7 Participation

Few accounts of the role of the voluntary sector will fail to mention the benefits of participation. Voluntary agencies, it is argued, offer opportunities for citizens to voluntarily contribute their money, time and skills to promote certain services and activities. They allow citizens a part in decision-making processes and thus, perhaps, 'democratise' and 'de-concentrate' resource allocation procedures. They improve the target efficiency and local accountability of service provision, tailoring resources to local needs and wants. Participation, then, is the promotion of volunteerism, self-help or mutual aid, democracy, efficiency and effectiveness, and communication. It counters the dirigisme of the state. As Douglas (1983) has described, governments face a host of constraints which can leave them impervious to the needs and preferences of citizens and unable to offer opportunities for reciprocation.

Participation as a local, democratic, consumerist vehicle for allocating resources and changing patterns of provision, can enhance social stability, reduce alienation, strengthen consensus and social control, generate greater equality and offer opportunities for self-realisation.

Participative organisations, which foster consumer or patron control and citizen involvement, may attract the approval and money of governments. In particular, volunteerism becomes a rationale for funding. Even though the public sector makes extensive use of volunteers (for example, see Holme and Maizels, 1978; Kramer, 1981), voluntary organisations are the primary conduits for volunteerism (Hadley et al, 1975; Wolfenden, 1978; Weisbrod, 1982; Steinberg, 1986). Volunteers can increase the total amount of a service offered; they supplement that statutory, private and voluntary sector provision which is only made possible by the employment of paid staff. Services produced in part or in total by volunteers will thus often be cheaper than their alternatives, although politicans take great pains to emphasise that volunteerism is not promoted to save money. Volunteering confers benefits on the volunteers from altruism, self-interest and sociability (Aves, 1969). There are also 'negative rationales' that can be just as powerful in explaining public sector support. Public money may be injected into the sector to expand provision or to open up volunteerism to groups presently under-represented. Again, Salamon's four dimensions of philanthropic failure are relevant to the British context.

Self-help or mutual aid groups also promote participation. Members have rights and responsibilities which help to blur the distinction between the 'helper' and the 'helped', between service provider and service consumer. This is consumerism in its purest form (Katz and Bender, 1976; Ellman, 1982; Ben-Ner, 1983, 1987). It complements statutory provision; it does not substitute for or duplicate it. Public sector funding can subsidise the administrative costs of these organisations, offer respite and complementary support, and facilitate

the purchase of expertise and advice. Public funding can therefore be justified on the grounds of cost-effectiveness (greater service outputs and enhanced community benefits from the same or smaller funding bases), empowerment and consumerism.

But, the reality of self-help is not always so rosy. Informal, mutual or neighbourhood provision can be very costly to the providers. It is not uncommon for self-help and mutual aid groups to become dominated by a small elite. Finch (1984), for example, catalogues the difficulties encountered in trying to impose the middle class concept of a pre-school play group on working class mothers in economically deprived areas. The groups were tainted with the patronage of the middle class volunteer, or dominated by a small group with expertise or professional competence in the service area of the organisation.

Mutual aid organisations may grow as a direct consequence of government funding, and will need to be increasingly alert to the onset of undemocratic procedures. Large size brings with it the need for formalised systems of governance, and many of the original participative benefits may quickly evaporate (Brenton, 1978; Rowe, 1978; Mellor, 1985). Indeed, public agencies may require a hierarchical governance structure as a condition for funding, (Russell et al., 1996, found that an "effective-looking infrastructure" was influential in persuading funders that a voluntary organisation was up to the job (p.405). Young argues that a 'participative regime ... loosens administrative control ... and makes it more difficult for the executive to translate its intents into action' (1987: 172). The very existence of public support, therefore, may immediately introduce a centrifugal force which pulls 'helper' and 'helped' apart, thus

changing, marginally or fundamentally, the nature of the organisation.

4.4 LOCATING THIS WORK.

As the preceding discussion reveals whilst it is clear what the voluntary sector might be able to do, or what roles it might be able to play, it is not clear what the voluntary sector can really do and certainly there is not much evidence on what it can do best. Also as the literature suggests, it is far from clear what happens when links between statutory and voluntary agencies are formalised (as they have been under the health and community care reforms) the reality of which requires social service departments in their enabling role to make informed decisions based on the respective advantages and disadvantages of the different sectors.

The next chapter utilises data collected in the four study areas and a range of other 'evidence' to answer the question: How do voluntary agencies view the rationales for governnent support?

CHAPTER 5

PERSPECTIVES FROM AGENCIES

5.1 INTRODUCTION

The previous chapter offered a range of theoretical explanations for supporting the voluntary sector, but what sense do people working in the sector make of these? In some cases where an agency is offering a highly specialised service - special needs housing for young people with disabilities for example - the theory/practice link is transparent but in others it may be less clear, eg. where a parallel service is deemed to be more cost-effective. What sense would our manager from a hundred years ago make of the consumer choice rationale at a time when principal concerns were about less eligibility and indiscriminate charity or our contemporary manager of the advocacy rationale when the practice context in which she is working threatens to undermine this?

What also emerged in an earlier chapter (chapter 3) was the tenuity of many of the assumptions about the abilities of the sector. The mythology which surrounds the sector is distinctly unhelpful when trying to understand why the statutory sector funds the voluntary sector to provide services. Waddington and Henwood (1996:82), in an evaluation of the British Red Cross Home from Hospital schemes, found that the reasons given for supporting the voluntary sector were based on anecdotal evidence about the sector's capabilities and

effectiveness rather than grounded in systematically collected 'evidence' of performance. Likewise the decision to stop funding the sector also seemed to be based on anecdote. As we shall see later in this chapter this was also the case in the hospital closure study where decisions to fund or not fund agencies at times was based on completely false information.

Reflecting on the process of data collection for this thesis, I realise that myth is a confounding variable when interviewing key actors and surveying related populations. This mythology impacts upon the way in which people conceptualise the sector and what it is capable of and this undoubtedly affects not only how people respond to questions about the sector but also the relationship their agency has with it. For example Russell et al (1996: 405) argue that the perception the funder holds about the agency is one of four key factors which will determine 'success' in the funding stakes. For example, collecting information from a purchaser about why s/he funds a particular service is not as simple as it may sound. As I argued in the last chapter (p4.17) it is unlikely that s/he can consider this ahistorically and to some extent, as Judge and Smith (1983) argue, an agency may be funded simply because it is there (see also Leat, 1985) or because of historical accident. A related reason may be because the transaction costs of doing anything else are too high, although this is at least based partly on a consideration of what the sector has to offer (Salamon, 1987).

Although of importance, tradition is not a sufficient explanation for funding decisions. It takes no account of the way in which organisations may have changed or the shifting priorities of funders. This latter point is crucial to a consideration of present day

motivations, particularly in the light of the factors which are driving services today. It is therefore necessary to look for present day rationales for funding and in order to do this we need to know more about what informs the decisions which people take.

A valuable addition to our theoretical understanding, therefore, would be agency perspectives on their own roles and the roles of others. This chapter aims to bring together a number of sources of evidence to provide this and examines the practical context of care in the community by the voluntary sector for people with long-term care needs. Each one of these evidence bases will contribute in different ways to our understanding of the rationales for funding the sector. Some rationales benefit from adopting a user's-eye view of services and I will be drawing on work conducted in a user evaluation of day care appended in full as appendix A. Also appended in full (appendix B) is a case study in change which examines the issues arising from the involvement of the sector in hospital closure. The study provides valuable data about the way in which agencies view one another. Chapter 6, which examines the funding of care, also adds to our practice knowledge of the way in which mechanisms for achieving service mix impacts upon the care of people with long term health and social needs.

As outlined in Chapter 2, this thesis utilises a range of data sources which reflect the work conducted by the author in and around this study. A variety of methods and different data sets have been drawn upon in this chapter (see p2.7).

In chapter 3 the factors which have shaped the way in which we care

for people with long term care needs were considered. Viewing the changing role of the sector in the care of people with long-term care needs over time made the dynamism of these influences more apparent. If we consider just one of the trends identified by Wistow et al (1994, 1996), **supply-led to needs-led care**, we can appreciate the different perspective which a voluntary organisation might have in comparison to a statutory agency. For many voluntary organisations their raison d'etre is to offer a more sensitive service for the client group they work with. As is the case in the contemporary example cited in chapter 3 - "the origin of the service is deeply rooted in a critique of the status quo" (p3.5). Over 60% of organisations in the DHA study also cite this rationale as a key descriptor of the service they provide. However the implications of the trend towards needs-led care for many agencies paradoxically is a threat to this central mission (Taylor, 1996). The move to a needs-led service can be handled in a number of ways. A service underpinned by market values will have different implications fo those working in it than one which is underpinned by mutuality and co-operation. For example, a principal issue for voluntary sector managers in the former is the erosion of trust engendered by competition and where the pressure to substitute for rather than supplement existing services (which increased service specification can imply) will also be of concern.

The activities undertaken by the voluntary sector in the Care in the Community demonstration programme suggested a number of reasons for support, most notably co-ordination of public agencies, flexibility, choice and access and expertise. I suggested that, in contrast to statutory-led projects, those involving the voluntary sector seemed to propel change forward at a faster rate often because they found

flexible solutions to intractable problems or because of highly developed networking abilities.

I also argued that although the voluntary sector was often the minor party in a collaboration the contribution was always distinctive in some way. At times it could be described as pivotal to the success of the project because it provided fundamental resources like housing, or satisfied the core aims of community care for many clients by providing flexible round the clock services or filled gaps in provision to ensure a comprehensive package of care. At other times this distinctive contribution was much harder to pin down but was linked to a certain ethos or spirit of voluntarism - the 'authentic core' of the voluntary sector as Billis and Harris (1996:244) call it.

It was evident that in many cases the credentials of the provider were important. Expertise, mutuality of experience and different ways of approaching care which ultimately lead to different models of provision were highly prized by clients and providers alike. The distinctive nature of the services offered was often reflected in the fact that the organisations involved were spear-heading developments in their localities and that the organisations were often led by welfare entrepreneurs or social entrepreneurs, in James' (1987) terminology.

5.1.1 What does this chapter do?

The chapter is essentially an empirical one which attempts to synthesise a range of views (practice, lay and user) about the previously suggested rationales for public support of the voluntary sector. For example, are practice decisions governed by notions of

trust and cost-effectiveness as the literature suggests? Furthermore, if these considerations are influential then what evidence underpins these beliefs?

Of equal interest is empirical evidence about the predicted outcomes of enhanced public funding which theory suggests. In other words in a time of flux does theory help us to predict what will happen to the respective sectors and to what extent can knowledge of theory help us to develop more sensitive policies towards the voluntary sector and the clients concerned? For example at the heart of contemporary practice and research discussions are questions of whether diversity is a hindrance or a help. Will organisations be in a good position to push their distinctiveness or will the changes swamp them?

In addition this chapter examines a number of other interesting questions. Can we predict what types of clients are more likely to be cared for by the voluntary sector? What are the significant predictors of independent care? Is there evidence to suggest that clients fare better in voluntary run schemes?

As the Care in the Community pilot programme demonstrated, the voluntary sector contributed to the care of people with long term care needs in a number of vital ways. What comparisons and distinctions can be made between the environment in which agencies were functioning at the time of the data collection and that which impacted on the pilot projects, which although it was a partial template for a market in health and social care was still essentially a grant aid culture?

And finally what reflections does the data allow us to make on what is prized about care for people with long term care needs and the contradictions which emerge as a result of differing ways of conceptualising the role of welfare and the role of the voluntary sector?

5.2 DATA SOURCES

The following section offers descriptive information about each of the data sources. Some of this information is also included in chapter 2 but is mentioned again here for ease of reference.

5.2.1 The DHA study

(i) Characteristics of areas

There were four areas for the DHA study: Warrington, Liverpool, Medway and Canterbury and Thanet. The first area, Warrington was dominated by a large "entrepreneurial" agency which had expanded rapidly, whereas the smaller organisations had remained fairly static. Any new initiatives in the field of mental health in Warrington had either been generated by the agency in question diversifying, or had been stimulated by statutory officers working directly with clients helping them to organise themselves.

Liverpool health authority covered a large connurbation characterised by a well established voluntary sector and politics which favoured the promotion of a flourishing voluntary sector.

In Medway there was an active voluntary sector but few organisations in the sector were major service providers. This was partially as a

result of the long stay hospitals being located out of district. The voluntary sector was characterised by heavy involvement of statutory sector and stimulation of the sector had been by secondment of statutory personnel. New use of the sector was confined to encouraging participation.

In Canterbury and Thanet the voluntary sector had not traditionally been encouraged as much as the private sector. The statutory sector had taken the lead in helping those leaving hospital but was heavily dependent on the service offered by the two major voluntary agencies in the area.

(ii) The characteristics of agencies

The DHA study looked at 27 organisations in depth. As Figure 5.1 shows the majority (20) had a catchment area which covered a district but 6 covered a broader area (2 international, 2 national and 2 regional). 1 served a small locality. The majority (22) were less than 10 years old (half less than 5) although two were over 70 years of age and a further two, less than 70 but over 20 years old. (see Figure 5.2)

Figure 5.1

Catchment area served

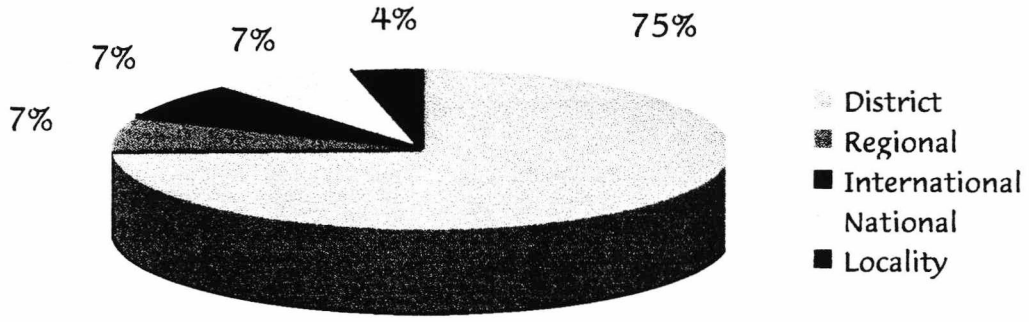
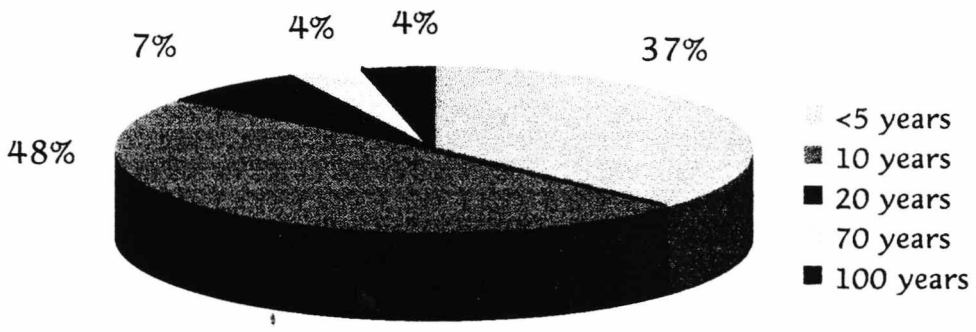


Figure 5.2

Age of organisations



Over two-thirds (67%) of agencies employed ten paid staff or less although a quarter (26%) employed in excess of 100 staff which is perhaps accounted for by the organisations in the sample who had broader constituencies (Figure 5.3).

The same pattern is reflected if income is examined with almost a third (31%) with incomes below £7,000 and another third with incomes over £100,000 (Figure 5.4).

Figure 5.3

Number of paid staff

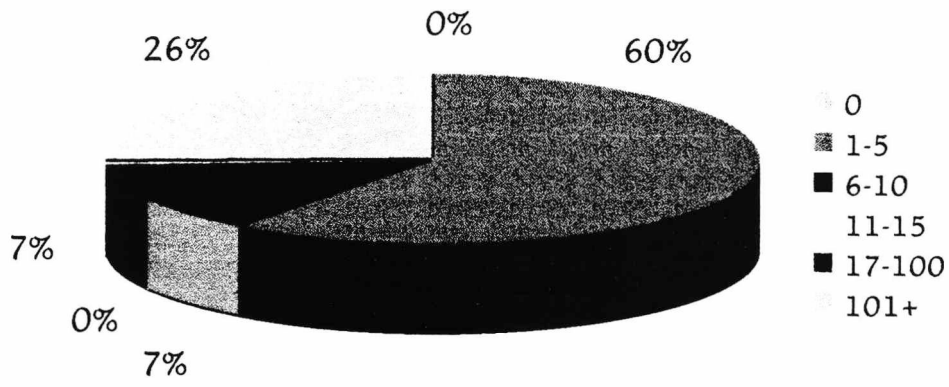
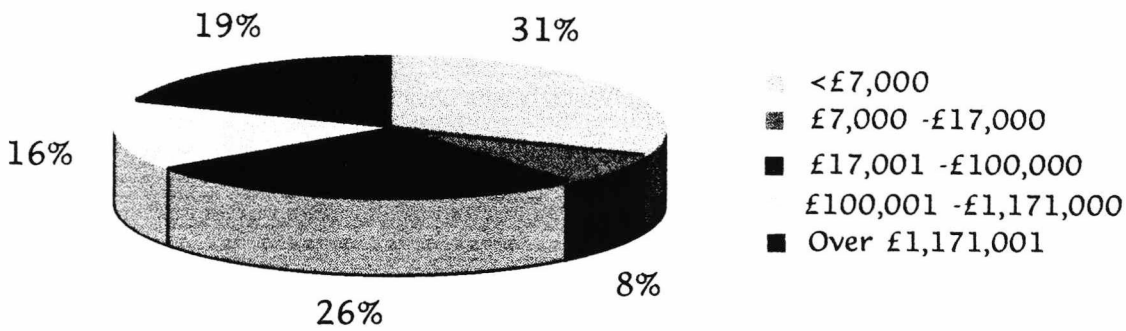


Figure 5.4

Income of agencies



Two-thirds said they provided a range of services, although as Figure 5.6 demonstrates only a third worked with more than one client group. Table 5.1 reveals in more detail the services which agencies provided. Almost half of the sample classified themselves as service providing agencies (46%) and just over one fifth (22%) as mutual aid organisations (Figure 5.5).

Table 5.1

Principal activities identified by agencies in the DHA studied.

Activity	Frequency
Social Activities	8
Support to people with LD & their families	5
Support to people with MI & their families	5
Housing	4
Spectrum of activities	4
Coordination	3
Self help	3
Pressure group/advocacy	2
Work	2

Figure 5.5

Service category

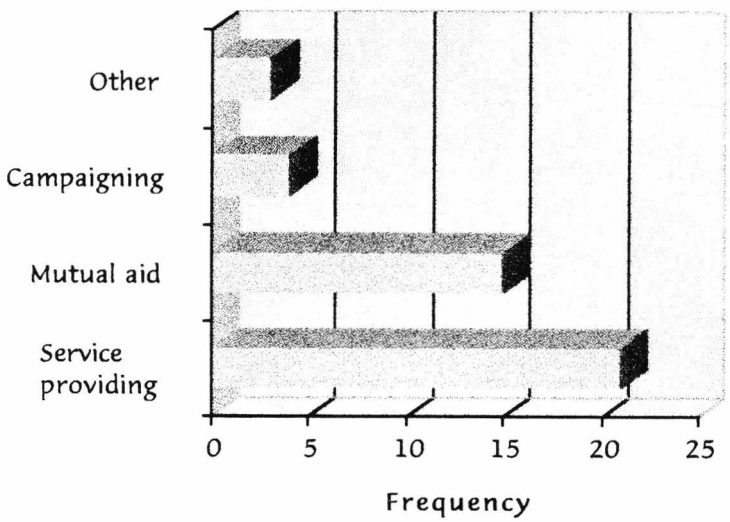
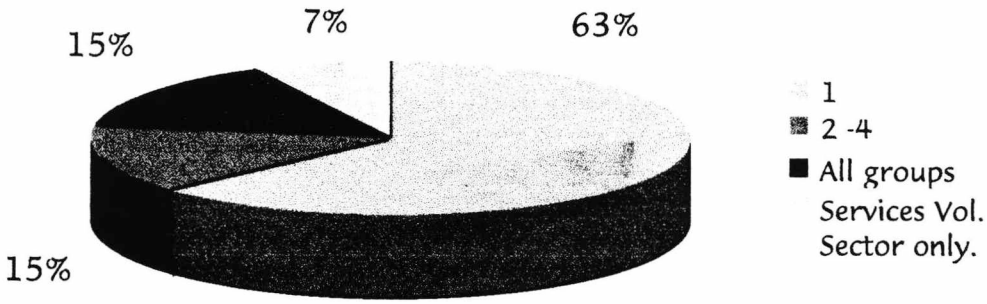


Figure 5.6

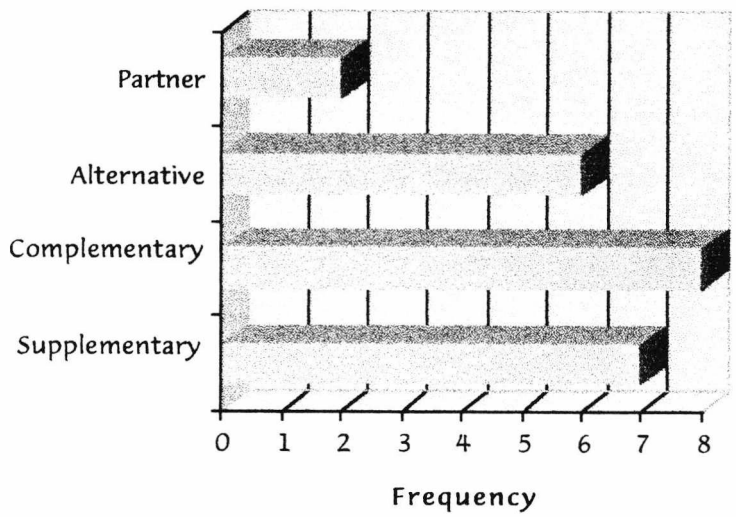
Number of client groups served



Most (80%) saw their role as complementary to statutory services (Figure 5.7) and when asked to describe the rationale for their service, descriptions which stressed the specialised and distinctive nature of services predominated (see Figure 5.8). Only half of all respondents saw themselves as offering an advocacy service or functioning as critics of the state, and surprisingly campaigning was mentioned most infrequently of all.

Figure 5.7

Relationship to statutory sector



(iii) What do organisations do?

When asked to comment on the time spent on a range of activities, support to members, fund-raising and liaison emerged as most important priorities (see Table 2). Overall it was found that research, campaigning and administration were deemed to take up less time, although 6 organisations rated administration as third in their priorities and 7 felt liaison was near the top of their list. Most people found the question difficult to answer either philosophically or practically, first because on reflection they were spending more time on activities which they did not value than they felt they should be and second because of the way the tasks were allocated in their agency eg. fundraising handled by a separate arm, or specific tasks handled by different people.

Figure 5.8
Description/rationale for service

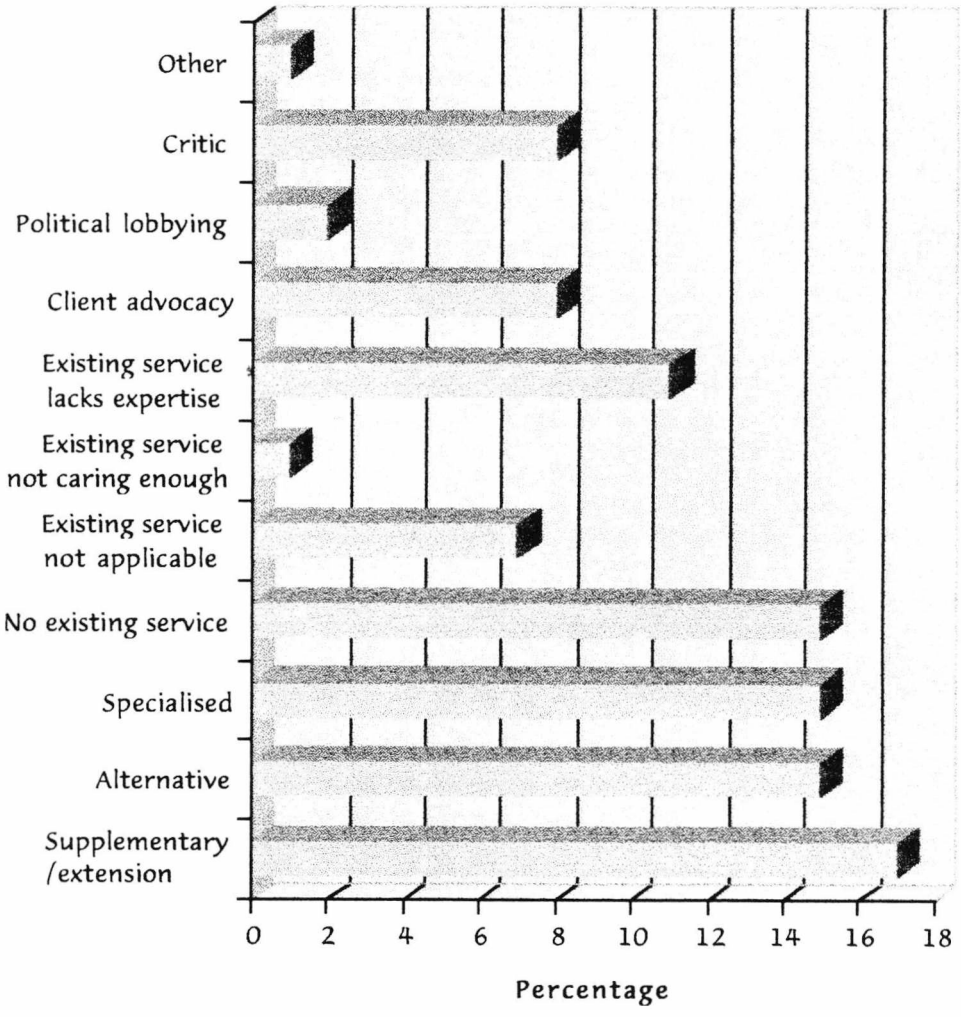


Table 5.2

Activities ranked in order of priority

Activity	Number	Average Ranking
Support to members	9	1
Fundraising	22	2.4
Liaison*	24	2.7
Research	25	2.8
Campaigning & lobbying	30	3.3
Administration**	43	4.8

* In 7 cases, liaison was placed 2nd.

** In 6 cases, administration was placed 3rd.

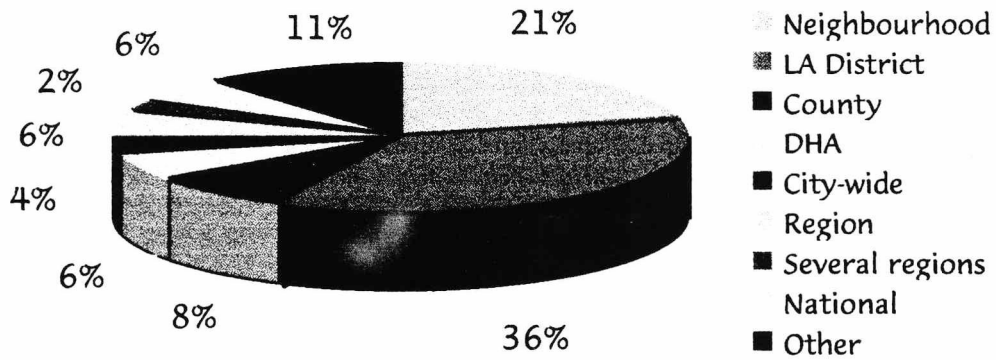
Rankings from 1-7, where 1 is most important, 7 is least important.
NB. Some have separate appeals departments e.g. LPSS and Barnados

5.2.2 The locality studies.

Data was drawn from locality studies in Camden and Canterbury and Thanet. Both studies were part of work being conducted by the PSSRU on a twelve country comparative study of the scale and nature of the voluntary sector. The study consisted of a postal survey of voluntary organisations in 1992, thought to be providing or supporting provision of personal social services. Information was received for 41 and 44 organisations respectively with response rates of 16 and 27% . Data from both sites has been combined for the purposes of this evaluation although it is worth noting that there were marked differences between the main features of the sector in London and Kent. Figures 5.9-5.17 offer descriptive information about the sample.

Figure 5.9

Catchment area

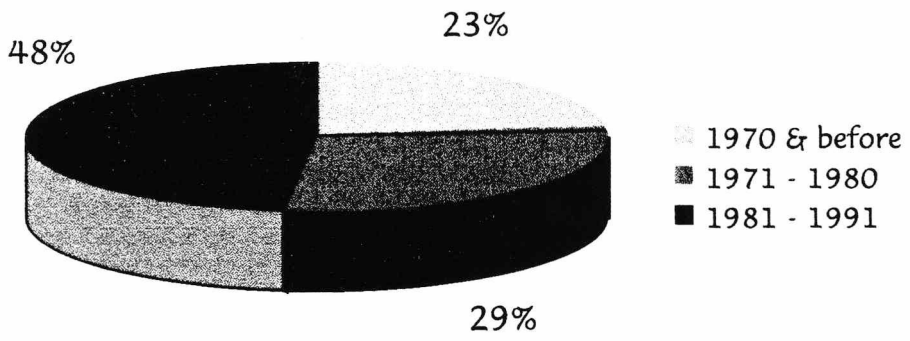


Two-thirds of organisations were operating in a catchment area no larger than the county boundary and a fifth were operating on a neighbourhood basis. 3 regional organisations, 3 national organisations, 6 in the "other" which were mainly those serving an international audience (see Figure 5.9).

Four organisations described themselves as umbrella organisations and five as HQ/parent organisations. Thirteen were affiliated to umbrella organisations and there were two branch agencies of parent organisations these four categories were probably mutually exclusive. The general impression is therefore of a number of local organisations, loosely affiliated to umbrella organisations, and a smaller number of larger organisations, which are either umbrella bodies themselves, or other organisations with a national catchment area.

Figure 5.10

Age of organisations



Almost half of the agencies in the sample (47%) were 11 years old or under, 29% were between 12 and 21 year old and 23% of organisations were 22 years of age or older (see Figure 5.10). Over three-quarters of agencies employed under 10 paid staff. The composition of the workforces differed between the two localities. The mean number of staff per agency in Camden was 13. Half of the sample employed volunteers, on average 16 per organisation. Canterbury and Thanet employed more part-time (1.9) than full-time staff (1.6) and fewer paid staff (mean 3) as a proportion of volunteer staff (mean 12). (See Figure 5.11).

Figure 5.11

Number of Staff

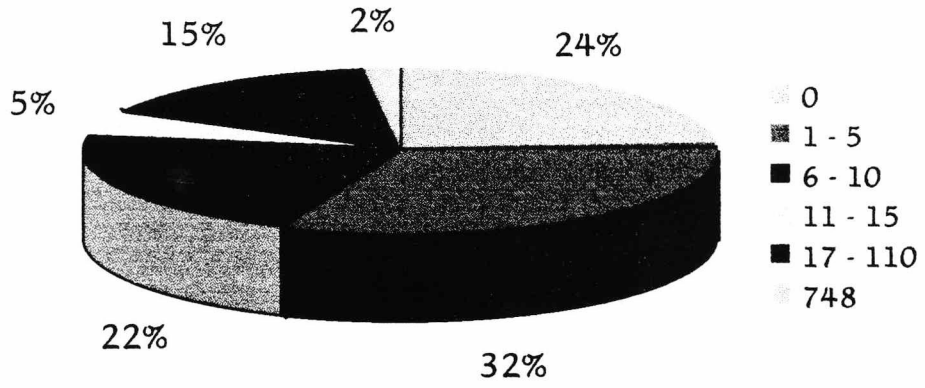
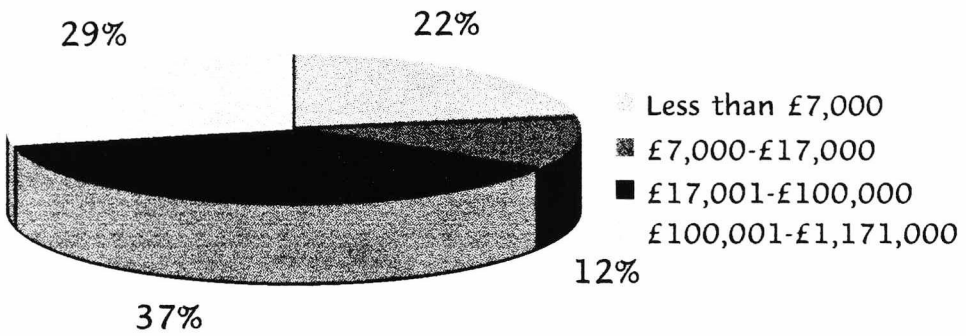


Figure 5.12

Income



Agencies in Camden had a mean total income of £265,000 in 1990 (six times that observed in Canterbury and Thanet). The median income was £123,900 with half the sample having an income higher than this (Figure 5.12). The median figure for Canterbury and Thanet was £7,940. An explanation for this could be that there is more generous public sector funding in Camden and more HQ

organisations because of the metropolitan location.

When organisations were asked to describe their main activity they identified a large number of diverse and related activities as listed below (Box 5.3 and Figure 5.13). The Canterbury and Thanet sample identified a total of 36 activities and respondents from Camden 27. Considering the sample is relatively small this is a vivid indication of the variety of roles played by the sector. The spectrum of activities also reveals the extent to which some fall outside the traditional social service categories of residential services, domiciliary services, and day care. Which in some measure provides support for the distictive role of the sector.

Box 5.3

Activities cited by Voluntary Welfare Associations in Canterbury & Thanet and in Camden.

provision of information	enabling/training	volunteer recruitment
counselling/therapy	community support centre	'sitting'
mutual support/self help	social day centre	meals
advocacy/liaison	craft activities	transport
support	sports activities	housing/ accommodation
advice	rehabilitation	development agency
listening	relief	provision of resources
campaigning/ promotion of need	child day care	training professionals
alcohol recovery	health promotion	service coordination
local forum	loans/grants	improved facilities
welfare	organise meetings	creation of work openings

Figure 5.13

Main activities identified by voluntary welfare agencies in Canterbury/Thanet and Camden.

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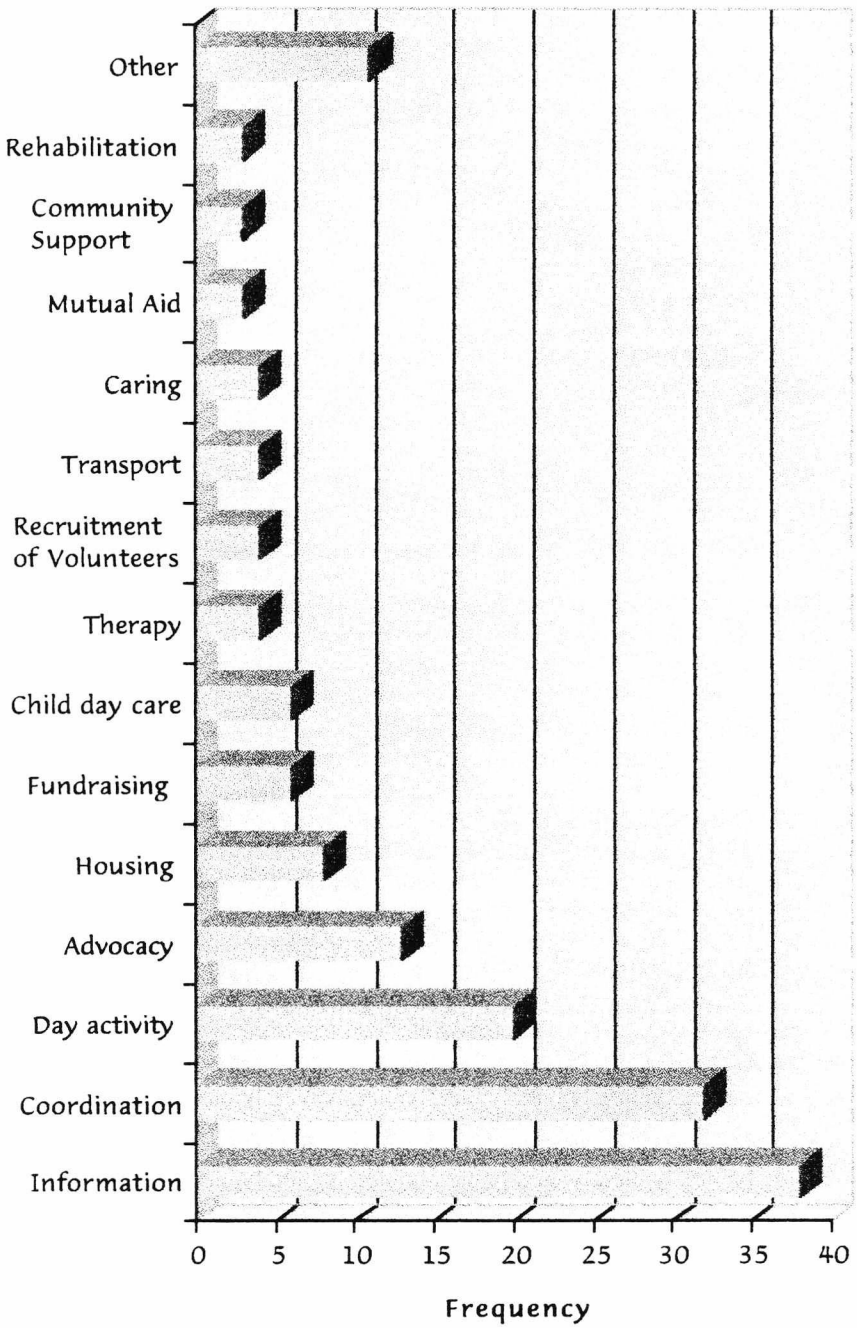


Table 5.4
Description/rationale for service identified by voluntary welfare organisations in Canterbury & Thanet and in Camden working in mental health and learning disabilities.

	LD	MH	LD +MH	Other	Total	%serving LD/MH/ LD&MH
Mutual aid	8	7	12	18	45	60
Comm. dev.	5	4	10	11	30	63
User advocacy	5	6	14	10	35	71
Grant-making trust	-	-	-	2	2	0
Service provider	5	10	13	16	44	64
Coordination	1	2	1	6	10	40
Pressure group	3	7	2	9	21	57
Research	-	3	4	6	13	54
Political action	1	2	-	2	5	60
Information	7	10	12	29	58	50
Public awareness	7	10	13	19	49	61
Other	1	2	1	5	9	44
N =	14	17	23			

Figure 5.14

Service areas cited by organisations sampled.

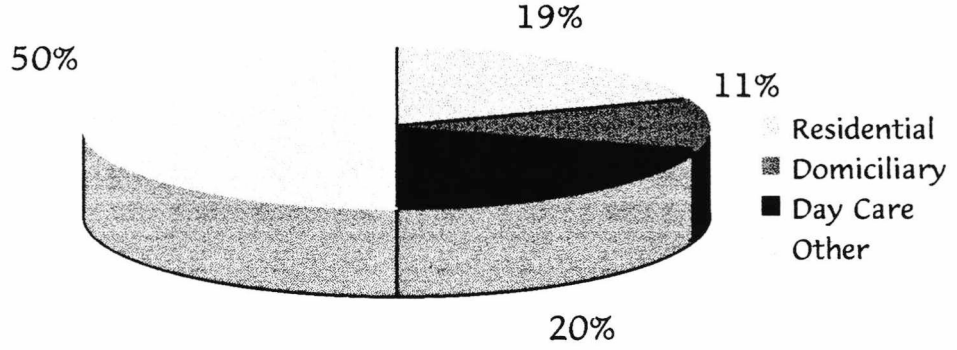


Figure 5.15

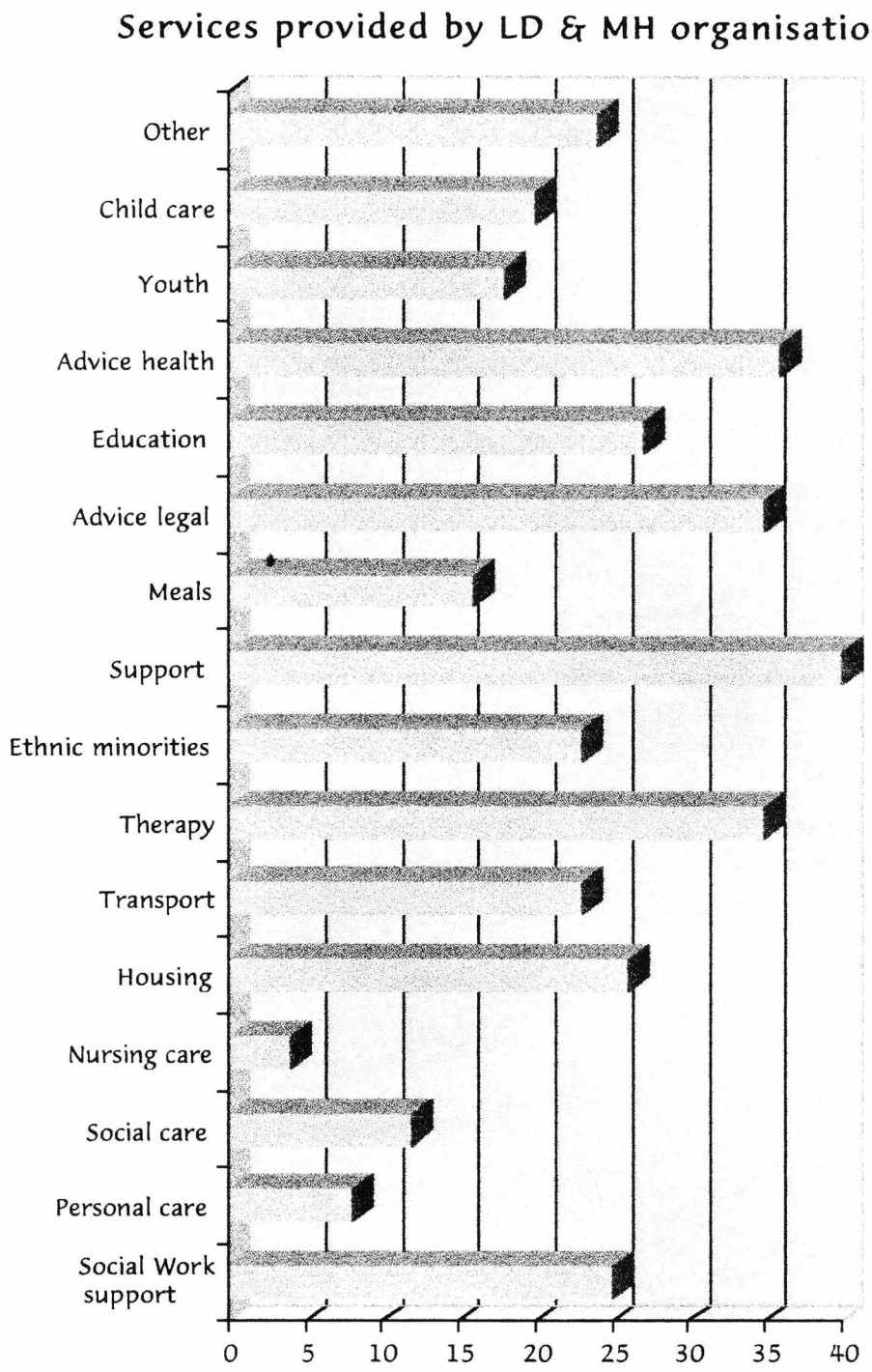


Table 5.4 reports the description of service cited by organisations in the locality studies. Although some service provision scores highly other roles are also prioritised such as mutual aid, providing information, user

advocacy and increasing public awareness. Figure 5.14 illustrates that half the sample are providing services other than residential, domiciliary and day care. Figure 5.15 further defines the types of services which organisations serving the two client groups specifically provide. Support for clients was the most commonly cited but advice services, particularly in the areas of health and the law as well as therapy, are also featured.

The organisations in the locality studies served a range of client groups as Figure 5.16 illustrates. Figure 5.17 reports the extent to which those reporting 'other' client group coverage also serve the two client groups in which this thesis is particulary interested.

Figure 5.16

Client group coverage of voluntary welfare organisations in Canterbury & Thanet and in Camden

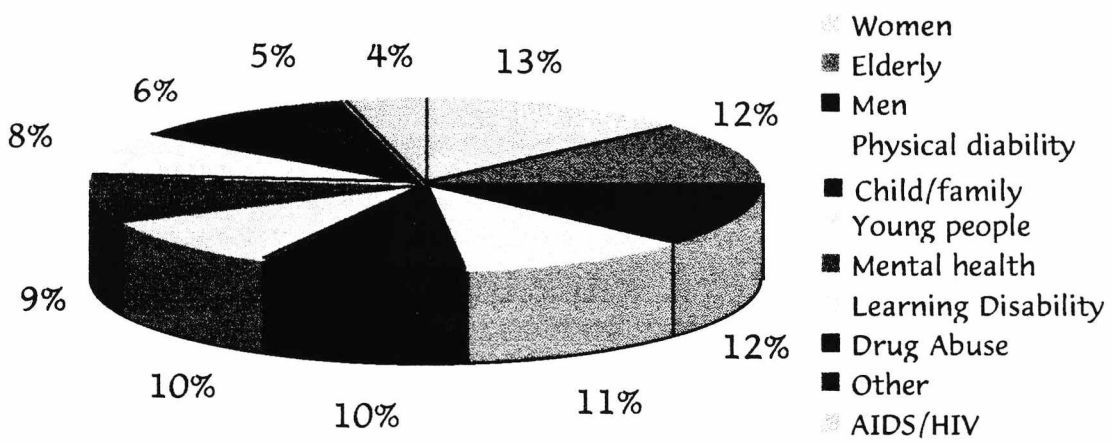
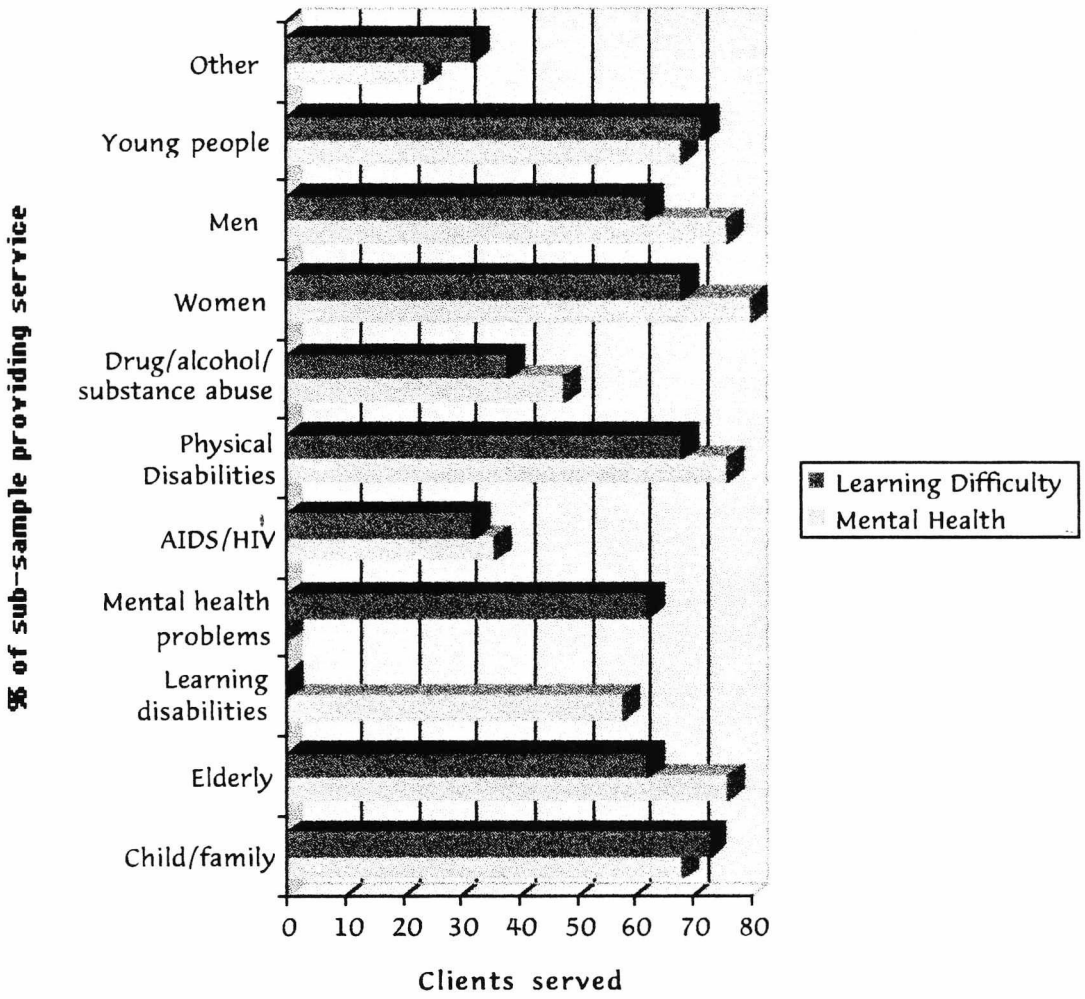


Figure 5.17

Client group coverage by welfare organisation type in Canterbury & Thanet and in Camden



Sample: Mental Health 40 organisations

Learning Difficulty 37 organisations

Table 5.5
Combined responses for perceptions about the voluntary sector by sub population and rationale

	WORKED IN VOLUNTARY SECTOR			WORKED IN LOCAL AUTHORITY			WORKED IN HEALTH SERVICE			HAVE BEEN A SERVICE USER			UNCLEAR ABOUT WHO PROVIDES WHICH SERVICE			ALL RESPONSES		
	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %
Cost effectiveness.	22	67	11	21	70	9	23	66	12	29	67	5	32	56	11	21	67	5
Participation and self-advocacy.	50	40	10	44	47	9	47	40	13	62	31	7	33	46	21	45	42	14
Choice & specialisation.	39	21	9	55	34	11	54	33	13	55	37	7	56	33	11	54	34	13
Innovation & flexibility.	42	47	12	38	49	13	42	45	13	47	44	9	35	48	17	39	46	14
Political advocacy.	45	43	12	39	40	20	51	38	11	39	46	14	45	30	26	45	38	17
Consequences of enhanced funding.	21	70	9	18	73	9	23	68	9	27	66	7	18	68	14	21	68	11

5.2.3 Perceptions checklist.

Data was drawn from a questionnaire distributed randomly to a range of actors involved in the care of people with long term care needs and clients themselves. Findings are based on a sample size of 97 respondents. Table 5.5 provides a summary of responses by sub-population and rationale. The origin of responses was approximately equal - 25% from each study area. Fourteen users were represented in the total sample and the age profile of respondents varied, the majority (72%) being between the ages of 30 and 49.

5.2.4 Day care evaluations

Indepth studies of three day care settings for the mentally ill, which included interviews with users also provided data for this chapter. Although data is drawn from all three settings the evaluation appended at Appendix A was the most comprehensive. Forty service users took part in the evaluation although the descriptive information is based on a smaller sample of 18. The profile of participants is described in Figure AA.2, p AA.17. The Canterbury evaluation involved interviews with 20 clients and the pilot study in Cheshire 10 clients.

5.2.5 A study of hospital closure.

Data was drawn from a study of a 'fast-tracked' hospital closure in one of the study areas. Full details of the study are appended at Appendix B. The findings are drawn from interviews with 13 key actors from the health authority, local authority, and a range of voluntary organisations and from two brainstorming days which allowed discussion and debate about key aspects of the closure. These days involved a broader sample of participants. Although relevant data is

referred to in this chapter and some of the results are presented here for ease of reference. (The full report can be found in Appendix B.)

5.2.6 A study of a home from hospital scheme.

Data drawn from a small study of a British Red Cross Home from Hospital Service, described in chapter 2 (p.2.27), is used in an illustrative way in this thesis rather than in tabular from because of the preliminary nature of the findings at the time of completion of this thesis. The findings are of particular value because of the nature of the work conducted by these services at the interface between health and social care.

5.3 THE FINDINGS

In chapter 2 six research questions were identified. I will return to these again in the final chapter but use them now to order some of the findings. The evidence to address question 4 - which is concerned with public sector support of voluntary agencies - is presented in the next chapter. Data related to question 5 is presented here but discussed more fully in chapter 7.

As I argue in chapter 2 the work carried out on the rationalisations offered by the public sector for support of the voluntary sector was a useful vehicle for structuring the data collection and for examining perceptions about the sector. In addition a range of questions emerge when looking at the literature relating to these rationales and the changing nature of inter-sectoral relationships. These emerged in the previous chapter and provide a useful framework for the discussion of the various data sources which this study has drawn upon. The rest of

this chapter then adopts this model to consider each of the rationales generated in the previous chapter and to address the questions which theory has generated.

5.3.1 How do the sectors view one another?

It is notoriously difficult to accumulate 'rigorous' data on attitudes to the respective sectors. Furthermore it is difficult to make meaningful connections between views and intentions as we try to 'test' rationales for public funding. It is at best an imperfect art, but it is vital to at least try to expose the many truths which are likely to result.

As was mentioned earlier, views about the sectors were sought in a number of ways: purposively via personal interviews with key actors and the perceptions checklist; and also as a very valuable 'by-product' of discussions about services in which it would have been difficult not to pick up views about the strengths/weaknesses/attributes of the respective sectors.

In this section I have tried to draw together this mixture of data to make sense of what people 'know' about each other. Data is drawn from a number of the data sources mentioned earlier. They are illustrative of the range of views held by the respective sectors about each other. To some extent one might argue that the statements reflect stereotypical views of sectoral roles and attributes. This may be the case and in part it would be impossible to prove in any way that these views are representative or that they have influenced the direction of public money. They are however fascinating.

(i) What are the public sector expectations and assumptions about the role of the voluntary sector?

a) Central government expectations

The Conservative government's main objectives for community care as set out in the 1990 Act were essentially threefold: easing the transition to the new arrangements; promoting independent living outside of institutional settings; and encouraging private and voluntary sector providers. Overlaying these aims were various political, social and economic agenda, not necessarily mutually consistent (Wistow et al., 1996). The encouragement of the non-statutory sectors was linked to the core aims of greater choice, innovation and cost-effectiveness (Secretaries of State, 1989a). Similar sentiments prompted the health service reforms, with the government arguing that the 'independent sector' brought the advantages of wider choice for patients and general practitioners, cost-effectiveness, and a flexible and rapid response to patients' needs (Secretaries of State, 1989b). Although there were local departures from these national objectives, the Conservative government's three core reasons for encouraging independent sector activity - choice, flexibility and innovation, and cost-effectiveness - tended to be echoed locally, although with less pervasive acceptance and generally less enthusiasm. (There were, however, a few authorities that embraced the proposals with *enormous* enthusiasm.) Local authorities were also more likely to have reservations about the sector's role in the newly developing mixed economy.

Choice. The criterion of choice as promoted in the 1990 Act included the encouragement of specialisation and the targeting of services and support on assessed need. The voluntary sector was seen to be the first-choice provider for many people because of its distinctive

orientation, ideology or quality of service. In part this was a consequence - it was argued - of its autonomy and opportunity to tailor services to satisfy different preferences or needs. Tables 5.5, 5.8, 5.10, 5.12, 5.11, 5.14 and 5.15 summarise some views from the *Perceptions Checklist*. Central government certainly encouraged provider pluralism in the belief that choice conferred benefits on service users, and specialist roles for the voluntary sector have long been promoted when central or local government was the purchaser. The drawback was the risk of higher transaction costs, the creation of supply niches and the associated market power for some providers. There was potential tension between provider pluralism (and therefore choice) and the efficiency gains which the government expected from its new market environment, and which local purchasers needed if they were to cope with considerable budget pressures.

Cost-effectiveness. The claim for voluntary sector cost-effectiveness has tended to be based on arguments about its style of governance, less bureaucratic administration, a ready supply of volunteer labour, greater staff commitment, lower wages, fewer constraints from trade unions, ability to recoup some costs from users, multiplier funding effects from donations, and simple economies of scale. Whilst central government viewed the voluntary and private sectors as cost-effective alternatives to state sector provision, local purchasers recognised the lower costs, but expressed reservations about the poorer quality of care being offered. Over the course of the 1990s these local views have changed, as evidenced by the growth of contracting out (although the 85% STG rule was also a significant factor here) and the rapid and widescale 'externalisation' of local authority services.

In summary the expressed public sector expectations and assumptions about the voluntary sector which were likely to influence funding and 'other support' decisions particularly emphasised three criteria regularly associated with public support for the voluntary sector in the research and earlier policy literatures (choice; flexibility and innovation; cost-effectiveness). At the same time, there were local concerns which mirror Salamon's (1987) 'philanthropic failures' of amateurism, particularism, insufficiency and paternalism (see Table 5.7).

b) Local authority assumptions

Evidence gathered in the MEOC study (and re-examined as part of this collection of work) broadly support these views (Wistow et al., 1994,1996). In 1991, many voluntary organisations were already working closely with local authorities, in contrast to their somewhat distant relations with the private sector. There was still some hostility to organisations that local authorities 'associated with middle-class charity' (Challis et al., 1988), but there was a lot of mutual learning in the new policy context (often facilitated by overlapping governance structures), voluntary sector participation in joint planning, and a fairly relaxed grant-based funding environment. Local authority doubts focussed mainly on the sector's capacity to respond to new supply opportunities. Many social services chairs and directors thought that voluntary organisations lacked experience and expertise in managing contracts, as well as supporting 'infrastructure'. They saw unevenness and patchiness in the balance of available services, and shortages of volunteers. But they also recognised the possible dangers to some voluntary bodies of threats to autonomy,

independence and so on. Staff lower down in social services department hierarchies shared many of these views (Allen et al., 1992). These findings were also echoed in the hospital closure study (see Table 5.7). In other words there was widespread "goodwill trust" for voluntary organisations but not always 'competence trust" (Sako, 1992).

Although not part of the study being reported here, it is interesting to note that further work by Wistow et al. (1996) elicited later local authority views on possible supply-side developments. *Inter alia,* one in six authorities in 1993 had discouraged and two-thirds had encouraged the setting up of new services in the voluntary sector. A majority of authorities again expressed a clear preference for the voluntary sector over the private. This was based on: perceived similarities in values with the public sector (especially when services had been floated off from the local authority); long track records and long-standing public-voluntary sector relationships; and voluntary sector representation on joint planning machinery, together with - as before - often quite widespread ignorance and suspicion of the private sector.

Flexibility and innovation. Voluntary organisations have been seen by some as 'the living laboratory of aesthetic, spiritual, and intellectual innovation' (Neilson, 1979, p.5). Others have been more critical of over simplistic comparisons, pointing to 'invidious organisational stereotypes whereby government is perceived as intrinsically rigid, riddled with bureaupathology, and offering mass standardised services that are dehumanising" (Kramer, 1987, p.241). Many community care developments offer evidence of voluntary sector

innovativeness (Osborne, 1998), and the Conservative government encouraged this view. However, whether the sector is *more* innovative than the government or private sectors is very difficult to establish. The views of respondents to the *Perceptions Checklist* were not particularly consistent here (Table 5.12).

(ii) What expectations and assumptions does the voluntary sector hold about it's own roles and those of the public sector?

The views of some voluntary sector workers about key features of their sector are summarised in the first data column of Tables 5.5, 5.8, 5.11, 5.12, 5.14. The 27 voluntary organisations across the four DHA localities mostly (80%) saw themselves as complementary to statutory services, providing specialised care (15%), alternative care (15%) or supplementary/extension care (17%) (Figure 5.8). Generally there were few differences between the statutory and voluntary sectors with respect to the latter's roles in community care provision in the mental health and learning disability fields. In Table 5.8 - which displays information gathered from the Perceptions Checklist - it is interesting to see the similarity in true/false responses from the different sectors which on one level suggests some commonality in modes of thinking.

Earlier in this chapter I mentioned the role of 'myth' in influencing perspectives about the sector. But how influential is it in reality? The views expressed in Tables 5.6, 5.7 and 5.9 below, drawn from the closure study, are particularly interesting as we try to determine the power of myth. This particular exercise revealed a number of contradictions and inaccuracies in what the statutory sector believed about the voluntary sector and how it behaved towards it. In particular, one agency described by the health authority as having a

preference for more able clients had as its raison d'etre 'priority for the most rejected and profoundly handicapped.'

Table 5.6

Agency perspectives about themselves and each other.

	Voluntary	Statutory
Voluntary	No competition, no coordination Conflict with regional office Peer support from other organisations Competitors are in the voluntary sector Unaware of coordinating body in VS Voluntary sector needs strengthening Emotional allegiance to CVS but financial to statutory sector	Spend a lot of time explaining our special philosophy
Statutory	Cash is a major lever Rely on us for funds and services Relationship is about funding Can be hard to gain access to services Need VS on planning groups because of expertise and consumer feedback	We are not really delivering a service Health Service lack of contact with the real world Partnerships with HA most important Relationships with HA about money No joint strategy so conflict over policy Good people in statutory team - they are innovative

The agency mis-represented in this way was very different in form and

aspiration from the statutory sector which may possibly account for negative views towards it. This phenomenon has been noticed in other studies. For example, Lipsky and Smith (1990) argue that those agencies which most closely resemble government will be successful in the funding stakes. More recently Russell and colleagues (1996) have found that in part similarity and closeness to the statutory sector seem to be favourable indicators for success in the funding stakes. I would argue that the notion of 'othering' developed by de Beauvoir in the Second Sex (1957) from Sartre's theory of conflictual human realtions has some value here. The notion that we class as inferior and devalue that which is different from us, could usefully be employed to help us understand the attitudes that key players have about one another. I will return to this in Chapter 7.

a) What are the key strengths of the voluntary sector?

In interviews sensitivity to client need was cited as a key strength, although several respondents were concerned that this key attribute would suffer as organisations got bigger. Diversity in the sector was seen to be a key weakness by virtue of the fact that many groups did not wish to affiliate because they saw themselves as 'different' from other groups. This view is in partial contrast to the one expounded by Taylor (1990) - and later by Taylor and Kendall (1996) and Taylor and Lansley (1996) - who argue dthat diversity will be both a key strength and a weakness in the future.

If intersectoral views are considered, the hospital closure study interviews with key figures in all sectors revealed an interesting range of perspectives (see tables 5.6, 5.7, 5.9). Voluntary sector representatives felt that the statutory sector needed the voluntary

sector for its expertise and to allow consumers to have a voice. The statutory sector felt that the voluntary sector was good at supporting and taking the pressure off and that particular strengths lay in advocacy, its ability to respond at short notice and its interest in non mainstream services.

The statutory sector counted interest in non mainstream areas as a particular strength, its ability to respond at short notice and to give consumers a voice and its expertise. It was clear in two of the areas that the largest voluntary agencies were also leaders There was therefore a reliance on the sector for professional expertise in the field of provision and they dominated and influenced the debate about service provision.

b) How does the voluntary sector view the statutory sector?

When asked to consider the response of the statutory sector to changing voluntary/statutory relationships, representatives of the sector felt that many statutory agencies were finding it hard to come to terms with their enabling role. One social services manager commented that, "staff on the whole are finding it hard to make the ideological leap necessary to underpin the organisational change." These responses suggest some degree of **partnership** with the statutory sector or at least **empathy** for their situation.

c) What can be said about the voluntary/statutory sector divide?

I was not surprised by this 'empathy' as during the course of this work it became clear that there had been considerable interchange of staff between the sectors over the years. Staff who made this move

often explained career moves in terms of their frustration with rigidity in the statutory sector and the attraction of flexibility to deliver services to their client group in the voluntary sector. This suggests a general commitment to serve consumers and a certain ethos amongst statutory representatives which is challenged by re-designing services along market principles.

Respondents were positive that clients and carers would benefit from marketisation if agencies came together more and a cross sectoral partnership emerged rather than polarisation of positions and non-pooling of the limited resources.

d) How does the voluntary sector view the private sector?

When asked to consider the role of the private sector there was an air of confidence in the replies. Despite an initial increase in market share by the private sector - because the voluntary sector had been slow to respond - in the long term it was expected that the voluntary sector would be clearly the more acceptable partner because of quality care. Faith in the local authority to be loyal to the voluntary sector seemed to be influential here and also confidence in the trustworthiness of the sector relative to the for- profit sector.

Table 5.7

Agency perspectives about themselves and each other.

	Health	Vol	SSD
Health	Commitment to close hospital. Ability to do it + expertise.	Too precious. Disorganised. Not cost-effective. Not flexible. Good at raising issues.	Political constraints. Lack of ability. New Hall hostels. Never do anything.
Vol	Finance driven. Doubtful philosophy. Lack of ability of managers. Treat CC Trust differently.	Diverse. Unco-ordinated. Critical of each other. We have expertise.	No money. Supportive of vol sector. Pre-occupied with hostel complex
SSD	Trying to off-load service. Preoccupied with hospital closure - finance driven. Money available/CC Trust amalgam of convenience, less constrained.	Positive. Supportive - strong and versatile. Can help to respond in current climate.	Moving towards acceptance of mixed economy. Opposition to private sector.

Table 5.8
Views about respective sectors

	WORKED IN VOLUNTARY SECTOR			WORKED IN LOCAL AUTHORITY			WORKED IN HEALTH SERVICE			HAVE BEEN A SERVICE USER			UNCLEAR ABOUT WHO PROVIDES WHICH SERVICE			ALL RESPONSES		
The voluntary sector....	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %
.. staff tend not to have qualifications.	48	39	13	37	42	21	50	37	13	57	43	-	38	46	17	49	36	15
.....is not well organised.	24	59	17	25	60	15	24	64	13	29	64	7	4	71	25	23	59	19
...tends to be short-term.	6	89	6	4	90	6	5	87	7	-	93	7	4	79	17	5	88	7
...deals with non-urgent need.	24	67	9	23	71	6	29	64	7	21	64	14	13	79	8	25	67	8
.has only statutory services which are comprehensive.	13	83	4	16	84	-	17	76	7	7	86	7	13	70	17	14	78	8
....has no checks on standards.	10	84	6	6	88	6	11	80	9	7	86	7	4	88	8	10	83	7

Table 5.9

Views expressed by actors in the voluntary and statutory sectors about inter-sectoral relationships.

	Voluntary	Statutory
Voluntary	On the whole supportive.	Relationship forced because of financial dependence.
	But not co-ordinated.	Negative about the ability of statutory sector.
	Disagreement over whether competitive or not.	Need sector(VS) for expertise and consumer feedback.
Statutory	Supports rationale of choice, advocacy, responsiveness.	Best at overview, balancing needs and co-ordinating services; good at orchestrating the market.
	High quality service and interest in non-mainstream areas are particular strengths.	Some services aren't appropriate for contracting.
	Too precious and selective over what take on.	LA have more expertise and accountability.
	No good at overview/balancing need.	Still have responsibility for essential services - use voluntary sector to supplement.
	Problem with confidentiality and trust	Conflict over whether voluntary sector is less bureaucratic or not. Younger respondents and those of administrative backgrounds tended to believe more in the flexibility rationale.
	Not willing to grow or be accountable but good at supporting and taking pressure off.	

5.3.2 Evidence about the rationales

What evidence is there concerning the activities and performance of voluntary organisations?

(i) Choice and specialisation

Previous discussions suggest that, as the statutory sector looks more to the voluntary sector as providers of care, voluntary-run services will increasingly substitute for statutory services thus reducing output heterogeneity (in James (1987) terms) rather than enhancing it. Further, it is argued that one of the ramifications of this will be that more unusual needs, those of low visibility or low priority (for whatever reason) will not be met. In addition the switch from a grant culture to a contract culture will mean that diversity will be lost in the process of specification and so any choice which does exist will be between a limited range of options. Kramer (1981) suggests that specialisation is likely to be the main justification for contracting out.

Numerous questions are generated by these expectations. For example, why do agencies support specialised services? Is it to satisfy differentiated demand, or because they are more cost-effective or because services need to be separated out in some way either to promote innovation or because they are offering some form of advocacy?

A supplementary but equally important question is the capacity in which specialised services are used. Are specialist services an adjunct to existing services, are they viable alternatives, do they supplement or extend (in the Webbs (1912) terminology) the existing pool or are they substitutes for existing services?

The potential for the voluntary sector to offer a distinctive service in supporting people with mental health problems or learning disabilities was clear, and was identified by respondents in all sectors (see Tables 5.10 and 5.12). Evidence on voluntary sector distinctiveness came through other of our empirical activities, suggesting a specialist role that may be interpreted as consistent with broadening the range of choice. In the North London reprovision sample, specialist accommodation providers in the voluntary sector tended to accommodate slightly younger people, but these residents had generally had more in-patient admissions during their lives, and an average continuous length of stay prior to discharge (16 years) which was much lower than in NHS community accommodation (23 years) but greater than in private settings (11 years). The voluntary sector accommodated more people with schizophrenia than the private sector (81% compared to 58%). Other differences between the two independent sectors were reflected in measures of mental health symptoms, social behaviour, disabilities and some skills. Voluntary facility residents were generally rather more 'dependent'. However, voluntary sector residents were generally less dependent (on some of these same dimensions) than people in NHS accommodation. In a later national survey of residential mental health accommodation similar inter-sectoral differences were found (Knapp et al.,1998).

Choice can also be examined on an individual level in terms of how users' and carers' views are incorporated into the decision-making process and how users experience the notion of choice on a day to day level in terms of their daily living. For many clients with long-term care needs a range of services is important not only because of the breadth of need which exists but also because traditional services may

not offer the treatment preference which many clients are now looking for ie. a service based on the whole person which is responsive to need rather than a service which treats categories of "illness."

What can be said about the responsiveness of voluntary run services to user needs and preferences from the evidence gathered here? Perceptions checklist data (see Table 5.10) revealed a high level of agreement from people of all backgrounds that the voluntary sector is very responsive to consumer need. There was broad support across the board for the notion that the voluntary sector was more responsive to consumer needs (over 70% for people from all backgrounds). Users especially agreed with this (93%).

In interviews with key actors sensitivity to client need was cited as a key strength although concern was also expressed that this would suffer as organisations got bigger.

Figure 5.18

Responsiveness to needs of user

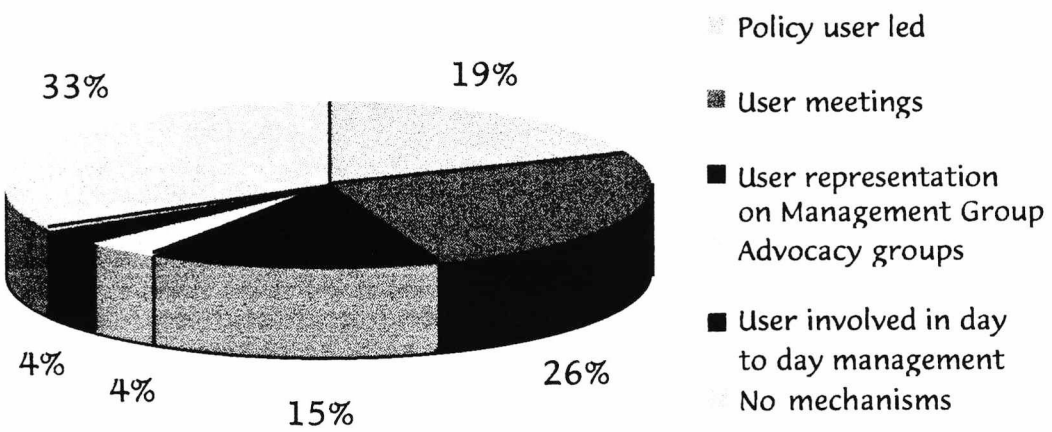


Table 5.10

Choice and specialisation

The voluntary sector	WORKED IN VOLUNTARY SECTOR			WORKED IN LOCAL AUTHORITY			WORKED IN HEALTH SERVICE			HAVE BEEN A SERVICE USER			UNCLEAR ABOUT WHO PROVIDES WHICH SERVICE			ALLRESPONSES		
	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %
.....is more responsive to consumer need.	70	19	11	73	17	10	71	22	7	93	7	0	63	29	8	70	21	9
.....provides different services.	62	32	6	56	38	6	52	41	7	55	38	7	50	33	17	55	37	8
.....caters for unusual needs.	37	41	21	37	46	17	38	36	25	21	64	14	54	38	8	36	43	21

In terms of formal mechanisms to make services responsive to consumer needs, two-thirds of agencies had mechanisms in place whereas one third did not. There was a feeling in some quarters that the mark of a truly responsive agency was not to have any mechanisms! (Figure 5.18).

Indepth studies of mental health day services in two of the study areas and in an independent study which ran alongside the research, furnished a range of data about user views of services. Interviews with users and staff revealed a higher level of reponsiveness in voluntary run day care than in their statutory counterparts. Consumer choice was part of this responsiveness (see Appendix A - Figure AA.8, p.AA.26).

In the study featured in Appendix A, the pilot study for this in a similar day centre in Chester and a day centre study in Canterbury there was an opportunity to talk to users about their needs and wants. An important aspect about the service which clients valued was the open door policy to the office and the lack of official record keeping. Also valued were the problem-solving and networking activities of the staff whose role seemed to be as much reactive as proactive.

The range and individuality of needs which emerged was striking, as was the simplicity of many needs, most reflecting practical assistance and social contact rather than medical intervention (see Figures 10-13 in Appendix A, pp. 29/30). Most respondents lived alone and the need for companionship emerged time and again as a reason for attending the centre, as a main problem faced by people (loneliness),

as something which helped to ease the symptoms of illness and as one of the things that people most desired in their lives.

The responsiveness and range of options open to clients at the centre was also deemed to help ameliorate the effects of their illness. The lack of medical 'focus' at the centre seems to fit with the way that clients felt about themselves eg only one person specifically identified symptoms of illness as a major problem. Also the choice to be involved in activities or to simply 'be' at the centre was also valued compared to the quite structured routines of other facilities.

Perhaps another important aspect of the day service was that it did not exist in isolation but was part of a network of facilities involving 'real' work schemes, housing and support for families, carers and service users. The range of services reflects a more holistic approach to mental health problems than the bio-medical approach which can tend to separate the condition from the person.

The majority of respondents (82%) felt involved in the running of the centre, although fewer (65%) felt they were consulted or that their comments were listened to or acted upon. In terms of facilitating participation, over half of the sample felt that they were encouraged by staff to say how the centre is run and are regularly invited to meetings. 41% of people felt they could put their views across at meetings and there were no suggestions for how meetings could be improved.

In chapter 4 (p. 4.18) output heterogeneity was considered and it was seen how services may be distinguished by religion, culture or

ethnicity , ideology, industry or employment, treatment preference or merely because they are voluntary or at least not statutory.

So is the voluntary sector seen as the producer of different services in response to different consumer tastes as theorised by Estelle James(1987)?

The data on service responsiveness certainly seems to support the treatment preference thesis. According to perception checklist data 50% of those interviewed felt that the voluntary sector provided different services to the statutory sector. Voluntary sector interviewees agreed with this more (2/3rds), which was perhaps not an unexpected finding. However, half of respondents did not agree with this proposition however which is interesting in itself considering the myth of responsiveness which surrounds the sector (see Marshall (1996) mentioned in chapter 3 p.3.10). As Figures 5.7 and 5.8 revealed earlier, most organisations viewed the rationale for their service as being the "alternative" nature of it.

Kramer (1981) argues that employing the voluntary sector allows for an extension to the range of some rationed statutory services for constituencies which have low visibility or low priority eg. user-focused mental health care or health care for lesbian women. However when asked whether the voluntary sector tended to cater for more unusual needs, checklist data did not reveal a large measure of agreement for the proposition. Users particularly disagreed with this. The statutory sector, however, counted interest in non-mainstream areas as a particular strength of the sector. Respondents were more likely to agree with the proposition if they also said they were unclear about the respective responsibilities of the sectors. This supports the argument made earlier about the power of myth in common

understandings of the sector.

Organisations in the DHA sample felt that their capacity for innovation was affected by the demands of contracts with the result that services were offering more of the same unless they could attract 'other' money to fund innovation. It was easier for the larger organisations to do this. This finding supports the substitutability thesis.

Why are specialised services supported?

Specialisation is distinguished here from choice as purchases by public agencies on behalf of, rather than by, clients mainly via purchase of service contracting. It was argued earlier in chapter 4 that specialised voluntary sector provision will be publicly supported not only because it satisfies differentiated demands or needs, but also because it is judged to be more cost-effective.

Where an agency is responding to unusual or rare needs it may be more cost-effective to contract out. Activities with effects only in the very long term are among the specialised outputs of the voluntary sector, as are innovative provision and advocacy.

In two of the three DHA areas the organisations were leaders in their field with no statutory and little voluntary competition and so they were being funded for their expertise and because there was no alternative. The homogenising of the sector as a result of negotiated service agreements and the influx to many areas of competition where there was none before is likely to alter this in the future and one of these areas was certainly beginning to experience competition from a

rapidly expanding agency which was offering services which were less distinctive but seemed to meet the priorities of purchasers (see results of hospital closure study in Appendix B).

Special needs housing is a very important way in which the voluntary sector has contributed to care of people with long term care needs. The analysis of the activities undertaken by the voluntary sector in the Care in the Community demonstration programme outlined in chapter 3 illustrates the importance of the sectors' specialist housing role.

However, there was clear evidence in each of the study areas that organisations that were offering specialised services were having their funding cut even though they provided highly acclaimed services. Financial pressure on purchasers seemed to be the root cause of these decisions. For example, in the DHA sample Firmstart in Medway, and Mustard Seed in Canterbury and Thanet had their budgets cut and the Warrington Day Centre was under threat of a reduction. In later work (Thomason and Mitchell, 1997) we found that the highly succesful Home from Hospital Service was experiencing the type of financial insecurity highlighted by Shore et al (1992) and Russell et al (1996). Chapter 6 focuses on their findings in more detail. In terms of the power of myths about the sector to influence decisions it appears that, in the face of more tangible pressures such as resource constraint, 'myth override ' may occur.

In summary, **no firm evidence** emerged from the data to support concerns about loss of service diversity, although many of the developments that agencies reported suggested that there was a

danger of this happening. Two such examples were first, services highly valued by clients in three of the localities were refused funding. even though they had been viewed as 'leading edge' and highly valued by clients . They were told that it was because they were too costly. Second, the view of some statutory sector actors that the voluntary sector is too precious over what it will take on. In terms of funding success it is true that certain types of agency have grown more rapidly and may therefore crowd out smaller agencies as envisaged by Deakin (1991) in his predictions about large providers 'parachuting into' areas to dominate service provision. It is certainly true that agencies have fared differentially for whatever reason and this will shape the service.

The findings of Burton et al (1994) and Russell et al (1996) indicate that diversity may be constrained because of the narrowing of statutory priorities and differential success rates respectively. In terms of responsiveness to consumer needs there was support in the attitudinal data (see table 5.10) for this attribute and from user evaluation of services.

The case study of hospital closure examined in depth the decision-making process involved in the re-provision of care for clients with learning disabilities. It was of particular value because it generated (in microcosm) many of the issues which arise in the mixed economy of community care for the types of clients of concern to this thesis. The pre-conditions for closure and the judgements which were made about the suitability of existing voluntary agencies to meet these conditions raises a number of issues which can help to shed light on the specialisation rationale.

The pre-conditions for closure in this case included the following:

- Hospital staff would have to be redeployed in order to release capital.

- To fund community services adequately (one third higher than existing schemes) health managers wished to make use of DSS allowances.

- Health managers wished to place people in ordinary housing, no more than 3 clients per house, and implement a pre-specified day care model.

- The policy regarding community placements and benefits outlined in the 1989 White Paper (before the delays and the DH announcement regarding legality) meant that the strategy would need to be implemented quickly or this source of additional funds would not be available.

Existing voluntary organisations were felt to be inappropriate for three reasons: first a reluctance to take on more disabled people who would require expensive schemes; second, agencies were perceived as having reached their constitutional and organisational limit in terms of management task; finally agencies were opposed to the use of board and lodging payments to fund placements contrary to RHA guidelines.

To circumvent this problem the health authority had for some time been promulgating the development of a locally based, flexible, voluntary agency. The health authority proposed that all agencies work together to form a trust but the health authority were keen to heavily influence the agency by framing the agency's articles of constitution in such a way as to ensure that it adhered to set principles.

It was also expected that the health authority and the agency would come

to an arrangement to transfer staff to the agency's payroll or have health authority staff seconded to the agency with the health authority being reimbursed for their services.

During this period any vestige of good joint working relationships disappeared, as communication broke down and negative beliefs held about motives and ability of agencies about each other hardened.
Interviewees from all sectors were asked to consider the services provided by other agencies. The following views emerged:-

*Crucial to the choice of a new breed agency to carry out the strategy was the judgement that the existing agencies could or would not meet the pre-conditions outlined above.

*When health service managers were asked to consider the strengths and weaknesses of organisations based on the extensive use of managing agencies in the past the question was answered in terms of whether or not organisations could meet the pre-conditions of the strategy in question rather than an overview of their performance or qualities. However, individualised assessments were made of what the health authority considered to be the adverse and favourable characteristics of agencies.

*Health service managers were asked to compare the two largest voluntaries with the new community care trust in terms of innovation, quality, value for money and closeness to consumer need. All agencies scored highly on innovation but the other agencies won on quality and how needs-led services were. The trust scored more highly on value for money.

When members of the voluntary sector were asked to consider the same criteria and how they prioritise them when designing their own services they also ranked closeness to consumer need and quality highly, followed by innovation and lastly value for money.

We can see that health service managers' perspectives of the voluntary sector and the voluntary sector 's own aims coincide, but the priorities attached by each sector to these different considerations are at variance. **This point is crucial to our understanding of inter-sectoral relationships.** Health authority managers judged that the Trust as a single agency was more cost-effective and because of the ordinary life model and the diversity within that, there was more chance of people getting what they wanted. On the down-side services were not allocated on the basis of need.

It was clear from the findings that financial considerations and pragmatic reasons such as time, personalities and connections with the health authority took precedence. The pressure on managers to save money perhaps sheds light on the anomalous situation expressed earlier where highly successful specialised services are having their budgets cut.

(ii)Cost-effectiveness

The supply-side theories mentioned in the previous chapter suggest that voluntary organisations for a variety of reasons may enjoy a cost advantage. These claims do not always stand up to close scrutiny but when a cost-effectiveness advantage is found or assumed, government funding - particularly through specific grant aid and purchase of service contracting - is likely to increase.

Establishing comparative cost-effectiveness or efficiency is far from straightfoward. Checks need to be made that the sectors are delivering equivalent services or supporting equivalent user groups (or that adequate adjustments have been made for differences) and that the salient characteristics of the sectors are measured consistently (for example, including accurate capital and overhead costs). Some previous PSSRU research had shown that - once adjustments had been made for user differences, and exogenous cost-raising factors - the apparent voluntary sector cost advantage may disappear (see for example, Knapp and Missiakoulis, 1982; Knapp, 1988).

The most thorough examination of cost-effectiveness in this field covers from a re-analysis of data from the evaluation of the closure of two north London hospitals by knapp et al (1999). The analyses focussed on 429 people with mental health problems living in specialist accommodation (ie. excluding those living independently or who had returned to hospital), and examined quality of care, costs and outcomes one year after discharge from hospital. Outcomes were measured as changes over time (between the hospital and community settings) in a wide range of clinical, behavioural, and social and self-care domains. The statistical analyses found that, although the different sectors were accommodating people with some differences in needs and dependency profiles (as reported above), costs were significantly higher than in the private sector. But these low private sector costs appeared to be achieved at the expense of poorer quality of care and fewer outcome improvements for users (full details in Knapp et al., 1999).

Quality of care was rated most highly in community facilities run under consortium arrangements between the NHS and voluntary organisations (housing associations). There were also suggestions in the data that user outcomes were better in these facilities. However, these were also the care arrangements that had the highest costs. In comparison to the other provider sectors, therefore, the voluntary sector, whether singly or in consortium arrangements, appeared to perform well by the quality and user outcome criteria, but was often more costly, a finding consistent with previous work in the mental health field in the US and UK (Schlesinger and Dorwart, 1984; Knapp et al., 1998.

The literature suggested that public sector mangers would be under increasing pressure to combine services into care packages in ways which would achieve value for money. The case study of hospital closure which formed part of this study (appended in full at Appendix B) revealed some interesting information about the respective weights placed on client need, quality of service and available funding when moving clients to the community and is discussed here in some depth.

Chapter 6 focuses in detail on funding issues, embracing both a national perspective on how voluntarism is supported and a local perspective on the scale and nature of support. The analysis here focuses principally on reflections about cost effectiveness by agencies involved in providing services for people with long term care needs.

So is the voluntary sector more cost effective? A range of people in the DHA study were asked to consider a number of

commonly held beliefs about the voluntary sector and cost-effectiveness. The results in Table 5.11 show that respondents on the whole did not see voluntary run services as a cheap option because they employ unpaid staff, are smaller or raise money solely from fundraising. Perhaps surprisingly, service users were most responsive when answering these questions whereas health service employees were more inclined to agree with some statements, in particular about organisations employing unpaid personnel.

The statutory sector tended to believe that services were not cheaper if all service costs were included, although in terms of the effectiveness part of the equation, the provision of high quality, needs-related services was deemed to be a major strength of the sector.

Table 5.11

Cost-effectiveness

	WORKED IN VOLUNTARY SECTOR			WORKED IN LOCAL AUTHORITY			WORKED IN HEALTH SERVICE			HAVE BEEN A SERVICE USER			UNCLEAR ABOUT WHO PROVIDES WHICH SERVICE			ALLRESPONSES		
The voluntary sector	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %
.....is cheaper because smaller.	30	54	16	29	56	15	26	59	15	36	64	0	39	43	17	29	52	20
.....gets money from fundraising.	19	76	6	19	79	2	20	71	9	36	57	7	33	63	4	17	77	6
.....is cheaper because staff are unpaid.	17	72	10	15	75	10	22	67	11	14	79	7	25	63	13	17	72	11

How do different funding sources impact on agencies?

In the locality studies, organisations responded to a range of questions about funding (see Table 5.18 and Figure 5.20). When asked to rate the importance of a number of questions relating to funding almost three quarters of the sample felt that increased reliance on sales and business income was not a problem for their organisation although there was more ambivalence in relation to fee income. There was also ambivalence over whether excessive dependence on the public sector and the switch from grants to contracts were of importance. If the results from the different localities are scrutinised they are remarkably similar on all funding questions with the exception of private funding and whether the lack of it is a problem. Two thirds of respondents in Canterbury and Thanet felt this issue was not important whereas 87% of the Camden sample did feel it to be of importance.

One issue raised in chapter 4 is that the very process of contracting-out can reduce or even remove the cost-effectiveness differential. Further, because the cost-effectiveness difference encourages substitution between the sectors, governments have an incentive to continue to contract-out until the difference disappears, other things being equal. These possible impacts are discussed in more detail in section 5.4 below and in Chapter 7.

To summarise, the attitudinal data suggested that a range of actors supported the notion of effectiveness believing that the provision of high quality services was a paticular strength of the sector. There was less unanimity over whether services were cheaper because of some of the commonly held beliefs about the sector (see Table 5.11). Overall

'the services are cheaper' option was not supported, although there was some support from health service personnel for a cost advantage on the personnel side.

When agencies in the locality studies were asked about the impact of the changing funding base on their work no strong picture emerged that this was causing them significant problems, although the more detailed data gained from face to face interviews suggested there were marked differences between agencies. This can in part be attributed to two inter-related things: one, the time at which the data was collected (health and social care were the last aspects of the welfare state to which the principles of marketisation were applied); and second, the extent to which agencies had begun to respond to the contract culture.

In view of the theoretical explanations for statutory support of specialised services and the hypothesised propensity for the statutory sector to contract out where a cost-effectiveness advantage was found (or suspected) - what evidence did this study find to support this notion? The study found support overall for the effectiveness argument from both survey information and face to face interviews, in terms of expertise, flexibility and high quality services. However, the experience of some agencies who had experienced the withdrawal of funding for highly acclaimed services contradicted this.

These experiences and the decision making process in the hospital closure programme indicates the relative power of those who hold the 'purse strings' to decide what is worthy of funding and what is too costly. The data from this study is re-inforced by later studies which point to the narrowing and changing nature of statutory priorities

(Bolton et al, 1994) and the web of factors which interact to determine funding success outlined by Russell and colleagues (1996).

The case study of hospital closure suggests that expedience may also be a very powerful rationale for contracting out. Motives such as these may be concealed by more worthy justifications for funding choices but one might argue that the mythology is adhered to insofar as it serves the needs of the funders concerned. It was clear from the findings that financial considerations and pragmatic reasons such as time, personalities and connections with the health authority took precedence over client need and philosophy of care. The countervailing pressure on managers to save money perhaps sheds light on the anomalous situation expressed earlier where highly successful specialised services are having their budgets cut.

(iii) Flexibility and innovation

There is limited evidence of the flexibility of voluntary organisations. Flexibility often carries unacceptable associated characteristics, such as inconsistency and lack of accountability, and the evidence collected from several of the data sources illustrates both the positive and negative aspects of the flexibility rationale. Table 5.12 demonstrates that the voluntary sector overall was held to be **responsive** and **flexible**. Perceptions about the relative flexibility and innovative potential of the sectors revealed that 50% of respondents viewed the voluntary sector as less rule-bound than statutory agencies, although responses varied according to

Table 5.12 Flexibility and innovation

The voluntary sector ...	WORKED IN VOLUNTARY SECTOR			WORKED IN LOCAL AUTHORITY			WORKED IN HEALTH SERVICE			HAVE BEEN A SERVICE USER			UNCLEAR ABOUT WHO PROVIDES WHICH SERVICE			ALL RESPONSES		
	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %
.is more responsive to consumer need.	70	19	11	73	17	10	71	22	7	93	7	0	63	29	8	70	21	9
...tend to be mutual aid groups.	23	67	10	17	77	6	25	65	9	36	50	14	13	71	17	21	69	10
.....is less rulebound.	57	35	7	53	39	8	49	42	9	71	29	0	46	42	13	55	35	10
...staff are keen social reformers.	39	43	17	35	38	27	46	37	17	36	36	29	38	25	38	37	37	25
...caters for unusual needs.	37	41	21	37	46	17	38	36	25	21	64	14	54	38	8	36	43	21
....finds it easier to make views known	60	31	9	48	37	15	56	25	18	71	29	0	38	38	25	53	40	17
...is for short term projects.	6	89	6	4	90	6	5	87	7	0	93	7	4	79	17	5	88	7

employment background, age and agency. Administrators were strongly in favour of this quality as were those under the age of 30. This may of course reflect the experience and needs of the respondents who often expressed frustration at the powerlessness they felt in their own roles.

In the hospital closure case study, the statutory sector tended to view the voluntary sector as **too selective** to provide essential services or to be responsive in a strategic sense. This view was also expressed in interviews with some statutory sector managers although it was difficult to pick up any discernable pattern to account for negative views about the sector.

As was argued earlier, it is very difficult to find evidence of the relative rigidities or flexibilities of the sectors. Kramer (1987: 241) argues that beliefs about the sectors are based on 'invidious organisational stereotypes whereby government is perceived as intrinsically rigid, riddled with bureaupathology, and offering mass standardised services that are dehumanising'. The voluntary sector in marked contrast is imbued with the ability to respond to anything which is thrown at it at any time (see the comments of Deakin in Chapter 3 p.3.18).

As I noted in Chapter 4 (p26) Brodkin and Young (1986:50) argue that these beliefs , may not be 'untestable empirically', but may well be 'empirically irrefutable ... that is ... not readily vulnerable to data'. As I argued at the beginning of this chapter this reality is hard to get around but acknowledging the impact that it has on the way people see the world not only in terms of answering the questions posed but also in terms of the actions they choose to take is an important

finding in itself. One respondent for example argued vehemently that views about sectoral strengths and weaknesses are 'bred into them (social workers) during their training' and therefore are hard to overcome when organising care in a different way. His argument is that these beliefs are a powerful obstacle to collaboration. Cooper et al. (1996) in their edited volume on collaborative working reinforce this very point..

These rationales were investigated by examining not only the respective views of key actors, which were illuminating in themselves, but also the extent to which agencies had been involved in changing what they did. Factors precipitating change were also examined such as leadership style, decision-making structures and responsiveness to consumer need. The case study in the management of change also addresses these rationales (see Appendix B).

Douglas (1983) argues that, because of the constraints upon them, bureaucratic public agencies can only squeeze citizens into the rigidly structured services of the public sector. For these reasons, it is rationalised, public sector departments should contract with, or otherwise subsidise, the voluntary sector in order to offer an improved service, more efficiently produced and more efficiently targeted on the needs of the population. Flexibility was a key attribute in the demonstration programme.

The User-eye view of a mental health day centre which formed part of this study (see Appendix A) also found that flexibility was the key to success in terms of client satisfaction. Trust and a belief that services were responsive to users' needs were identified as an important

element of its success.

Close analysis of the work of agencies in the DHA study revealed that taking individual needs into account was not a problem in the voluntary sector. Paradoxically, public funding may itself impair the flexibility of voluntary agencies. Leat et al. (1986) found some evidence of a positive relationship between the level of grant aid and expressed feelings of a loss of independence. Many agencies expressed concern that responsiveness would suffer as their agency grew. The implications of the reforms are discussed later in this chapter and in chapter 7. Complacency and lassitude were also suggested as possible bi-products of more secure funding.

In terms of pioneering roles, in two of the areas the key agencies had led innovation and frequently changed the direction of their work. In terms of inter-sectoral partnerships in one area both sectors had worked closely together to provide a service. In another the voluntary sector was stimulated by the statutory sector and in yet another the statutory sector seconded personnel to effect change. Most were now involved in some measure of change of direction as a result of the reforms (see Table 5.13).

Table 5.13

Presence of structural changes in study sample of voluntary organisations

Change	Number
Review mission	10
Review priorities	10
Review of programme/procedures	9
New accounting system	9
Change of image	8
Long-range planning	6
Use of management consultant	6
Installation of Management Information System	6

n = 11

To recap, survey data revealed a good deal of support for the view that the sector was responsive and flexible with over half of all respondents agreeing that the sector was less rulebound. The work with users also revealed that clients felt that the services run by the voluntary sector were distinctive from the other services with which they had contact and were closer to their wants and needs.

There was no shortage of evidence to support the pioneering role of the sector in all of the DHA areas, although in the mental health field,

where good community services demanded very different models of care to the statutory examples which had gone before this was perhaps not surprising. Two particular characteristics of the work of the sector seem to be important factors here: One is the willingness to take risks which seems to be difficult for statutory agencies, in part because of their legal responsibilities for vulnerable people. Second, the different value base of voluntary agencies tends to make them prioritise different things. This trait perhaps explains why agencies heavily resist the notion that their mission might be diluted or altered in any way (see responses to the questions in the locality surveys Table 5.18). There is also plenty of evidence to show how agencies have found ways around regulation to do just this. However, as I will examine in chapter 7, does this tendency mean that some services will always be provided however much the statutory sector squeezes that service because workers (paid or voluntary) absorb the cost? This 'personal' cost to carers undoubtedly damages the notion of volunteerism being beneficial for those who volunteer and thus for society as a whole.

In summary, there was some evidence that positive views about the voluntary sector were associated with good working relationships between the sectors, leading to some understanding of what services were trying to do. Secondly, the views expressed by key actors re-inforced the power of beliefs about the relative strengths and weaknesses of the sectors and how they affected the funding decisions that people took. Finally, some of the conflicting views expressed about agencies seemed to support Kramer's view about stereotyping.

One could argue that a multiplicity of agencies and energetic

managers in itself maximises the potential for innovation. Thus even if the voluntary sector was no more innovative than the public, the continued existence of voluntary providers alongside statutory agencies would enhance innovative activity. Provided those innovations could be built upon in subsequent delivery systems, public subsidies would be worthwhile. An important way in which the voluntary sector contributed to the Care in the Community Programme was to resolve stalemates over responsibility for care. Where confusion and argument existed about whose responsibility care should become, the voluntary sector often cut through inter-agency squabbles. Homes for minority groups is a key example of this (Knapp and Thomason 1987). The resulting arrangements were often replicated by all sectors building on the innovation. The Home from Hospital service is a prime example of the voluntary sector operating at the point of friction between other agencies - in this case the health and social care divide (Waddington and Henwood, 1996).

(iv) Participation and advocacy

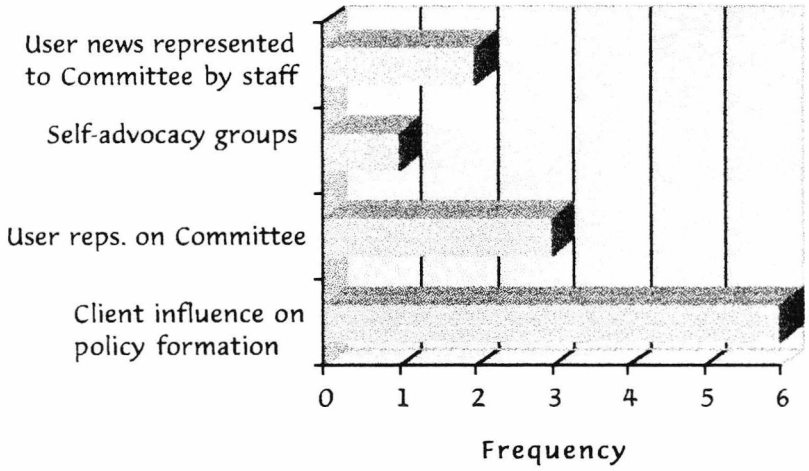
As was argued earlier, accounts of the voluntary sector seldom fail to mention the benefits of participation which accrue from the involvement of the sector in care. Participation is referred to on a number of level. First, it is seen through volunteerism - extending the range and nature of services through the use of volunteers and conferring benefits on the volunteers themselves via their altruistic behaviour (Aves, 1969). Second, participation is valued as a democratic, consumerist vehicle, where citizens can take part in local decision-making, thus democratising and deconcentrating resource allocation procedures and fostering self-help and mutual aid. Third, participation can be a counterbalance to statutory agencies

constrained by factors which make them impervious to the needs and preferences of citizens (Douglas 1983). If we utilise these three conceptualisations to examine the empirical findings, some interesting results emerge, particularly in respect of participation as a democratic consumerist vehicle.

As we saw earlier when looking at responsiveness (see Figure 5.18.), if we measure the capacity of an organisation to be participative in terms of conventional measures like user representation on committees and user fora etc, then the voluntary sector does not appears to be no more participative, than many statutory services. Figure 5.18 uses data drawn from interviews with managers of voluntary organisations in the DHA study and reinforces the data from another source displayed in Figure 5.18. What is interesting about this dimension is how actors interpreted the term 'participative': For some the height of participation was achieved if their service was **for** the clients, driven by **their** needs. The service was seen to so responsive it did not need formal mechanisms to make this happen, in fact it was felt that formalisation would be likely to damage this quality. As I mentioned earlier, this very different way of viewing this important dimension is an example of "cognitive dissonance" a phenomenon which Cooper et al (1996), in their work on interdisciplinary working, identify as a significant barrier to progress in joint working. I will return to this important issue in Chapter 7.

Figure 5.18

Dimensions for measuring participation



Responses to questions about consultation and participation were often contradictory, the respondents seemingly being unable to make the link, for example, if clients are not involved, consulted or invited to meetings but they are encouraged to offer their comments about services which are then acted upon.

Just over two thirds of the DHA sample (see Figure 5.18) had mechanisms to involve consumers. Of those that did not, there was a feeling that the way the organisation functioned allowed participation, that it was a 'way of life' for the organisation. This was not always obvious in practice when talking to clients or observing services. As organisations grew in size some were identifying lack of responsiveness as a problem.

A second but related question is relevant here. Do voluntary organisations empower their clients? The overall picture painted by clients was that voluntary organisations were more democratic but not if measured by looking at the mechanisms cited above. User interviews

revealed that clients 'felt' more involved regardless of whether mechanisms were or were not in place. This could be explained by the different ethos and possibly the smaller scale of many of these services.

This seems to support the rather unusual views expressed by managers of voluntary bodies. However, this 'closeness to the consumer' and the symbiotic nature of client need and organisational raison d'etre would seem to be disrupted by size of organisation ie. changing organisational structure to accommodate growth impacts on the organisation's relationship with the consumer. A quarter of all voluntary sector managers raised this as a matter of concern in the DHA study.

If participation is measured by how involved people feel and whether thay feel their voice can be heard, the following results support the proposition that the voluntary sector is more participative. 50 % of respondents felt that it was easier to make one's views known in statutory-run services (see Table 5.14). Users and representatives of the voluntary sector particula.rly agreed with this view. Local authority interviewees were least likely to concur. This in part supports the notion of a perceived lack of accountability in the sector. Only half of the sample in the attitudinal survey agreed with the proposition that it is easier to make one's views known in the voluntary sector, although 80% of users agreed with this statement. Those with NHS backgrounds were least likely to feel positively about this.

The data collection did not address the conceptualisation of

participation as volunteerism in great detail, mainly because many of the staff working in the organisations in the DHA study were paid staff. The locality studies reveal the importance of the work of volunteers to many of the agencies (see Figure 5.11). The service providers in the DHA sample were on the whole less reliant on volunteer labour, although many of the agencies received support in the form of consultancy advice, and had unpaid members on their management committees.

Table 5.14

Participation & self advocacy

	WORKED IN VOLUNTARY SECTOR			WORKED IN LOCAL AUTHORITY			WORKED IN HEALTH SERVICE			HAVE BEEN A SERVICE USER			UNCLEAR ABOUT WHO PROVIDES WHICH SERVICE			ALLRESPONSES		
The voluntary sector ...	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %
...tends to be mutual aid groups	23	67	10	17	77	6	25	65	9	36	50	14	13	71	17	21	69	10
...finds it easier to make views known	60	31	9	48	37	15	56	25	18	71	29	0	38	38	25	53	31	17
finds it easier to get involved in voluntary services	67	21	11	65	27	8	58	29	13	79	14	7	50	29	21	61	25	14

Services provided by the sector tended to be viewed as professional services, not mutual aid groups. Health authority employees were most adamant about this. Figure 5.5 illustrates that 22% of agencies in the DHA study saw themselves as mutual aid organisations. This result is perhaps usefully qualified by the finding that over half of the sample had mutual aid ast he historical starting point for their organisations, the service provision element having assumed a greater role over the years. Of all the respondents, service users were more likely to agree with the 'mutual aid' classification which may reflect positive feelings of involvement in a service and common goals for staff and users.

The third conceptualisation of participation is the voluntary sector as a counterbalance to statutory agencies that are perceived to be constrained and impervious to the needs of citizens. This is the role of the sector as an innovatory force and advocate. If we focus on policy advocacy as an expression of participation, the literature suggests a number of rationales - both positive (Douglas' knowledge and size constraints) and negative (Salamon's voluntary failure) - for why voluntary organisations will attract public money for policy advocacy. This is what Kramer (1981) describes as the sectors 'quintessential function.' When asked to classify themselves, 50% of organisations said they offered an advocacy service and functioned as critics of the statutory sector. Campaigning was mentioned most infrequently of all, although it was very apparent in at least two of the areas that voluntary sector actors were very influential on planning and working groups.

The policy advocacy role of organisations was investigated by looking at the extent of their campaigning role and how this was changing in response to the reforms. In interviews with key actors it was clear that the statutory sector viewed the voluntary sector role as 'critic' as essential, although concern was also expressed over who would best assume this role in the future. Independence was deemed an essential pre-requisite for an effective role as critic.

There was evidence from the DHA study that organisations had been able to provide political muscle for clients by raising the profile of clients and giving consumers a voice, and that agencies were protecting their campaigning role and fiercely guarding it.

Table 5.15
Political advocacy

	WORKED IN VOLUNTARY SECTOR			WORKED IN LOCAL AUTHORITY			WORKED IN HEALTH SERVICE			HAVE BEEN A SERVICE USER			UNCLEAR ABOUT WHO PROVIDES WHICH SERVICE			ALLRESPONSES		
	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %	True %	False %	D/K %
Staff are keen social reformers.	39	43	17	35	38	27	46	37	17	36	36	29	38	25	38	37	37	25
Good at promoting what it does.	51	42	7	44	42	13	56	38	5	43	57	-	52	35	13	54	38	8

In Table 5.15 responses to the policy advocacy related questions from the Perceptions Checklist data is recorded by origin of respondent. One of the attributes often assigned to people who choose to work in the voluntary sector is the strong commitment they feel to the issue or client group with which they are working. The opportunity to progress their work - which the flexibility of the sector affords them - is often said to be recompense for the lower rates of pay available in the sector. So what type of people inhabit the voluntary sector? generally, there were equal numbers agreeing and disagreeing with the proposition that staff working in the sector are keen social reformers. A quarter of the sample did not know. Over 40% of people who had been employed in the voluntary sector disagreed with the assertion, 46% of those who had worked in the health service agreed.

In terms of being good at promoting the work that it does ,there was a clearer positive response to this question overall. Those who had worked in the health service were most likely to agree with the assertion (56%) and service users being least likely to disagree (57%).

5.4 THE IMPACT OF ENHANCED FUNDING ON THE SECTOR

5.4.1 Predicting the future

When respondents in the DHA study were asked to make predictions about the future shape of services the tone of response revealed anxiety and uncertainty. Key concerns revolved around the loss of the 'benevolent' voluntary sector - defined as 'small groups doing invaluable work for little money'. The implications of this as far as

respondents were concerned would be the loss of the qualities which bring the sector closer to the meeting of consumer need. In other words, the capacity of the sector to offer participative, responsive and different services would be expected to decline or to be lost altogether.

Respondents from the voluntary sector were clearer about the future role of co-ordinating agencies in the sector such as the Councils for Voluntary Service than they were about their own agencies. They predicted that co-ordination bodies would have a vital role to play in terms of resource co-ordination, advice, reducing competition, and providing information and support.

5.4.2 Problem areas for organisations

Organisations in the locality studies were asked to comment on the major problems confronting then (see Table 5.16). The views expressed suggested that public awareness of their agency and declining support from the statutory sector - as well as the inadequacy of any replacement funding - were the issues which were of most import. However, it was interesting to note that over two-thirds of respondents felt that a lack of clear policy direction from central government was either 'quite' or 'very' important.

Over half of respondents felt that the replacement of grants with contracts was not a major issue for them, although the timing of this survey (1991) probably meant that the move from a grant-based to a contract-based commissioning culture had not really been widely experienced yet. (Also see Bolton et al, 1994, on this point.)

Table 5.16

Major problems facing organisations in Canterbury & Thanet and in Camden.

Problem Areas for Organisations	Not Important	Quite Important	Very Important
Inadequate private funding	37	26	37
Inadequate or declining public sector support.	26	28	46
Increased reliance on fee income.	54	22	24
Increased reliance on sales & business income.	71	11	18
Excessive dependence on the public sector.	44	30	26
Replacement of public sector grants with contracts.	54	19	27
Excessive UK government pressures.	59	26	16
Lack of clear UK government policy direction.	33	36	31
Public sector restrictions on policy advocacy/campaigning.	74	16	10
Pressures from political faction.	88	9	3
Dealing with the European Community.	87	5	8
Competition from private (for profit) businesses.	46	34	20
Limited public awareness of the organisation.	10	40	50
Ethical issues in fundraising.	67	24	9
Other ethical issues.	68	24	8
Political instability.	70	17	12

Table 5.17
Major problems confronting voluntary organisations in the welfare field in relation to staff in canterbury and Thanet and Camden.

What are the major problems confronting your organisation in relation to staff?	Not Important	Quite Important	Very Important
Difficulties recruiting staff with appropriate skills.	46	30	14
Low salaries and benefits.	49	31	20
Excessive professionalisation of staff.	85	9	6
Inadequate resources for training.	45	30	25
Difficulties in supporting front-line staff.	51	30	19
Difficulties in attracting volunteers.	48	23	29
Difficulties managing volunteers.	52	31	17

Table 5.17 shows responses to personnel-related questions in the locality studies. Over half of the sample felt that the inadequacy of resources for staff training was important. These infrastructural issues arose time and again in interviews with key personnel in the sector and have been raised by others, for example Russell et al (1996) and Osborne (1996). These views are likely to reflect the anxieties of people who are being asked to cope with a health and welfare system based on radically new principles.

Almost two-thirds of the sample said that difficulties in attracting

volunteers was an issue for them. Eighty-five per cent of respondents said that excessive professionalisation of staff was not a problem for their agency which probably reflects the small size of many of these local bodies as much as a different operational philosophy.

The work of Lipsky and Smith (1990) on organisational type and associated success in the contract culture in the US. Scrutiny of the effect of contracting in the US facilitated the design of a questionnaire which directed voluntary organisations to think about the future (see Appendix F). Organisations were asked to respond to a range of questions about the effects of contracting. The range and number of organisations provided the opportunity to look for an association between organisational size (measured in terms of catchment area, number of staff and total income) and responses to this range of issues. The results below are based on responses from 85 organisations in locality studies in Canterbury and Camden. Table 5.18 documents the mean response by population to issues and Table 5.19 displays this more graphically in terms of agreement ambivalence and disagreement. Table 5.20 displays the same data but utilises pictures to demonstrate the connection between size of organisation and level of agreement with questions.

Table 5.18 demonstrates the lack of deviation from the mean in most cases. Organisations seemed to respond in similar ways to a range of questions regardless of their size, with the exception of the question about dependence on government money. The statistical significance of the relationship between different characteristics and response was assessed with a chi-square test. Income was found to be a significant variable in responses to three of the questions - those about adequate

funding levels, the diversion of money away from client care to administer contracts and the similarity to for-profit agencies. Number of staff was significant for two questions - assessing the advantages and disadvantages of public sector support and predictions about how easy the next few years would be. Client group was also a significant variable for this question as it was for questions related to mission and diversion of energies away from client care and for the question about the ability of minority groups to survive.

It is perhaps easier to see where diversity occurs in Table 5.20. For example, the question about distortion of mission shows litle disagreement in comparison to the question about how closely organisations resemble for-profit organisations where answers demonstrate more of a spread. Table 5.19 demonstrates the issues around which there are the strongest feelings eg. the insufficiency of funds for community care and whether voluntary organisations closely resemble bureaucratic and unresponsive government agencies.

In the locality surveys one of the questions which a range of organisations responded to was about the ability of services for minority groups to survive in the contract culture. Organisations of all sizes and descriptions were unanimous in agreeing (mildly) that they would find it difficult. Larger groups tended to agree with this more (Table 5.18 and Table 5.19).

What is the impact of increased service specification on output heterogeneity? Concerns about the negative effects of increased service specification on responsiveness and choice were voiced in interviews. For example regulatory practices aimed at

setting certain standards may alter flexible regimes and formalise what was previously somwhat spontaneous activity. Examples are fire doors and flame retardant/waterproof furniture, which may give an institutional rather than a homely feel to the care setting, and the formalisation of relationships with clients through mechanisms for consultation, care programmes, and structured activities which might separate the carer from the user.

It has been argued that the participative benefits of small organisations may quickly evaporate if they grow (Brenton, 1978; Rowe,1978; Mellor, 1985). Large size brings with it the need for formalised systems of governance, and many of the original participative benefits may quickly evaporate The very existence of public support, therefore, may immediately introduce a centrifugal force which pulls 'helper' and 'helped' apart, thus changing, marginally or fundamentally, the nature of the organisation. Statutory demands to monitor clients in the Home from Hospital Service have the potential to seriously affect the special relationship which a volunteer forms with the client. This relationship is a one -to-one interaction based on trust and is confidential unless the client wishes for information to be passed on. A volunteer helper is severely compromised if asked to break this confidence.

It is argued that the greatest danger of public funding is that policy advocacy groups cease to be independent of government. Writing in the early 1980s, Kramer (1979, 1981) could find no evidence to suggest that governments pull the rug out from underneath embarrassing or irritating policy advocacy groups in the voluntary sector. Nor did his study bear out the familiar concern that the

administrative burdens generated by the requirements of fund-raising and accountability to government divert voluntary bodies from what they do best. Johnson (1981) and Brenton (1985) however, reached the opposite conclusion. This trend accorded with responses to questions about policy advocacy which were asked of a wider range of voluntary sector personnel in the two locality surveys: 74% said this was not a problem for their agency. This seems to support Kramer's findings (see Table 5.16).

Table 5.18

Opinions of voluntary agencies on a number of issues related to changing role of the sector. Mean responses (rounded) of entire population and selected sub-populations.

	ENTIRE POPUL-ATION	CLIENT GROUP SERVED			CATCHMENT AREA			NUMBER OF STAFF			TOTAL INCOME		
		LD	MH	MH+LD	Neigh' hood	District	Regio-nal	Very Small	Medium	Large	Small	Medium	Large
A 'market based' approach to social care is the most effective way of achieving society's aims.	1	1	1	1	-1	-1	-1	-1	-1	-1	-1	-1	-1
The Government has not provided sufficient resources to implement its community care policies.	2	2	2	2	2	2	2	2	2	1	2	2	2
The public sector provides adequate funding for voluntary organisations.	-2	-2	-2	-1	-2	-1	-1	-2	-1	-1	-1	-1	-1
The public sector makes adequate provision to involve voluntary organisations in its policy formation and review.	-1	-1	-2	-1	-1	-1	0	0	-1	-1	0	-1	-1
The replacement of grants by contracts undermines the autonomy of voluntary organisations.	1	0	1	1	1	1	0	0	1	1	0	1	0
Administering contracts diverts resources away from care activities.	1	1	1	1	1	1	0	1	1	1	1	1	0

Key: Strongly disagree -2 Mildly disagree -1 Neither agree or disagree 0 Mildly agree 1 Strongly agree 2

Table 5.18 (continued)

	ENTIRE POPUL-ATION	CLIENT GROUP SERVED			CATCHMENT AREA			NUMBER OF STAFF			TOTAL INCOME		
		LD	MH	MH+LD	Neigh' hood	District	Regio-nal	Very Small	Medium	Large	Small	Medium	Large
On balance, the advantages of public sector support outweigh the disadvantages.	1	1	1	1	1	1	0	1	0	1	1	1	1
The public sector often views organisations like ours with suspicion and distrust.	0	1	0	0	0	0	0	0	0	0	0	0	1
Our organisation has become too dependent on government money.	-1	-2	0	-1	-1	0	-2	-1	0	0	-1	0	0
Our organisation is concentrating too much on service delivery and too little on advocacy/campaigning.	0	0	0	0	0	0	-1	-1	0	0	0	-1	0
Increases in fees and charges have strained our organisation's ability to target priority needs.	0	0	-1	1	0	0	-1	-1	1	0	0	0	0
In recent years, we have had to devote a much larger share of our resources to fundraising.	0	-1	-1	-1	0	0	0	0	1	0	0	0	0

Key: Strongly disagree -2 Mildly disagree -1 Neither agree or disagree 0 Mildly agree 1 Strongly agree 2

Table 5.18 (continued)

	ENTIRE POPUL-ATION	CLIENT GROUP SERVED			CATCHMENT AREA			NUMBER OF STAFF			TOTAL INCOME		
		LD	MH	MH+LD	Neigh' hood	District	Regio-nal	Very Small	Medium	Large	Small	Medium	Large
Our organisation is increasingly being called on to accept additional tasks shifted to us from the public sector.	1	1	1	1	1	1	0	1	1	1	1	1	1
Organisations like ours are really as bureaucratic and unresponsive as government.	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-1	-2	-1
We are increasingly becoming more like a (for-profit) business enterprise.	0	0	-1	0	-1	-1	-1	-2	-1	0	0	-1	1
Receipt of government funds has distorted our organisation's purpose.	-1	-1	-2	-2	-1	-2	-2	-1	-1	-2	-2	-1	-1
Local grassroots support has decreased in recent years.	0	0	0	0	0	0	0	-1	0	0	0	0	0
The next two years promise to be much easier for our organisation compared to the last two years.	-1	-1	-1	-1	0	-1	-1	0	-1	-1	-1	-1	-1
Services for minority groups will find it hard to survive in the contract culture.	1	1	1	0	1	1	1	0	1	1	0	1	1

Key: Strongly disagree -2; Mildly disagree -1; Neither agree or disagree 0; Mildly agree 1; Strongly agree 2

Table 5.19

Mean responses to questions about voluntary sector issues.

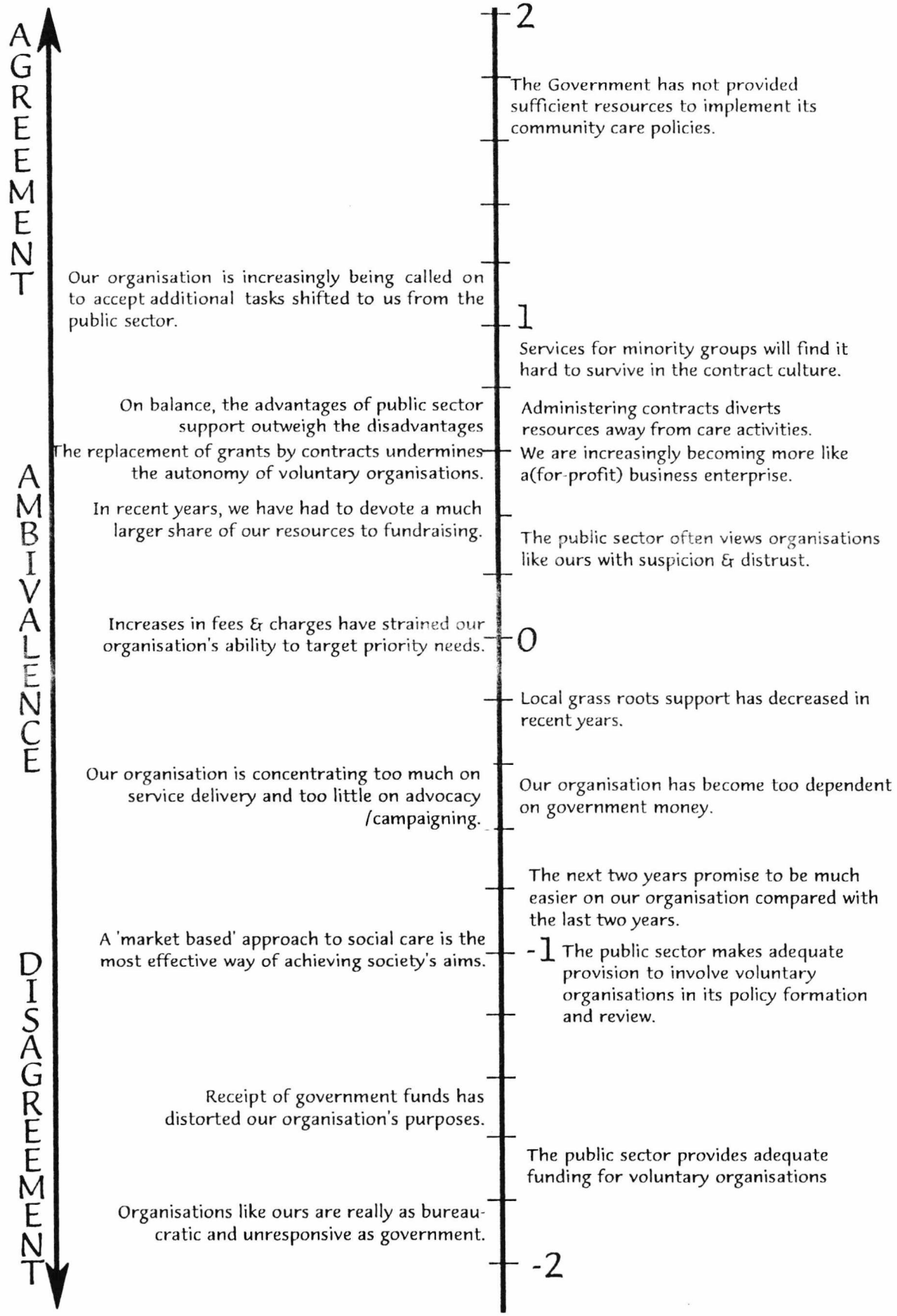


Table 5.20

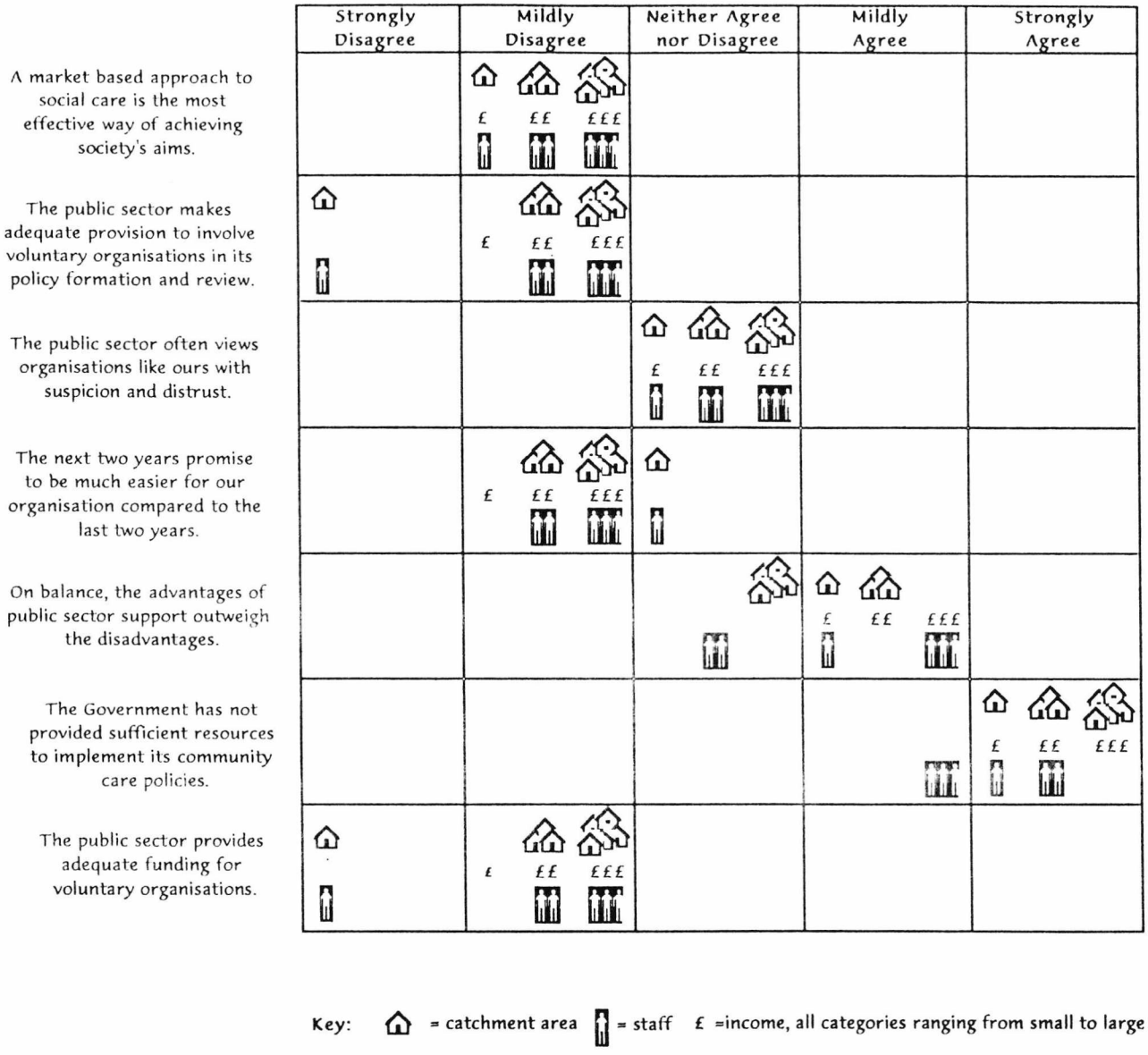
Responses to a range of voluntary sector issues by size of organisation.

	Strongly Disagree	Mildly Disagree	Neither Agree nor Disagree	Mildly Agree	Strongly Agree
The replacement of grants by contracts undermines the autonomy of voluntary organisations			Catchment: large; Income: £, £££; Staff: small	Catchment: small, medium; Income: ££; Staff: medium, large	
Administering contracts diverts resources away from care activities			Catchment: large; Income: £££	Catchment: small, medium; Income: £, ££; Staff: small, medium, large	
Our organisation has become too dependent on government money	Catchment: large	Catchment: small; Income: £; Staff: small	Catchment: medium; Income: ££, £££; Staff: medium, large		
Our organisation is concentrating too much on service delivery and too little on advocacy/campaigning.		Catchment: large; Income: ££; Staff: small	Catchment: small, medium; Income: £, £££; Staff: medium, large		
Organisations like ours are really as bureaucratic and unresponsive as government.	Catchment: small, medium, large; Income: ££; Staff: small, medium, large	Income: £, £££			
Services for minority groups will find it hard to survive in the contract culture.			Income: £; Staff: small	Catchment: small, medium, large; Income: ££, £££; Staff: medium, large	
Increases in fees and charges have strained our organisation's ability to target priority needs		Catchment: large; Staff: small	Catchment: small, medium; Income: £, ££, £££; Staff: large	Staff: medium	
In recent years, we have had to devote a much larger share of our resources to fundraising.			Catchment: small, medium, large; Income: £, ££, £££; Staff: small, large	Staff: medium	
Our organisation is increasingly being called on to accept additional tasks shifted to us from the public sector.			Catchment: large	Catchment: small, medium; Income: £, ££, £££; Staff: small, medium, large	
Receipt of government funds has distorted our organisation's purpose.	Catchment: medium, large; Income: £; Staff: large	Catchment: small; Income: ££, £££; Staff: small, medium			
We are increasingly becoming more like a (for-profit) business enterprise.	Staff: small	Catchment: small, medium, large; Income: ££; Staff: medium	Income: £; Staff: large	Income: £££	
Local grass roots support has decreased in recent years.		Income: £	Catchment: small, medium, large; Income: ££, £££; Staff: small, medium, large		

Key: ⌂ = catchment area; staff icon = staff; £ = income, all categories ranging from small to large

Table 5.20 (continued)

Responses to a range of voluntary sector issues by size of organisation.



Key: = catchment area = staff £ =income, all categories ranging from small to large

5.4.3 Organisational changes

The data collection in the DHA and locality studies was conducted at a time of impending upheaval for many orgnisations. It was therefore interesting to consider in what ways organisations had changed.

A sub sample of the twelve major service providers in the DHA study were examined for signs of organisational change. Table 5.13 shows how ten had renewed their mission or their priorities and installed new accounting systems. Three-quarters had changed their image and half had used the services of management consultants or installed management information systems.The most important changes for agencies were cited as: - expansion, change in ethos, and the negative effects of growth, although these were not specified.

When asked to comment on the most important issues discussed by their management group, the following were cited in order of priority: whether to grow, restructuring, changing ethos, domestic issues, becoming a company, the reforms, management agreements, then effects of statutory pressure.

Current problems facing organisations were identified as resources, distortion of role/aims, burden of accountability/administration requirements, long-term future/role

5.4.4 Views about the reforms.

Organisations were asked what the reforms in health and social care meant to them. Inevitably responses were varied and therefore hard to categorise. It is interesting to note, however, that they were on the

whole positive in nature and those most frequently cited were:

* An opportunity for the sector to at last be taken seriously
* It will force the sector to change, sharpen up and professionalise
* We feel a threat from the private sector
* It is no different form the direction we are going in already
* It will be hard for us to retain our ethos
* The local authority will suffer because it is not up to the task and is reluctant to assume it
* More burden - no extra cash
* We need to restructure/adapt to retain our attributes.

5.4.5 The impact on characteristics of agencies.

Agencies were asked to comment on the ways in which enhanced funding was impacting on the shape of their organisations and the work that they did. In terms of funding, respondents identified a range of advantages and disadvantages of different routes.

The majority of the larger service providers received most of their funding from contracting, government grants and benefits. Others worked hard at extending income by pursuing one-off grants from trusts and charities, but most emphasised the disproportionate effort involved compared to the benefits gained. Chapter 6 considers these issues in more depth.

Table 5.21

ADVANTAGES/DISADVANTAGES OF DIFFERENT FUNDING SOURCES AS SPECIFIED IN INTERVIEWS WITH THE VOLUNTARY SECTOR

Advantages	Disadvantages
Preference is for diversity of funders so that all eggs are not in one basket. More money from one source at least allows you to know what your budget is. Voluntary funding allows you complete freedom, no strings/conditions but never sure how much.	Will the statutory sector fund according to need? Different pay and conditions in the different sectors is problematic for assessing levels of funding. Experience has shown that amounts to cover inflation are always insufficient. Will LA's be adequately resourced? If not there will be implications for VS. Money may only be available for client groups with most need, therefore in order to be funded an organisation may have to expand its service areas. The private sector is a particular challenge to housing associations, high interest rates push up the cost of HA accommodation because of repayment of mortgages. DSS income is not inflation-proofed. Monitoring can be intrusive and often the goal posts are suddenly removed. Poison chalice/double-edged sword. Never know when money will run out. Charges are a pain. You have to become more commercial than LA or NHS to pay your way and need to budget to occupancy. Grants are difficult because LA levels of inflation are different and it is problematic to get additional monies. Charging system is different.

Table 5.22

Degree of influence exerted on decision making by external factors in sample of organisations.

Factor	Mean Value Scored
Mission/trad	1.9
Desire to pioneer	1.9
Statutory influence	1.6
Policy statements	1.5
Lead from executive	1.4
New research	0.9
What will attract financial support	0.9

n = 11

Mean Value scored

2 = Major, 1 = Minor, 0 = No influence

Agencies were asked to consider which factors most influenced policy decisions (see Table 5.22). Perhaps surprisingly 'what will attract financial support' was only classed as a prime influence by two agencies. Mission/ tradition and the desire to pioneer were still identified as strong influences by most agencies. What was apparent was an awareness of shifting sands and an acknowledgement that factors which had not previously influenced policy decisions were now

creeping onto the agenda. Most agencies had ways of 'getting around' these types of conflicts but there was an acknowledgement that things might not be as easy in the future. When I examined the highest total scores per agency (high = strongest influence), organisations which were most responsive to external pressures also shared many of the characteristics identified by Lipsky & Smith (1990) in their typology of an 'entrepreneurial' agency eg. funding led, highly responsive to needs of government, most revenue from statutory sources.

Table 5.23

The impact of increased dependence on public funding on major characteristics of voluntary organisations

	A lot	To some extent	A little
Service	3	4	1
Staffing	2	5	-
Clientele	2	5	1
Organisational goals	2	2	4
Inter-agency relationships	2	4	2
Total	11	20	8

Agencies were asked to consider a number of aspects of service

provision and whether they were affected by more reliance on statutory funds (see Table 5.23). Type of service and staffing were felt to be most affected, and clientele and inter-agency working were felt to be affected to some extent. The goals of agencies were not unaffected but most agencies felt to a lesser extent than other aspects of their organisations. Those who felt under most pressure were agencies which were furthest away in nature from Lipsky & Smith's 'entrepreneurial' description; those closest to the community-based/ mutual aid category. Having said this, most agencies talked of resisting the pressures and the importance of developing strategies which would enable them to reap the benefits of more secure funding whilst avoiding the penalties in terms of changed ethos. An important outcome is no doubt to emphasise the fact that for many organisations, particularly those thathave expanded rapidly in the last few years, responsiveness to external pressure and the resultant effects on aspects of service design and delivery are not construed as a bad thing, indeed the opposite. And even for those organisations which were feeling under pressure there was a sense in which they are dealing constructively with this by reviewing their central aims and future direction.

5.5 CONCLUDING REMARKS

The aim of this chapter has been to synthesise a range of views (practice, lay and user) about the previously suggested rationales for public support of the voluntary sector and to present evidence about; a) the performance of voluntary organisations in respect of these attributes and: b) the predicted outcomes of enhanced public funding which theory suggests.

Earlier in section 5.1.1. I posed a number of questions, the answers to which lie within the data presented here. Chapter 6 presents further evidence in respect of the voluntary sector and finance which particularly helps to address question 4 of this study. Before I move on to address the funding issues, however, I revisit these earlier questions to re-emphasise what the data has enabled me to uncover.

When considering the voluntary sector one cannot escape the fact that it embraces diversity both in organisational form and activity/function. Is this particular characteristic of the sector a hindrance or a help in the changing funding environment?

The treatment preference thesis appeared to be supported in this study particularly by mental health service users who valued the 'alternative nature' of services provided by the voluntary sector. The responsiveness of services (as perceived by both clients and representatives of the statutory sector) was particularly prized. The sector did offer specialised services which were not on offer elewhere. Concerns about whether this 'distictiveness' would be compromised in a changing funding environment were frequently expressed but at the time of data collection no firm evidence emerged to support concerns about loss of service diversity.

Other qualities prized about the voluntary sector included its role in advocating on behalf of clients, and it's ability to circumvent 'red tape', in other words it's capacity for flexibility - although this particular rationale for funding proved impossible to validate in practice.

In terms of predicting what type of clients are more likely to be cared for by the voluntary sector, data on community mental health care from the TAPS study found that the sectors were accommodating people with some differences in needs and dependency profiles. In particular the voluntary sector was more likely to care for younger clients with longer histories of mental ill health than the private sector. These clients were also generally more dependent than private sector residents but not as dependent as those cared for by the NHS.

The cost of care provided by the voluntary sector was lower than statutory care but higher than private sector care. The low private sector costs were, however, associated with poorer quality outcomes. In comparison to the other provider sectors, therefore, the voluntary sector whether singly or in consortium arrangements, appeared to perform well by the quality and user outcome criteria, but was often more costly.

In many ways the 'voluntary sector' which this thesis has been examining shares much with the part of the sector represented in the Care in the Community Programme. Certainly the functions and activities performed by both for people with long-term care needs are similar. There are some important differences however. Agencies involved in the demonstration programme were more likely to be receiving unconditional monies. In the period since the 1990 Act there have been many changes, not only the gradual replacement of social security payments for care (demand side subsidies) by contracts (supply-side subsidies), but also marked growth in public sector contracting-out of provision to the private and voluntary sectors, the increasing formalisation of the financial links between

public and other sectors, greater competition for public sector contracts and heightened awareness of what this might imply for all parties.

One of the consequences of these changing financial links is a concomitant worsening of relationships betwen the sectors which manifests itself - in part - in the lessening of 'goodwill trust'"outlined by people in this study and elsewhere.

As the data suggests the changing financial base of the sector impacts not only on what the sector does and how it does it but also on how it is viewed. The next chapter examines in detail how the sector is financed and how this has chaged over time. The data presented here and in the next chapter will then be drawn upon in the final chapter to consider in detail the consequences of public funding of the sector and what policy lessons can be drawn from this study.

CHAPTER 6

FINANCING

6.1 INTRODUCTION

In chapter 5 I examined the assumptions and expectations agencies held about themselves and each other (research questions 1 and 2) and I also examined evidence to substantiate or refute these beliefs (research question 3). Chapter 7 looks in detail at the consequences of public funding of the sector (research question 5) and this chapter looks at the level and nature of public funding (research question 4).

When trying to explicate the influence that some of the beliefs and rationalisations had on funding decisions the centrality of finance soon became apparent. For example, a service distinctive because it aims to take "those in most need" will be more costly because it is more likely to have referrals for very dependent clients who require one-to-one care. Many of the elements which combine to make it a high quality and specialised service are arguably not amenable to quantification and therefore it might prove difficult to sustain this type of service in a competitive culture which is stressing values other than 'responding to the most needy' - such as cost-effectiveness - and imposing accountability requirements which take carers away from their clients.

Issues to do with funding are therefore high on the agenda of most

contemporary voluntary organisations and the bodies that resource them. Stories about the impact of growing reliance on public sector funding are legion: the Director spending 75% of her time 'running' the contract (Lewis 1996:105); the only paid member of staff spending over 60% of their time meeting the accountability requirements and administration connected with different funding sources (Leat 1996:74); the insecurity felt by staff and users of regularly awaiting news of the outcome of funding applications (Russell et al 1996:405, and Thomason and Mitchell 1997). It is perhaps surprising then, as was suggested in Chapter 5, that when asked which factors most influenced policy decisions "what will attract financial support" was only classed as a prime influence by two agencies (see Chapter 5). The power of beliefs about the voluntary sector (from within and without) perhaps prevent an admission of the prioritisation of aims such as these.

Myths abound about the sector and money. The general consensus is that most voluntary agencies are entirely run on voluntary effort or are at most 'shoestring' operations (see Marshall 1996) which earn a little money from flag days and summer fetes or perhaps from national appeals like Children in Need or Telethon or as beneficiaries of the National Lottery. It is less well known that at least some organisations have incomes of millions and hundreds of paid staff and are receiving a large proportion of their income from government (see previous chapter figs. 5.3 and 5.4).

A range of factors can conspire to impede, thwart or facilitate policy implementation and it is instructive therefore to understand more about the policy environment in which organisations operate and the

impact it has on what they do and their very nature. For example Taylor (1996) argues that many organisations are at one and the same time facing growing need against a background of restricted resources. This two-way pressure is bound to require some readjustment of priorities by agencies involved in provision and where the contradiction lies unacknowledged the picture can become very confused and unclear.

As we saw in chapter 3 a confounding factor is "the voluntary sector" itself, which Marshall (1996) suggests might be better described as four or more voluntary sectors. This he suggests, might help to account 'for its apparent incoherence and lack of clarity' (p52). To recap Marshall examines six sectors of organised action: private, statutory, religious, philanthropic, community and informal. His analysis distinguishes between the sectors by identifying for each sector where the locus of control lies; by what criteria action is allocated to the sector; and what contribution the sector makes to social change.

It is perhaps not surprising that practice responses will be different for different organisations, that some will thrive, some will wither and some will transform. It is important for planners of care for people with long-term care needs to know what impact an enhanced role will have on services. If what we prize most about services for people with learning disabilities disappears then this is not a good policy for clients, although it is perhaps not too perverse to suggest that client needs may be low on the list of priorities compared to financial considerations, as the hospital closure study suggested (see Appendix B).

From the discussion to date I would suggest that a number of factors are emerging about the voluntary sector in general, and about voluntary sector activity in community care in particular, which are worth re-emphasising. First, there is incongruence between what we know and what we think we know about the sector. Second, the sector comprises tremendous diversity of forms and activities. Third, in a dynamic and indeed volatile environment organisations are trying to operationalise their goals. This is the backdrop against which to examine the financing of the voluntary sector.

The links between money and the sector are interesting. Many organisations existed before there was any public funding, but in fact concern about the opportunities and consequences of public funding are not new. Taylor (1996:16) cites Owen's (1964) account of the dramatic impact of conditional funding on the Foundling Hospital in London which was asked to provide services on a nationwide basis and in so doing almost met its demise in the face of overwhelming need.

The complexity of the environment in which policy is enacted means that perhaps the best we can do as far as policy is concerned is to appreciate more where public money or regulation might curb intent or impact on service. Kendall and Knapp (1996) pose the following questions: Are many of the issues faced by organisations today the same as those faced by organisations in the 1980s or is the contract culture significantly different to an operating environment dominated by grants? Will the impact on UK organisations be similar to the (widely evaluated) effect on organisations in the US? What can be learned from both experiences? Or, as Jane Lewis (1996:100) suggests,

is it just too early to tell?

This chapter addresses these and a number of other questions: What is the scale and nature of funding in the voluntary sector and in particular for agencies providing services for people with long-term care needs? How has that funding changed over time? What are the issues for all concerned of different funding routes? What is the relationship between the care that people receive and different funding routes? For example, what weight do funding issues assume compared to other factors like philosophy of care?

In chapter 5 I described the size of agencies in terms of income, staff and coverage, and also summarised the range of perspectives on funding. Before drawing upon these data in this chapter I will first turn to the information sources which can be brought together to provide both national and local pictures of voluntary sector funding.

6.2 THE FUNDING PICTURE

What is known about how the sector is funded? Does a clear picture emerge? Is local government providing a larger proportion of income than central government, for example, and if so is that money in the form of a general grant or a contract for a specific service? Which particular services are attracting the most money? And most particularly for the purpose of this thesis, what is happening to the funding of local welfare organisations providing health and social care for people with long-term care needs?

6.2.1 Information sources

In order to build up a picture of trends in funding it is necessary to draw on a range of work which has looked at funding from a number of perspectives. It is useful here to describe these sources and explain exactly what they can offer in terms of analysis.

Kendall and Knapp (1996) mapped the sector as part of the Johns Hopkins Comparative Non-Profit Sector Project (Salamon and Anheier, 1993). This study was concerned with mapping the sector in 13 countries to assess the relative scale and composition of the sector. The broad figures on the UK offer some interesting baseline information in terms of broad trends in funding and market share. The figures are particularly useful in identifying changes in funding which have accompanied shifts in policy like the encouragement of housing associations in the 1980s and some of the perverse incentives offered by generous board and lodgings payments in the late 1980s resulting in the dramatic growth of independent sector care homes, (private sector homes in particular). Their detailed examination of particular sub-sectors, in particular for the purpose of this thesis, health and social care, is also instructive.

The NCVO's survey of local authority support for the voluntary sector (Bolton et al, 1994) is a useful resource as we try to track and understand the way in which this source of support is changing over time. The donation of individual time in the form of volunteering is a vital resource for many organisations and Knapp et al (1996) have examined the scale of this source of support across the sector. These data will also be drawn upon.

A national overview and, where possible, a glimpse of how the UK sector compares to other countries is interesting. It can help us to appreciate the relative scale of the sector compared to other sectors and as far as this work is concerned the relative nature of public support. However, the national picture is not sensitive enough for an in-depth view of the extent and impact of public support on agencies. A national picture cannot help us to discriminate with any degree of precision between agencies in terms of activity, age or size. It is also in danger of hiding from view much of the very small and localised services which sustain people with long-term care needs. I will therefore be drawing on data from a number of local studies, three of which are associated with the larger Johns Hopkins cross-national study. These are studies of the local voluntary sector in Liverpool (Shore et al 1994, Canterbury and Thanet (French, 1992) and Camden (French and Ring, 1993). Schneider's (1996) work on national and local mental health organisations is also informative. In addition the work of Russell, Scott and Wilding (1996) on a small sample of voluntary organisations in the north of England is most helpful in its analysis of recent trends in support for the sector.

6.2.2 The national picture

Kendall and Knapp's (1996) study of the UK voluntary sector found that health and social care organisations accounted for 20% of all staff employed in the total sector and had an income of 14% of the total sectoral income of £29 billion. Compared with organisations specialising in other activities, health and social care organisations had substantial financial and social links with the public sector.

Organisations received a significant part of their income from grants and contracts and also received substantial support in kind such as for training and accommodation, and via staff secondments. There was also a mutual reliance in terms of membership of committees and planning groups. This was the case for some but not all of the organisations in the DHA study. Social services voluntary organisations in three UK received a total income of £3062 million, 25% of this from government, a third from commercial activity and two-fifths from donations. However the way in which the income of any one group was made up varied considerably. For example, services for people with learning disabilities were reliant for 75% of their income from government, compared with only 5% for pre-school play groups.

Total income for health organisations was £790 million. Income from commercial activities amounted to just over half of the total in this category. Mental health groups were most heavily reliant on public funding at 58%.

From Table 6.1 the significance of the way in which voluntary organisations are funded. is apparent. The table summarises data on local authority expenditure on grants and contracts as a proportion of total expenditure on that client group. We can see that almost 17% of expenditure on the mentally ill was via contracts, with the lion's share going on residential services compared to just over 5% on grants. Services for people with learning disabilities are similar, almost 19% of expenditure going on contracts but less than 1% on grants which suggests greater specification of these services.

Table 6.1

Local authority social services expenditure, England 1990/91: payments ("contracts") and general contributions ("grants") to voluntary organisations by user group and service type.

User group	Expenditure going to voluntary organisations as a percentage of total expenditure on the corresponding user group and/or service type		
	Payments "contracts"		General contributions
	Residential care %	Other services %	All services %
Elderly	2.2	1.0	0.7
Younger physically disabled	40.3	8.0	5.3
Mentally ill	14.1	2.8	5.4
Adults with learning disabilities	16.8	2.1	0.8
Children with learning disabilities	12.8	na	na
Other children	8.9	na	na
All children	na	3.9	1.6
Mixed client group	1.6	1.7	8.4
All user groups	3.5		1.4

Source: Local authority RO3 returns (PSS General Fund Revenue Account, 1990/91) as analysed by Wistow et al. (1994, Tables 3.1-3.3). Cited in Kendall and Knapp (1996:208)

Table 6.2

(a) Operating expenditures and paid employment in social services (subgroup 4 100) 1990

Client group	ICNPO code	Operating expenditure £ million	FTE employment 000s	%
Children and families	4 110	280	16.0	11.1
Elderly	4 120	424	25.8	17.9
Learning disabilities	4 130	93	9.2	6.4
Physical and sensory disabilities	4 140	380	21.9	15.3
Women's groups	4 150	28	0.8	0.6
Carers' groups	4 160	8	0.5	0.3
Pre-school playgroups	4 170	133	50.1	34.9
Youth development	4 180	1,359	6.1	4.3
Multiple client groups	4 190	250	13.0	9.1
Total	4 100	2,955	143.5	100.0

(b) Income in social services (subgroup 4 100), 1990

Client group	Total Operating Income £ million	Income from Govt. %	Private earned income %	Private giving %
Children and families	282	43.6	17.4	39.0
Elderly	476	39.9	50.4	9.7
Learning disabilities	98	73.5	8.2	18.3
Physical and sensory disabilities	399	43.9	20.3	35.8
Women's groups	24	33.3	41.6	25.0
Carers' groups	8	75.0	12.5	12.5
Pre-school playgroups	203	4.9	91.1	3.9
Youth development	1,315	7.9	31.3	60.8
Multiple client groups	257	59.9	11.7	28.8
Total	3,062	27.5	33.1	39.4

Source: Kendall and Knapp (1996: 206)

Using a number of measures to define the scope of the sector, Kendall and Knapp found a number of interesting characteristics of services provided by the social services sub group. As table 6.2 (b) demonstrates, agencies serving clients with learning disabilities receive the highest proportion of their income from government (73.5%). The largest groups in terms of total income are agencies serving the elderly, physical and sensory disabilities, youth development and children and families. Pre-school play-groups employ the most staff and attract most fee income.

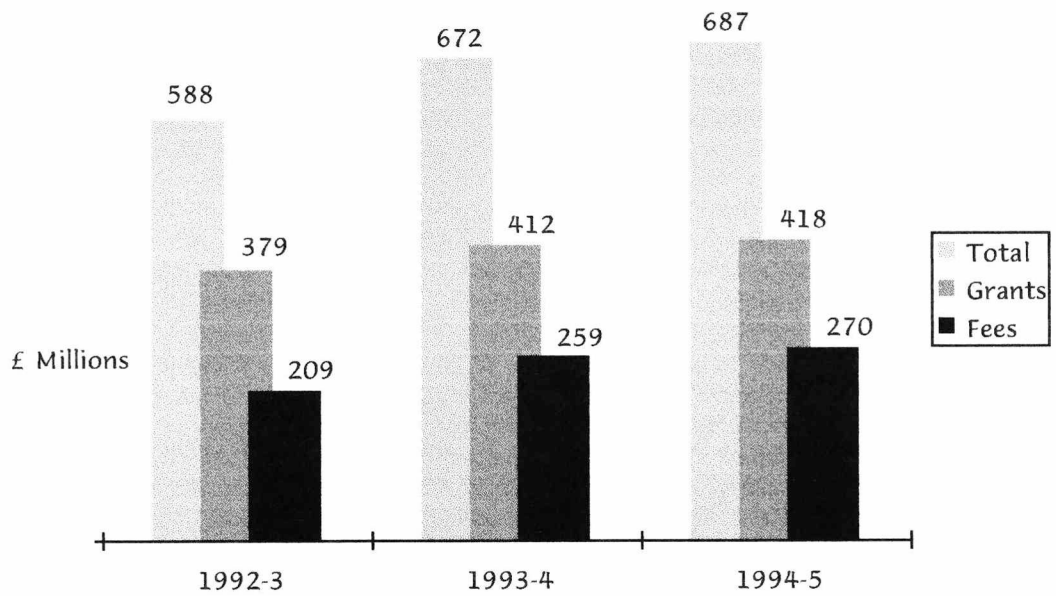
The NCVO (Bolton et al, 1994) in its 1993 local authority funding survey found that the voluntary sector had received increasing proportions of their revenue from local authority sources. If funding to housing associations is excluded then local authority funding of the sector exceeds central government grants. In 1993/4 it was predicted that local authority funding to the sector would be in the order of £687 million - a 14% increase since 1992/93. The global figure which suggests growth masks reductions in the funding of some activities eg. a £7 million drop in education funding.

The increase is attributed to the implementation of the community care reforms and related financial incentives for local authorities to contract with the independent sector. One important incentive came in the form of the Special Transitional Grant, which amounted to £600 million in 1994/5. One condition of receipt of this grant was that 85% of the total had to be spent on independent sector services which was paid to local authorities (and diverted from the social security budget which had formerly supported low-income residents in

private and voluntary sector residential homes).

Figure 6.1

Overall Local Authority Revenue Funding for Voluntary Organisations



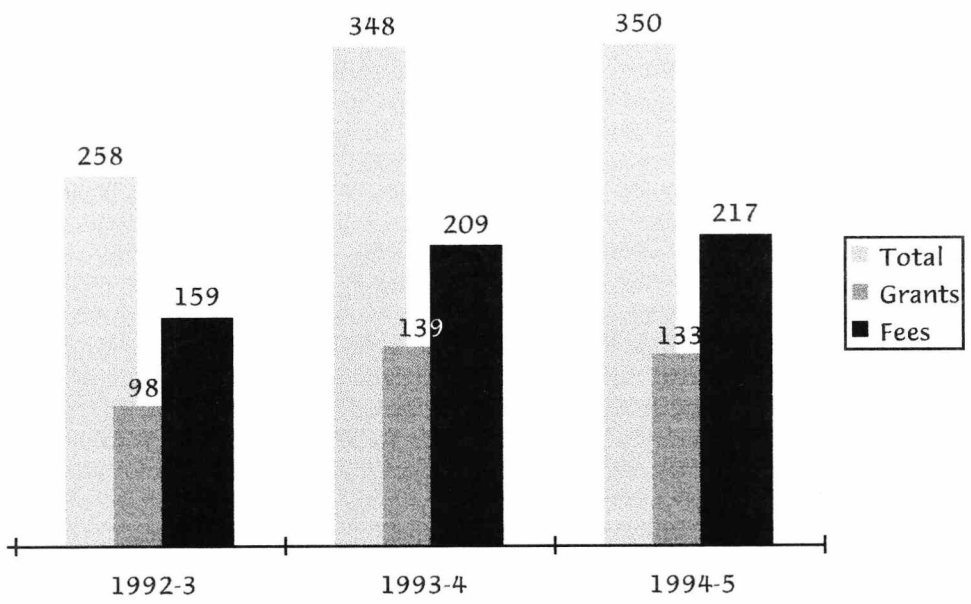
Source Bolton et al (1994:9).

In Figure 6.1 we can see data collected bythe NCVO on overall local authority revenue funding for the voluntary sector. The data suggests that by 1993 this form of support had increased overall, and that generalised grants were still a more popular form of support than fee for service. However if this overall picture is disaggregated, as in Figure 6.2, we can see that funding coming from social service committees showed rather a different trend.

Total support had increased by over a third since 1992/3. But although still comprising the same proportion of total support, in monetary terms generalised grants had not increased at the same rate as contract income, dropping 4% from 1993/94 to 1994/5 compared to an increase of 4% in contract income. Revenue from other sources had declined however.

Figure 6.2

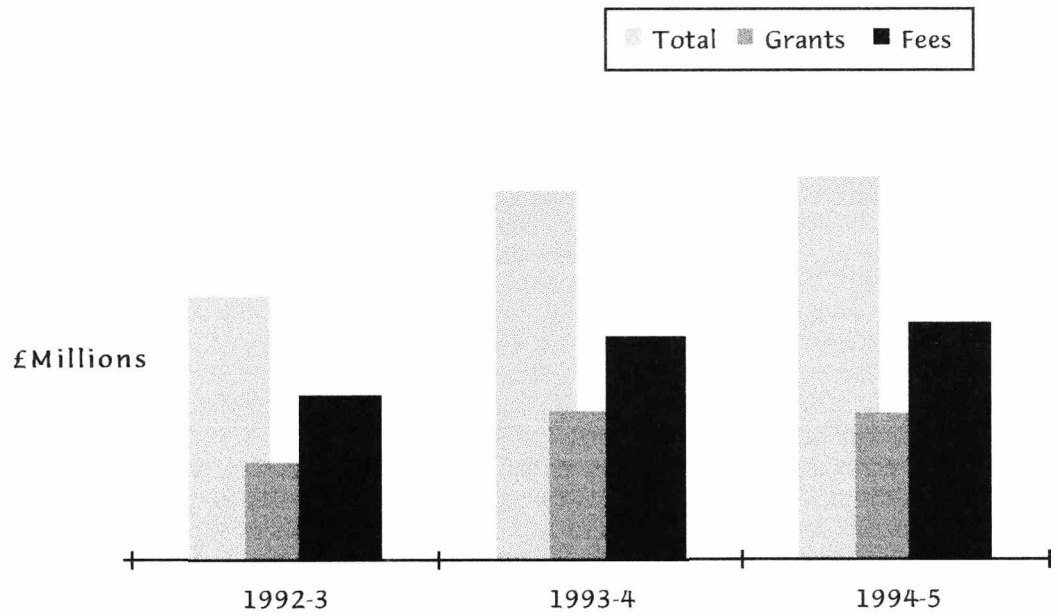
Social Services Committee Revenue Funding for voluntary Organisations



Source Bolton et al (1994:9)

Figure 6.3

Social Services Committee Revenue Funding for Voluntary Organisations providing Community Care Services



Source: Bolton et al. (1994:10)

If we focus particularly on data that can help us to understand what was happening to services for people with long-term care needs, Figure 6.3 shows the money given specifically to the voluntary sector for community care services. Total income had risen as had fee income and there had been a slight decline in grant income between 1993/4 and 1994/5 (over half of the income was fee income which represented by far the highest proportion of any of the revenue from any other committee for any other service).

The figures from the NCVO suggest that although local authority

expenditure on voluntary agencies in the mid-1990s had increased overall, there was variation in how the money was targeted both in terms of services and location. Furthermore some activities had experienced a diminution of funding in real terms.

6.2.3 The local picture

Bringing the level of analysis down to individual organisations, Russell et al (1996) found that the governmental component of income for 17 local organisations grew by on average 40% between 1989 and 1993

Table 6.3

Distribution of income of the sample by source in real terms (£)

Source	1989/90	1990/91	1991/92	1992/93	1993/94
Statutory funding	422,283	601,069	740,437	917,684	1,217,182
Trusts and charities	145,960	183,272	157,378	166,335	210,075
Corporate donations	6,769	3,405	3,347	2,440	10,836
Other donations	81,931	116,731	134,349	139,907	140,526
Bequests	52,376	36,442	69,695	33,875	138,315
Trading income	140,915	136,606	153,051	184,588	177,248
Fundraising events	75,225	84,467	107,092	75,995	71,308
Investments	74,537	81,882	91,709	83,067	83,158
TV appeals	4,808	13,300	900	6,550	3,710
Other income	17,766	17,354	20,232	11,752	37,688

Source: Russell et al (1996:401)

but grew rapidly by 26% in the following year until two-thirds of income was from a statutory source. Their study documents the 5 year funding experiences of seventeen voluntary organisations from three contrasting locations in the North of England. The study also focuses on smaller organisations and ones working in the field of community

care. Overall, the study demonstrates the importance of statutory funding as a proportion of total income for these organisations and how this had increased over time. Statutory funding increased by 145% in real terms overall from 1989/90 to 1993/4 and as a proportion of that total from 41% to 58%. Their study suggested that this was likely to increase by a further 30%, a total of £1.6 million in 1994/5.

In terms of the composition of total income statutory funding was over five times more important than the next income source which was from trusts and charities. Other income sources like fundraising, donative income or money from business or TV appeals like Children in Need were not significant for this group of agencies, which the authors suggest shows the lack of impact after 10 years of these types of ventures even though they are heavily hyped in the media. This finding challenges another myth asociated with the voluntary sector - that TV appeals give substantial funds to 'good causes'.

Statutory funding encompasses a range of different funding sources. The most important source is from local authorities, although it is significant that only 25% of the total increase in funding from this source has come from mainstream budgets. Table 6.3 demonstrates that the contribution from local authorities has remained stable at 40% although this conceals the fluctuating nature of how this input is derived. Russell et al (1996) suggest that organisations in their sample, whilst all experiencing an overall increase in public sector support, fared differentially. Some organisations had experienced consistent dramatic growth over the period studied, whilst others had grown rapidly at some point and then stabilised. This differential

impact could often be explained by one-off grants, provides evidence in support of their finding about the predominance of income from insecure sources.

The figures also demonstrate differences between client groups, services for the elderly growing by 34% whereas services for children and families by only 16%. Such changes in public sector support are manifestations of shifting policy priorities which in itself is a source of insecurity for agencies which are specialising in services for one client group. The NCVO also found differential progress in the funding stakes.

Schneider's (1996) study of national and local mental health organisations, which compared the results of surveys of their income in 1990 and 1994, showed the differences in funding between them. Table 6.4 shows the position in 1990. Whilst the overall income of local organisations increased 'by 80% more than inflation', she argues that their funding profile did not markedly change. Statutory funding grew but it did not change as a proportion of total funding. If disaggregated the fortunes of individual organisations varied dramatically 'from 22% to 1872% of expected income in 1994' (p8).

Schneider reports more striking changes in the national picture. The contribution made by European Union funding increased from 0.2% to 11%. Income generated by the agencies themselves through services and sales doubled to just under a quarter of total income. In contrast donations fell dramatically from just under a quarter to only 1.6% of overall income.

Table 6.4

Voluntary organisations in mental health: Local surveys 1990

Variable	Liverpool n=9	Stafford n=13	Overall n=22
Total mean income	£1,055,794	£13,364	£439,994
Median income	£15,000	£5,044	£5,622
	%	%	%
Central Government Grants	28.8	15.4	28.8
Central Government Contracts	0.3	1	
Local Government Grants	12.9	24.2	29.1
Local Government contracts	16.2	1	
Social security/housing benefit	37.1	2	36.3
Donations from individuals	0.6	22.4	1.0
Donations from foundations/trusts	0.5	6.0	0.6
Donations from companies	0.1	*	0.1
Income from federated funds	*	2	*
Fees for services	*	0.5	*
Sales	2.6	12.0	2.8
Other income - interest, transfer from parent organisations, sale of fixed assets and miscellaneous	1.0	19.5	1.3

*less than 0.05%

Source: Schneider (1996:17)

Statutory income increased overall but its composition changed,

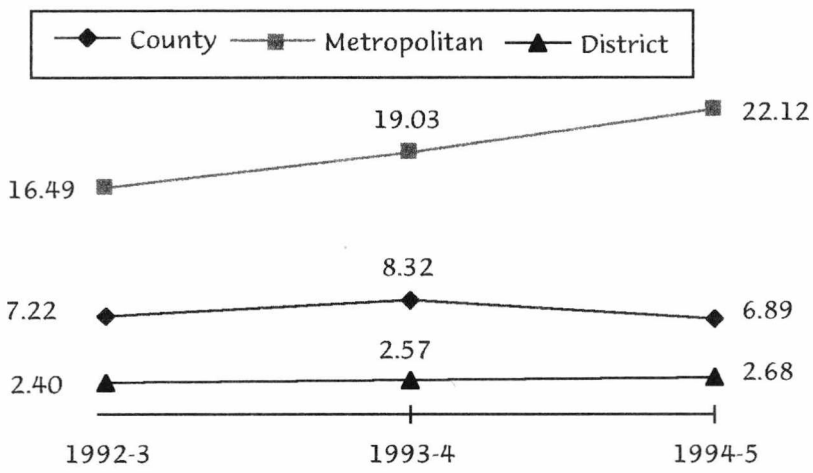
1 Although this category was not used in the Staffordshire survey, we have assumed in this table that 'grants' would include any contract income, and for the overall amount both grants and contracts have been included.

2 Not asked.

money from the centre changing little but grant income from local government increasing three-fold to a fifth of overall income, and contracts showing some development by 1994 at 2.3% of the total from a baseline of 0% in 1990.

Figure 6.4

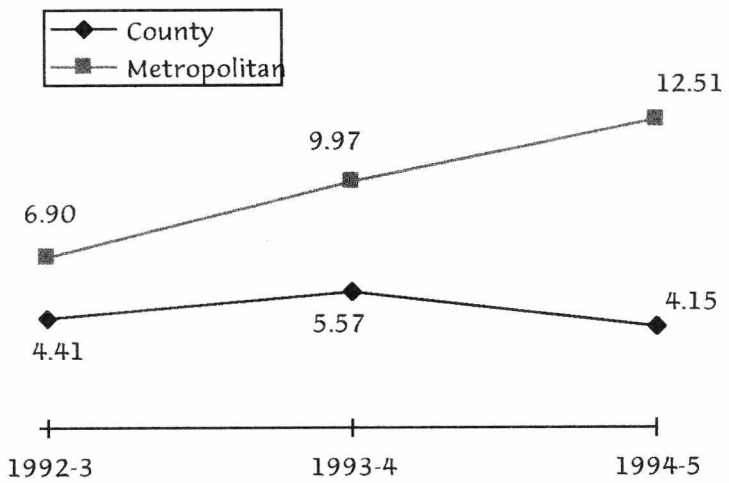
Overall per Capita Revenue Funding of Voluntary Organisations, by type of Authority



The NCVO study shows trends in local authority funding per capita by type of authority (Figure 6.4). Figure 6.5 shows graphically how social services committee funding by metropolitan authorities increased sharply from 1993/4, yet in contrast falls sharply for county authorities.

Figure 6.5

Social Services Committee per Capita Revenue Funding of Voluntary Organisations, by type of Authority



Source Bolton et al. (1994:14)

How do some of the broad trends in sources of income and employment compare with the local picture? Kendall and Knapp (1996) demonstrated that in the health category half of the income is earned (50.7%), a quarter is from private donations (26.3%), and a quarter from government (22%). The pattern for social services is different, a quarter from government, a third earned income and 40% from private giving. In contrast ,education and research receive over 60% of their income from statutory sources.

Table 6.5

Average numbers of staff and volunteers (mean)

Activity/Industry	FT staff	PT staff	FTE staff	Trainee	Management committee	Volunteers
Culture and arts	4.3	2.2	5.4	0.3	6.5	8.2
Recreation	1.5	1.6	2.2	0.1	10.2	11.9
Service clubs	0	0	0	0	9.0	39.0
Primary and Secondary Education	49.0	15.0	60.1	4.0	16.0	0
Other Education	5.0	5.3	7.0	2.5	12.5	14.8
Mental Health	42.1	6.9	45.8	4.4	10.9	6.1
Other health	14.0	31.2	28.8	0.0	12.4	178.5
Social services	12.4	9.9	17.4	6.9	12.9	68.4
Income support	0	0	0	0	6.0	0
Environment	2.3	2.7	4.1	2.0	17.7	6.0
Economic, social and community development	3.2	1.6	4.0	11.5	14.5	13.9
Housing	76.3	38.6	106.5	4.3	13.3	5.7
Employment and training	13.7	2.3	14.7	67.5	6.9	0.8
Civic and advocacy	4.0	0	4.0	0	9.3	110.0
Law and legal services	3.2	0.4	3.4	3.4	12.5	10.4
Philanthropic intermediaries	1.3	1.2	1.7	0.0	7.2	22.5
Business/professional	2.0	0.5	2.3	0.5	4.0	0
Total	10.5	7.0	14.0	7.2	11.4	38.7

Source: Shore et al (1994:121)

In Table 6.5, drawn from the local sectoral study in Liverpool (Shore et al 1994), we see the largest staff complements in housing with a mean of 106 ftes. Agencies providing this service are less likely to employ volunteers. Social services agencies have a high ratio of volunteers to full-time equivalent staff. The "other health" category has the highest mean number of volunteers in the workforce of 178.5. The issue of how to tackle the administrative burden associated with contracting is brought into sharp focus when an agency is dependent on more part-

time staff than full-time staff. Housing organisations have a high proportion of full-time to part-time staff. Does this mean they are more geared up to meet the administrative demands of contracting and will therefore be more likely to attract funds, or is the staffing picture a consequence of coping with the requirements of contracts? Mental health agencies have a high ratio of full-time staff and few volunteers. Is this for continuity for the client, or because it is an unpopular volunteer site?

In terms of activity it was difficult to determine what agencies did. 17% cited social services as their main activity whereas 58% said they were active in this category. For mental health the picture was more blurred, 7.1% saying they were active in the area but only 1.5% citing it as their main activity.

Table 6.6
Sources of income by selected activity/industry for the Liverpool Voluntary Sector

ICPNO Category	Mental Health	Other Health	Social Service
Central Government Grants	28.7	16.6	8.3
Central Government Contracts	0.3	0	13.4
Local Government Grants	12.9	7.4	14.9
Local Government Contracts	16.4	0	36.2
Social Security Housing Benefit	37	11.1	2.1
Fees and charges	0	22.9	6.4
Total Income (£000)	8430	1129	21310

Source: Adapted from Shore. P., et al. The Local Voluntary Sector in Liverpool Table 8.7 (1994:122)

Table 6.6 was compiled using data from the Liverpool locality study (Shore et al., 1994) selecting the areas of activity relevant to this study to further understand how they are resourced. There is significant variation in income source even between those categories of service which focus on at least similar areas of interest. For example, the two largest sources of income for mental health groups are user subsidies and central government grants, whereas for other health projects although central government grants are important, fees and charges provide the most income. Social service agencies receive most of their income from local government contracts, local government grants and central government contracts.

Size in terms of income revealed that almost half of all groups serving mental health users had incomes of under £10,000 whereas almost 60% of social services groups had incomes between £1000-£100,000. Other health groups tended to be neither very poor nor very rich - 60% fell in to the £1000 - £100,000 category which is perhaps surprising considering the large number of volunteers working in this field, which might suggest at least some organisations with incomes of less than £1000.

Russell et al (1996) argue that statutory income has always been the major source of income for agencies in their study but that year on year this income as a percentage of total income has risen, whereas income from trusts and charities has decreased. The overall trend in statutory funding is therefore quite clear but what of its component parts? Which sources have increased and which have diminished?

Table 6.7 shows that local government provides most money but this has dropped more recently by 40%. Money from the urban programme was a third of total income but dropped significantly after 1990. Money from the health authority increased rapidly from 1989/90 to 1990/91 but then levelled to just under 10%. 1994/5 figures show the significance of STG which comprises 26% of total income.

Table 6.7

Statutory funding of the sample of voluntary organisations - 1989/90-1994/95 by source of funding(%)

Source of funding	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95
Local authority budgets	40	46	53	53	52	40
Health authority budgets	3	10	8	11	9	8
Urban Programme	32	19	19	12	6	3
Joint Finance	9	7	4	5	6	6
Opportunities for volunteering	3	2	2	2	4	3
Section II Funding	8	6	5	4	3	2
STG	-	-	-	-	3	26
Other	5	11	9	13	16	12

Source: Russell et al (1996:402)

6.3 THE FUNDING EXPERIENCE OF AGENCIES IN THE DHA STUDY

With hindsight the information which I collected from agencies in the DHA study now seems rather general in comparison to the specific studies of funding cited above. The questions asked of organisations in respect of total income and how this was constituted are appended to this thesis.

I encountered similar problems to my colleagues working in the locality studies extracting even this basic data (Shore et al, 1994, French and Ring, 1993 and French, 1992). Interviewees often had only a vague idea of broad funding patterns because other people dealt with "the finance side of the agency's work." In marked contrast, others had more detail than I thought I needed at the time. Other interviewees directed me to annual accounts or reports or to colleagues in other parts of the organisation. Again in common with my colleagues I found it was often difficult to meaningfully analyse some of the information from these secondary sources because of the various ways in which they were compiled (even within the same organisation, two years' accounts could be compiled under overlapping or completely different headings).

In view of the above, the strictly numerical and source-disaggregated data from this study is not particularly helpful, although some interesting trends are still apparent and I will comment on these. Where the data is especially rich, however, is in respect of the impact on the organisation of different types of funding and the role of finance in the work that the organisation does. Much of this data has

been referred to in the previous chapter but will continue to feature in discussions of what is happening to the sector because it sheds light on the experiences of those providing care.

As Figure 5.4 showed in the previous chapter 39% of agencies in the sample had incomes of £17,000 or under, the majority being under £7,000. Some organisations with incomes over £100,000 (37%) were part of national or international organisations. The study areas differed in terms of the numbers of small medium and large income organisations. For example, of the seven organisations studied in Medway/Swale, only one had an income over £7,000, the majority being self-help groups or principally campaigning organisations. The Warrington and Canterbury sub-samples had a range of organisations with medium incomes. The seven organisations in the Liverpool sample all had incomes over £100,000 although this was often because they were affiliated to regional or nationwide groups.

In three of the areas there were organisations which closely resembled the 'entrepreneurial' agency type outlined by Lipsky and Smith (1990). In terms of the sources of their funding they shared similar experiences. Each received the lion's share of their money from the statutory sector either in terms of mangement fees or third party subsidies. The proportion of income from these sources had shown dramatic growth over the last 3 years (this referred to the late 1980s). Two of the agencies received 90% of their funding from these sources, whereas the other received approximately two-thirds from statutory sources, the other third being trust money. This agency commented on how much work was involved applying for grants from trusts and how because of this it was not worth "putting pen to paper for less

than £12,000" (Director voluntary organisation in Medway/Swale).

What came through most strongly in interviews was the insecure nature of most of this funding. Insecurity manifested itself in a number of ways: - First, money had to be re-applied for on an annual basis: - Second, agencies were often unaware of whether they had been awarded money until close to the end of the contract or even in some cases they were asked to continue with the service on the assurance that the money would be forthcoming. Shore et al (1994) and Russell et al (1996) also report this type of uncertainty for agencies in their studies. In addition this situation also implies some voluntary subsidy of services or at least the organisation's ability to do this. The NCVO study also suggested that agencies who could do this were more likely to be funded: - Third, many interviewees talked about funders moving the goalposts in terms of the type of services they were prioritising, or the level of funding not keeping pace with inflation, or the cost of complying with the accountability requirements of funders which often happened post hoc and were not covered by the fee. Other authors have emphasised many of these points. For example Taylor (1996) refers to the burden of funding an evaluation of service requested by a funder in the middle of a contract and Bolton et al in the NCVO study stress the increasing tendency of funders to specify services within a strictly prioritised list which can leave an agency and their clients exposed if those services are no longer a priority. Holding on to diversity then may also be as much to do with self-preservation as the desire to be responsive.

On reflection, it is interesting that many of the key actors interviewed in this study were unaware of what was meant by many of the funding

categories which I used when talking about finance. There was a marked difference between agencies however, in terms of the focus of the discussion. Those close to the new entrepreneurial classification were more au fait with the full range of funding sources, displaying business acumen in the way they talked about the financial side of their agency. However these same agencies differed in the diversity of funding sources they attracted. Some were dependent purely on statutory sources and did not endeavour to extend their funding base except by taking on new work. Others portrayed a much more proactive approach and attracted multiple funding from sponsors, conference fees, and from Europe. The managers of these agencies were very knowledgeable about a range of sources and a key part of their role was to constantly be on the look out for new money and ways of promoting the agency they managed. One manager described the constant round of bidding which he was involved in. He said he knew that only 1 in 6 of his bids were likely to be successful and therefore that the process had to be an ongoing part of his job.

In Liverpool one interviewee who worked for a co-ordinating body confirmed the trend identified in the practice literature about the availability of money for certain activities when he noted that the money given for community care activities in Liverpool equalled that given for all other activities in the sector. Part of his point was that other parts of the sector were contracting and fading away. He referred to many of these agencies evocatively as the 'bankrupt relics of Victorian philanthropy'.

6.4 POLICY AND PRACTICE ISSUES

In examining the funding of the sector and the way this is changing, a number of policy and practice issues have already been alluded to. Two of these are the increasing targeting of funding as specified in the NCVO survey and the increase in less 'secure' forms of funding such as inner-city partnership monies. Other research has highlighted a range of issues concerning the financing of the voluntary sector. In the concluding section I will examine some of these issues raised by other commentators in the light of the findings from this research.

6.4.1 What is the impact of contracting on the voluntary sector in theory?

In the work on public support for the voluntary sector conducted for the Home office (Knapp, Robertson and Thomason, 1990) my colleagues and I suggested a fivefold categorisation of the impact of contracting on voluntary organisations: bureaucratisation; inappropriate regulation; threats to autonomy; financial insecurity; and the impact on the citizen. Kendall and Knapp (1996) built on this framework and argued that the impact on organisations fall into five main categories; that the structural demands of contracting leads to a formalisation of agency organisation; that demands to regulate providers will interfere with the service provided; that dependence on public support may adversely affect the goals and independence of organisations; that increased funding will paradoxically make the funding base of agencies more insecure (which echoes the findings of Russell et al); and finally that paradoxically, the comparative advantage which is being sought may prove to be eroded by the side effects suggested above.

Russell et al (1996) argue that the picture they paint of the local organisations they studied is overall a successful one in terms of funding. However, they are at pains to add that organisations paid a price for this 'success'. They articulate six continuing financial and administrative problems which affect many of the sample: uncertainty, short-terminism, growth with constraint, transaction costs, competition, and core funding.

Their overall findings are that, although it is difficult to make generalisations in a highly differentiated sector, organisations show an increased dependence on the statutory sector; traditional areas of work appear to have been weakened by new funding priorities; there was some evidence of values being undermined by financial imperatives; that most organisations because of a lack of infrastructure were stretching all of their resources just to keep up and were therefore starting from weak bargaining positions; that there was definite evidence of the erosion of core funding; and that winners and losers were beginning to emerge (p405).

Shore et al (1994) argue that money from local government is most open to policy change. There was an overall decline in this source of income from £5.6 m to £5.2 m from 1983/84 - 1991/92. Grants were cut by £0.56M to £100,000 for the social services category but the impact of this for agencies within this grouping is not uniform. For example, cuts have been more severe for some groups - around community and youth in particular. Delays in notifying people caused a lot of problems for groups in Liverpool, which is reaffirmed in the findings of Russell and colleagues who talk of increased insecurity in the face of increased income. Cuts have impacted less on other groups,

for example those serving mental health users.

6.4.2 Predictors of funding success

Russell and colleagues (1996) argue that there is no clear pattern between their two earlier snap shots (in 1989 and 1993) to give an indication of which types of agencies were more successful in the battle for funding, but that by 1994 a clear distinction was becoming apparent. Organisations for older people seemed to be faring better overall. This they attributed to the impact of the Special Transitional Grant as the twin themes of encouraging the independent sector and making a reality of care in community settings for people with long-term care needs were prioritised. A similar picture was demonstrated in the NCVO study. However, not all organisations who might have attracted funds for these priorities did. As Russell and colleagues argue, some tried and failed, and some did not try at all. In an effort to explain some of the factors which contributed to 'success' in the funding stakes they suggest four factors which they feel are significant (p.404).

First, they argue that the policies and priorities of the statutory sector are influential. An agency is likely to be more successful if it is offering a service which happens to fit the requirements of the purchaser. This suggests that the extent to which voluntary priorities and statutory priorities match may be different depending on the locale you happen to work in. Another way to ensure that there is a match, of course, is to make sure that you are part of the process which determines those priorities or are willing to respond to those priorities. This point connects with the second and third factors identified by Russell and colleagues: the response of the voluntary

agencies themselves and their 'connectedness' in the policy and practice environment.

In terms of response, some decided against expansion and diversification, while some saw it as an opportunity. Some had a very clear notion of priorities and their own role. In terms of connectedness, organisations seemed to do better if their formal and informal networks were well developed. For example, it was helpful if they had membership of professional forums where they could meet influential social and political contacts and where they in turn could be an advocate for their 'cause.' This finding echoed the experience of agencies in the DHA sample. In Warrington, for example, the agency which most resembled the "new entrepreneurial type" was hosting conferences on community care and the reforms as early as 1990. In so doing it was publicising itself and leading the debate in the area. Two years on it had undergone rapid expansion while other agencies were still contemplating how to respond. The same was characteristic of the large agency in Medway/Swale which was convening a planning group on service development for people with learning disabilities.

In the DHA study the influence of voluntary sector entrepreneurs was marked. In two areas they led discussions about care of the client group they worked with because they were leaders in their field and had more expertise than their statutory collaborators. This was often because of their contacts outside the area - involvement in national initiatives, for example, and research which put them at the leading edge of care.

The possibility of race and gender as significant factors in success or

failure in the funding stakes was tentatively raised by Russell and colleagues. They observed that most local authority decision-makers were white middle class men and that their peers in voluntary agencies were women. Reflecting on the process of collaboration, both in the care in the community programme and in this research, I feel this is an interesting thesis for the following reasons; first, much of the networking that I observed took place in local hostelries, after evening meetings. These are not venues or times which necessarily exclude women but may be more difficult for women to take part in because of what is known about the 'double/triple' shift which many women work (Beechey, 1987; Hewitt, 1993). Second, and perhaps more pervasive is the different value base underpinning male and female ways of working which may impede the achievement of shared understanding or a common value base (see Gilligan, 1987 and Gann, 1996).

Finally, the role of perceptions about the sector was highlighted. Russell et al argue that a strong positive perception of the effectiveness, worthiness or competence of an agency will serve it well in the funding stakes even if it is misplaced.

6.4.3 So what motivates public sector support?

The NCVO study sums up the rationale for funding in a nutshell:-

> "The survey results show that local authorities increasingly appreciate that voluntary organisations can make a valuable contribution to policy development and service delivery. However, because of resource constraints and the pressure on authorities to demonstrate value for money, it appears that authorities' increased interest in the collaborative work may be driven primarily by financial considerations." (NCVO, 1994:23)

They found that clearer strategic priorities were being developed by statutory funders which would mean that if the service did not fit those priorities it would be increasingly likely that a service would not be funded even when the service had been "successful" in terms of meeting other goals. This trend poses a significant problem for the funding of innovative work which breaks new ground which presumably is less likely to be on a list of statutory priorities unless the voluntary sector has been able to influence the selection of those priorities in some way.

The attitudinal part of the DHA work did not particularly support the myths associated with the cost-effectiveness advantage (see table 5.11) although health service respondents were more likely to support some of these statements. However it was also clear that there was an expectation that because voluntary organisations had the potential for multiple funding that they were in a position to subsidise contract price, and those that showed such a willingness to pursue multiple sources would be more likely to be funded.

Kendall and Knapp (1996:209) discuss a number of studies which have looked at motivations of funders. They argue that 'it is a complex web of inter-connected political, social and economic factors which explains social service department support for voluntary sector providers.' To support their argument they cite Wistow et al (1994) who found that Conservative-controlled councils in comparison to those controlled by other parties in the early 1990s were more likely to contract out although they found no similar link between politics and grant giving. Judge and Smith (1983) argue that "the beliefs and

prejudices of local decision-makers and the historical experience of different patterns of welfare provision in particular areas" were more important than technical arguments based on specialisation, choice, cost-effectiveness or innovation (quoted in Kendall and Knapp. 1996:209). Knapp (1986) found that relative cost considerations did significantly influence local authority residential child care placements.

Highlighting the different value bases which underpin the sectors and professional training, Challis et al (1988) argued that encouraging the sector was seen by some as a betrayal of Fabian principles. However work by Wistow and colleagues (1996), following up their 1994 book, found a generally favourable view among local authorities to the work of the voluntary sector, commending its specialised services, its flexibility and the distinctive contribution made by the campaigning and advocacy roles.

In the later interviews over half of the respondents expressed a preference for voluntary over private providers. Respondents gave a number of reasons for their preference. These are interesting as some of them are areas of concern which have been expressed by voluntary actors in other studies. The reasons given for a preference were commonality of shared values and ideologies, shared perceptions of social need, mutual trust, the absence of the profit motive, and a strong foundation based on years of close working on planning groups with overlapping governance structures and membership.

This is contradicted by one of the case studies cited by Hadley and Clough (1996) where a Director of a voluntary organisation

articulates that one of the key problems she now faces is lack of trust (where before it was there):

> "It was almost like from April 3rd 1993 or whenever it was, somehow we providers became tainted and if we were going to suggest anything in relation to a person it would obviously be because we wanted to provide the service. So it would suddenly be seen in business terms; we were trying to get the market or the money. Yet on March 31st we had obviously been regarded as talking about our clients in a thoroughly professional, responsible way."(1996:127)

Lack of trust and conflicting value bases have been raised by others (eg Paton, 1996:29-44) and this was a recurring theme in the interviews with key actors in the DHA study and in the work with the British Red Cross (Thomason and Mitchell 1997).

6.4.4 What did the agencies in this study have to say?

In the previous chapter I reported how agencies in the locality studies cited declining public support and the inadequacy of replacement funding as issues which were very important to them. However, at the time of data collection concerns about the impact of contracting were not paramount for agencies. There was indeed a strong feeling that mission and aims would remain intact, no matter what (Table 5.18).

The face-to-face interviews with voluntary sector managers reveal a rather different picture and allow the identification of six key issues which I will summarise here and then take forward to the next chapter when the consequences of growth will be examined in more detail. The **first** issue is **the bidding process** itself and the associated resources which it takes at all stages of the process. The **second** is

funding insufficiency. Examples are: income not being inflation proofed; the inability to bid for more funding if the original bid falls short for any reason (eg. client is more expensive); the imposition of 'average' funding by some purchasers which can cause practical problems for providers when the costs of supporting some clients exceed that level; and the expectation that providers will subsidise deficits, as highlighted by Bolton et al (1994).

Third, there is **uncertainty** about the continuance of funding because of changing priorities, competition from other providers and the climate of resource constraint;. Closely associated with this is insecurity about even the short-term future where decisions over funding are delayed and the uncertainties mentioned above compound the issue. In addition funding sources themselves are more 'insecure' as identified in the NCVO study.

The **last three issues** are all related to the changing value base which the switch from the contract culture has generated. Issues of **trust** and more recently lack of trust were raised as significant barriers to collaborative relationships. **Values issues** seem to lie at the heart of dissonance between the sectors over priorities and between agencies within the sector and within agencies themselves. Finally, **increased competition from new agencies** which may meet statutory requirements more closely than existing organisations and the related issue - that in an environment which stresses specification that which cannot be specified may not attract funding. If we acknowledge that much of the care that sustains people is that which cannot be specified - that which is invisible - then this is problematic. These issues and others are explored in more depth as I examine the

consequences of growth in chapter 7.

CHAPTER 7

CONCLUSIONS: THE CONSEQUENCES OF GROWTH

7.1 INTRODUCTION

The two preceding chapters have examined evidence gathered in the data sources cited in chapter 2, allowing further examination of the questions outlined at the beginning of this thesis. This final concluding chapter has a number of functions; first it addresses the fifth of the research aims outlined in section 1.2 as it focuses on the consequences of the public funding of voluntary agencies. Second, it addresses the final research question drawing out some policy lessons from the findings of this thesis. The chapter closes with reflections on the contribution which this thesis has made to an understanding of the role of the voluntary sector in community care.

7.2 WHAT ARE THE EFFECTS OF PUBLIC SECTOR SUPPORT?

Over the past two decades, voluntary and (especially) private sector provision has expanded considerably, and at the same time has become increasingly reliant on public funding. The two trends are, of course, closely interconnected. Looking over the last decade, voluntary social services organisations in 1990 received 43% of their gross revenue from the public sector (excluding youth organisations), but substantially more just five years later (Kendall and Almond, 1998). Overall, these same

authors point out that employment and operating expenditures for these organisations grew at around 5% per annum. On the health care side, mental health and learning disability have been the most prominent specialties for which the NHS has been willing and able to contract for provision from outside the statutory sector (Raftery et al., 1994), and Department of Health statistics (available on their website) show that the independent sectors' market shares of specialist residential accommodation for all adult client groups grew steadily during the 1990s.

In earlier work (Knapp, Robertson and Thomason, 1987 and 1990; Knapp and Thomason, 1987) my colleagues and I set out hypotheses about the impacts on voluntary organisations of public sector support, particularly the growing scale and proportional importance of that support and its likely formalisation through contracts rather than grants. In summarising the findings of the present study, in the context of other empirical evidence for the UK published since 1990 (especially Lewis, 1993; Taylor and Lewis, 1993; Richardson, 1995; Taylor et al., 1995; and see Kramer, 1993 and 1994, for international comparative evidence), it is helpful to identify five categories of impact (slight varients of those in the earlier work). In looking at these potential consequences, it is also useful to consider some of the findings from the two locality surveys of social services voluntary organisations. The overall impression gained from the responses summarised in Table 7.1 to the questions asked in the postal survey was that organisations in these local voluntary sectors were not facing major difficulties as a result of the community care changes then just beginning to work their way through the system. However, as I mentioned at the end of the previous chapter, face to face interviews with voluntary sector managers in the DHA study revealed concerns around six key areas which I will expand upon in the next section.

7.2.1 Formalisation

The formalisation of funding links took many forms: not just the replacement of grants with contracts, but competition for funds (and the formal structures that competition in the service sector usually requires), imposition of minimum standards, regulation of process, auditing of expenditure and assessment of performance. Generally, whilst none of these demands on providers proved to be as onerous or as distracting as many in the voluntary sector had feared, there was a newly identified (although actually quite long-standing) administrative burden (transaction cost) and also some erosion (as the voluntary sector saw it) of the 'goodwill' trust' that had grown between the voluntary and public sectors over the years (see Table 7.2). Smaller organisations were more likely to describe these impacts (not shown in tables 7.1 and 7.2, but an observable trend in our data), and these are likely to have been the organisations that also had greater difficulty convincing funders of their competence in an enhanced provider role in the developing mixed economy of care. Organisations similar to those described by Lipsky and Smith (1990) as entrepreneurial (see page 3.15) were most likely to be affected by external factors. There was no clear evidence from our sample that formalisation of the kind experienced by voluntary organisations active in the community care field had 'crowded out' donations or other non-statutory income.

7.2.2 Inappropriate regulation

Another common fear in the voluntary sector was that the 'post 1990 Act' funding environment would bring inappropriate regulations, in the sense that purchasers' requirements would create the wrong incentives. But most public sector purchasers seemed well aware of these dangers and, in

TABLE 7.1: PROBLEMS FACING VOLUNTARY SOCIAL SERVICES ORGANISATIONS

Problem areas for organisation	% not important	% quite important	% very important
Inadequate private funding	37	26	37
Inadequate or declining public sector support	26	28	46
Increased reliance on fee income	54	22	24
Increased reliance on sales and business income	71	11	18
Excessive dependence on the public sector	44	30	26
Replacement of grants with contracts	54	19	27
Excessive UK government pressures	59	26	16
Lack of clear UK government policy direction	33	36	31
Public sector restrictions on policy advocacy	74	16	10
Pressures from political factions	88	9	3
Dealing with the EU	87	5	8
Competition from private sector bodies	46	34	20
Limited public awareness of the organisation	10	40	50
Ethical issues in fundraising	67	24	9
Other ethical issues	68	24	8
Political instability	70	17	12
Difficulties recruiting staff with appropriate skills	46	30	14
Low salaries and benefits	49	31	20
Excessive professionalisation of staff	85	9	6
Inadequate resources for training	45	30	25
Difficulties in supporting front-line staff	51	30	19
Difficulties in attracting volunteers	48	23	29
Difficulty in managing volunteers	52	31	17

TABLE 7.2: VOLUNTARY ORGANISATION OPINIONS ON THE CHANGING ROLES OF THE VOLUNTARY SECTOR. MEAN RESPONSES

Statement	User group		
	All	LD	MH
A 'market-based' approach to social care is the most effective way of achieving society's aims.	+1	+1	+1
The government has not provided sufficient resources to implement its community care policies.	+2	+2	+2
The public sector provides adequate funding for voluntary organisations.	-2	-2	-2
The public sector makes adequate provision to involve voluntary organisations in its policy formulation and review.	-1	-1	-2
The replacement of grants by contracts undermines the autonomy of voluntary organisations.	+1	0	+1
Administering contracts diverts resources away from care activities.	+1	+1	+1
Our organisation is increasingly being asked to accept additional tasks shifted to us from the public sector.	+1	+1	+1
Organisations like ours are really as bureaucratic and unresponsive as government.	-2	-2	-2
We are increasingly becoming more like a for-profit business enterprise.	0	0	-1
Receipt of government funds has distorted our organisation's purpose.	-1	-1	-2
Local grassroots support has decreased in recent years.	0	0	0
The next two years promise to be much easier for our organisation compared to the last two years.	-1	-1	-1
Services for minority groups will find it hard to survive in the contract culture.	+1	+1	+1
On balance, the advantages of public sector support outweigh the disadvantages.	+1	+1	+1
The public sector often views organisations like ours with suspicion and distrust.	0	+1	0
Our organisation has become too dependent on government money.	-1	-2	0
Our organisation is concentrating too much on service delivery and too little on advocacy/campaigning.	0	0	0
Increases in fees have strained our organisation's ability to target priority needs.	0	0	-1
In recent years, we have had to devote a much larger share of our resources to fundraising.	0	-1	-1

Key to mean responses: -2 = strongly disagree; -1 = mildly disagree; 0 = neither agree nor disagree; +1 = mildly agree; +2 = strongly agree.

the early years of the decade at least, most also appeared to be prepared to negotiate contractual and other links which did not have (too many) undesired effects. As the decade progressed, purchasers found they had less scope for flexibility although they of course did not want to threaten the very qualities of voluntary sector providers that they had long appreciated (Leat,1995; Wistow et al., 1996; and see below). Nevertheless quite a few voluntary providers had clearly struggled to get themselves onto local authorities' 'preferred provider' lists (or equivalent).

Voluntary sector managers' concerns about public sector demands for specification in the DHA study were also echoed in the work of others (Shore et al 1994; Russell et al, 1996) as well as in the Home from Hospital Service study (Thomason and Mitchell,1997).

7.2.3 Threats to autonomy

An associated danger is the threat to a voluntary organisation's independence and deflection from it's preferred goals; the fear that they become 'alternative, rather than autonomous providers of welfare' (Lewis, 1995:6). Although this was a common concern among the voluntary organisations studied (Table 7.2), in fact it was difficult to find evidence that this actually happened during the research period. Others have cast doubt on this impact over roughly the same period (eg. Richardson, 1995). In view of the increased dependence on statutory funding for that part of the voluntary sector which this thesis has been investigating it appears inconceivable that there has been no impact on autonomy. Again voluntary sector managers in the DHA study alluded to this type of threat. The very clear messages being given regarding the importance of mission (see Table 5.18) are encouraging, however, in respect of staving off this

particular threat.

7.2.4 Financial insecurity

The 1989 Community Care White Paper suggested that 'contracts would give voluntary organisations a sounder financial base and allow them a greater degree of certainty in planning for the future' (Secretaries of State, 1989a, papagraph 3.4.12). Few respondents were as optimistic as the White Paper's authors. A great deal depended on the form, length and contingency specifications of contracts. As subsequent experiences in the broader adult social care context have shown, some purchasers were able and prepared to put in place contracts that were, from the providers perspective, quite *insecure* (Wistow et al.,1996, chapter 5). Spot contracting was more common than block contracting, cost-and-volume contracts were rarely employed, and formal allowance for contingencies (particularly changes in users' needs) was also rare. Too often, it seemed, risks appeared to be carried disproportionately on the provider side of the contractual relationship. Moreover, some voluntary organisations found themselves obliged to cover deficits stemming from low public sector fees from their own resources. Over time, as purchasers grew in confidence, and as providers demonstrated their credentials in the developing mixed economy context, longer term contracts have been put in place. They make it possible for voluntary and private sector providers to make longer-term investments in staff, services and quality of care.

7.2.5 Erosion of comparative advantage

Pulling these various impacts together, a common concern was that voluntary organisations might lose some of their comparative advantages over the public and private sectors. This might not matter unduly except

that the public sector appears to assume some of these qualities in justifying its support for voluntary bodies. If a provider's costs are pushed up by the need to change working practices or to take more dependent users, it may lose its cost-effectiveness advantage. If the regulatory environment is too tight, the provider may lose the autonomy and flexibility prized by many users and purchasers. The heterogeneity that voluntary providers bring to the care 'market' may be compromised by the obligation to offer services which meet the exacting specifications of the contract.

Both of these impacts point to the need for purchasers to be well informed about the characteristics and motivations of the providers it supports, the nature of the services they are purchasing and the impact that arrangements such as non-contingent or highly regulated contracts can have. Although the findings point to some lessening of goodwill trust at the time of data collection there is some evidence - less systematic, more observational in nature - that trust is being rebuilt. In the case of the voluntary organisations I am currently involved with as a volunteer and trustee, some funders at least are displaying this sensitivity.

7.3. THE SCOPE AND NATURE OF THESE CONSEQUENCES

When this work was conceived the framework for the data colllection was shaped by existing knowledge, much of it from countries where the voluntary sector had a larger role. Whilst the heart of this work has been to address the key aims outlined in section 1.2 I have been fortunate enough to be able to draw on a range of data sets which have broadened my brief. In addition, over the lifetime of this study more has become known about the impacts of change. As a consequence throughout this thesis it has been difficult to talk about the voluntary sector without

referring to the impact that growth in public sector funding is having or might have. In fact it is worth noting just how difficult it was to identify some of the consequences of public funding and the changing funding base from the information collected for this thesis because reacting to change was so fundamental to the lives of agencies. Funding and its consequences have therefore been continuing themes in this thesis, raising their heads in some shape or form in most of the chapters. Even at the time of interviewing (in 1991/92) agencies were already effecting change in their organisations or discussing the possible impact that change might have on them (see Chapter 5).

The analysis above uses five categories to examine the effect of enhanced public sector support of the voluntary sector on organisations and the work that they do. I have already established that an important aspect of the voluntary sector is its heterogeneity not just in terms of the many forms it takes but also at times within organisations themselves, for example between national and local areas or between different branches of the same organisation. Differences in the balance between advocacy and service provision are cases in point. Because of the variety which is quintessentially the sector, and also because of the variety within organisations themselves, more can be said about the impacts of funding than has previously been the case by casting a different gaze on these impacts.

For example, the broad brush approach, whilst very useful when talking in general terms about the sector, fails to capture the variation in impacts on organisations. By way of illustration, from the perspective of a voluntary sector paid worker at national level, growth of the organisation may be on the whole a positive thing allowing for longer-term planning,

more training and greater ability to diversify, perhaps even better career chances. However, at the local level it may only be seen as a threat because the only visible impacts, especially in the short term, are negative in terms of additional work and various constraints imposed on existing work patterns by the conditions imposed as an accompaniment to funding.

This was the case for those working in the home-from-hospital service where local staff felt that officers at the centre had little or no understanding of the real issues on the ground. This scenario is not, of course, confined to the voluntary sector but is a feature of many organisations regardless of their sectoral home.

The role of this section then is to further our understanding of the scope of these consequences and where they impact. I would argue that the literature forces us to adopt a rather generalised view of the voluntary sector which stops us thinking of the variety both within the sector and between organisations themselves. Current literature falls down on two levels of generality: it doesn't specifically address impacts at different levels nor does it address care in the community specifically but the voluntary sector at large.

I therefore wish to take the analysis of impacts further by considering the consequences of growth identified in the literature at different levels of analysis; at the sectoral and organisational level; at the level of relationships and services; and perhaps most importantly the impact on people. What are the key issues at each of these levels of analysis generated by a growth in public sector funding? Most people focus on the first level - sectoral level - when discussing the consequences of enhanced

funding and fail to apply analysis any further down the organisational scale. Table 7.3 examines a range of issues generated in the literature which arise from an enhanced role for the sector in community care. For example, the issue of formalisation did not impact at every level but, one could argue, left more of an impression on some levels than others.

7.3.1 What is happening to the sectors?

The market share information introduced in chapter 1 and examined in chapter 6 demonstrates the shifts which have taken place in the relative share that the sectors have in the health and social care fields and the total funding they attract and from which sources.

Commentators have tended to focus on the way in which the sectors have responded to policy change and the availability and imperatives attached to differing funding sources. What are the implications for local authorities, for example, of suddenly becoming enablers rather than providers and for the voluntary sector of a diminution in some sources of funding and increased availability of others? Some commentators have theorised on the impact such changes have on voluntary sector shares of the market. Examples would be, the parallel bars /extension ladder conceptualisation advanced by the Webbs (1912) or the inevitability of the substitution effect in the face of a cost-effectiveness advantage - real or imaginary.

The notion of the blurring of boundaries between the sectors as clear distinctions between what they do diminishes has also been a focus of the literature (see Taylor, 1996 and earlier work, 1991 and 1993). Deakin (1991) and others have also focused on the mythology which has grown

TABLE 7.3 ISSUES GENERATED AT DIFFERENT LEVELS OF ANALYSIS BY AN ENHANCED ROLE FOR THE VOLUNTARY SECTOR IN SERVICE PROVISION FOR PEOPLE WITH LONG-TERM CARE NEEDS

What are the consequences of growth ...	... at sectoral level	... at organi-sational level	... at relation-ship level	... at service level	for people: staff	volunt-eers	clients
Formalisation	*		*		*	*	*
Inappropriate regulation		*		*			*
Financial insecurity		*			*		*
Threat to mission[goals]		*		*	*	*	
Accountability requirements		*			*		
Skills deficits	*	*			*	*	
Value conflict		*	*		*	*	*
Fragmentation			*				*
Differential impact on services for marginal groups				*			*
Transaction costs				*	*		*
Substitutability	*			*			*
Resistance					*		*
Innovative potential curtailed		*			*		*
Threat to autonomy		*					*
Threat to campaigning role		*					*
Issues of trust			*		*		*
Reduced service diversity				*			*
Responsiveness impeded							*

TABLE 7.3 Continued

What are the consequences of growth ...	... at sectoral level	... at organi-sational level	... at relation-ship level	... at service level	for people: staff	volunt-eers	clients
Competition, not collaboration			*		*		
Focus on most 'needy'				*			*
Personal cost to staff					*	*	
Issues of expertise			*		*		
Administrative burden		*			*		
Mythology about sectoral roles	*		*		*		
Blurring of boundaries	*				*		
"Othering"			*		*		
Lack of openness					*		
Devaluing of public service ethos					*	*	
Personal insecurity					*		*
Loss of service distinctiveness							*
Confidentiality	*	*	*	*	*	*	*
Organisational priorities	*	*	*	*	*	*	*
Short termism	*	*	*	*	*		

up around what the sectors do, and the power of those stereotypes has now been widely acknowledged.

7.3 2 What is happening to organisations?

The literature has focused particularly on the administrative burden (transaction cost) placed on agencies of applying for and receiving money and the accountability requirements attached to the receipt of public money.

Administrative burden takes the form of bidding for money and reporting back to funders on performance which involves record keeping and stricter regulation of all activities. This burden is of course potentially magnified where the agency has a multiple funding base. In addition agencies may need to put new and more complex management information systems in place to comply with the requirements of funders. These are costly and staff may not have the skill to use them; eg. a volunteer offering time to help may not wish to learn about computing as this is not where his/her skills are best employed.

Leat (1996) and others have written about the accountability requirements which agencies must fulfil in exchange for public support. Regulation will vary between funders and at different times but it is likely to include requirements to employ 'trained' staff (often reflecting the values and priorities of the state sector), the targeting of specific clients, service evaluations and alterations to facilities to comply with health and safety regulations. Marshall (1996:51) argues that this reflects the statutory sector's focus on legal responsibility. These impacts on organisations are included in what DiMaggio and Powell describe as

'coercive isomorphism' (1983).

7.3.3 What is happening to relationships?

Key relationship issues in the literaure are fragmentation, lack of trust, lack of openness, 'othering' of those who are different from ourselves and the formalisation of that which cannot be formalised. Earlier discussions stressed the crucial nature of collaborative working between agencies and services if good quality care in the community is to occur. A key issue in terms of relationships is therefore the question of whether the inevitable partner of contracting is fragmentation. Where specification of inputs and outputs is the modus operandi then the separation of services seems to occur.

This separation need not be divisive in nature where good working relationships exist, and yet evidence seems to suggest that previously good collaborative working has been affected by the move towards a contract culture. This has been illustrated in this thesis by the evidence from the hospital closure study (appendix B) and the observations of the voluntary sector manager in Chapter 3. The transformation of relationships in Warrington has provided another example of the decline in 'goodwill trust'.

Another key issue as far as relationships are concerned, at both inter- and intra-organisational levels, relates to values. It can be argued that values issues are the key thing which helps us to differentiate between the sectors. On a positive note they are the very things which are responsible for organisations choosing to put clients first, even when prevailing influences do not. For example, many organisations are driven by

principles which over-ride all other issues. L'arche, for example, has as its driving force - to serve the most needy - but principles such as these can leave an organisation open to charges of particularism. Taylor (1996) however, argues that perhaps we should spend less time focusing on the differences between organisations and concentrate on their similarities. An observation from my 18-year association with agencies providing community care for people with long-term care mental health problems or learning disabilities is how similar many of the key actors are, no matter from which sector, in terms of belief patterns, politics and commitment to the client group. Another interesting finding was the call to service based in religious commitment which was a trait I witnessed time and again, but again was not confined to any one sector.

Suspicion about the motives behind research is another bi-product of the move towards a more competitive market and is an example of the dimunition of 'goodwill trust' mentioned by some voluntary sector managers. To some extent there has always been a healthy scepticism about the aims of research, but the atmosphere has become a little less open because the competitive market can mean that contracts are hard to come by and people are unsure how evaluation results will be used.

Different value bases can also act as a barrier to understanding. A good example taken from the HfH service is a request by a funder to quantify the number of admissions prevented by the existence of the home from hospital service. The co-ordinator argued that this was impossible to quantify and also was not a particulary good indicator of the worth of the service. However the lack of quantifiable 'evidence' of effectiveness was used in an argument over whether funding should continue.

7.3.4 What is happening to services?

Many of the factors which commentators have focused on at the sectoral, organisational and relationship levels of course impact upon the shape and nature of services.

As the discussion in Chapter 1 suggests, public sector encouragement of housing associations has had a direct effect on the voluntary sector market share for this activity. Similarly changes in market share can be seen in residential and nursing home care and more recently in community care services. An important factor was funding by the STG with the associated imperative that most of the money must be spent in the independent sector.

The question of whether the availability of funding for particular initiatives diverts an organisation from their central mission is a contentious one. The threat of goal diversion has been theorised by a range of authors and yet Kramer (1987) found no evidence of this and respondents in the locality and DHA studies were adamant that their mission remained intact (although I would suggest that it may be taboo to suggest that your value base is threatened, particulary for agencies in the voluntary sector where values are writ large). However, some agencies did differentiate between some of the services they provided, admitting that some were 'good earners' and others were the 'core' of what they were about.

In other instances, resource considerations dominated the way in which the hospital closure was handled, for example, and shaped the service outcome more than anything else. A major concern in the literature is

about the differential impacts on organisations of different sizes. Deakin (1996) suggests that the transaction costs of contracting will act as an entry gate for smaller organisations, often those providing services for marginalised groups or those who may be politically unpopular.

Responses to direct questions about this in my fieldwork did not suggest that smaller agencies felt particularly under threat or that in general other agencies felt this was of direct concern. However, the trend suggested by the NCVO study (Bolton et al, 1994) of local authorities sharpening up their priorities and only funding in accordance with this preferred provider list has ramifications for the funding of more unusual, innovative or new services and suggests support for the notion of substitutability. The implication of this for service diversity, a key aim of the reform, is clear.

Although funding is increasing it is, as Russell et al (1996:405) argue, increasingly more insecure. They found that this was compounded by the slow decision taking of statutory agencies and the 'eleventh hour' decisions about funds, which meant that agencies were frequently working up to a funding deadline without knowing whether their service would exist tomorrow. Shore et al (1994) and this study uncovered similar experiences in the agencies evaluated. One way of coping with this is to have a multiple funding base with contracts which overlap so that these potential funding gaps are covered. This strategy, although perhaps convenient for statutory funders, carries the attendant problems of the time-consuming nature of the bidding process and related accountability requirements, with their obvious transaction cost consequences.

It is the impact of regulation on services which excites particular

attention in the literature. A particular problem which emerged in the Care in the Community Programme related to practice decisions, seemingly insignificant on their own but in combination transforming the nature of what a service was attempting to provide. Examples were fire-retardant and waterproof furniture, the appearance of which threatened the aim of 'normal living' for a service. Another classic example was the perverse incentives offered by the former board and lodging payments which provided enhanced rates for 'total' care. There was some evidence from the Care in the Community Programme that this encouraged client dependence and that clients could be "de-skilled" by services which provided for all of their care needs when in fact they might have been supported and encouraged to become more independent.

7.3.5 What is happening to people?

This is perhaps the most important of the five levels of analysis. Many people are involved in commissioning, providing and receiving services. Their experiences are interlinked but in many ways different and so I consider them separately here.

(i) Paid Staff

In the Care in the Community programme staffing issues emerged as a crucial dimension of implementing services for people with long-term care needs (Cambridge and Thomason, 1988; Knapp et al,1992). Other authors have also focused on the importance of staff as a key resource in successful reprovision of services (Allen et al, 1988; Stenfert-Kroese and Fleming, 1989).

What emerged from these studies was the stressful nature of caring for

people with long-term care needs, particularly in a context which was under-resourced. In addition, and paradoxically, the areas of the job which were identified as the most stressful were also nominated as the tasks which gave more job satisfaction.

Hadley and Clough (1996:164) highlight the impact on staff of all sectors of the switch to contracts in their series of case studies. They particularly cite the denigration of the public service ethos and the concomitant idealisation of the entrepreneur and argue that people are afraid to voice how they feel about the reforms (hence the rationale for their book).

They identify five factors which they say are conditions for effective professional work in community care. First, that relationships with the user should be needs-led and open and honest; second, that relationships with the organisation should encourage autonomy, accountability, security, continuity and participation; third, that relationships with colleagues should be based on shared values, trust and integrity and collaborative working; fourth, that there should be the possibility of improvement and the potential to influence the wider environment; and finally, personal development should be encouraged by the use of skill and opportunities for development.

As the findings of this study have shown, some of these conditions are things which people have cited as disappearing under the new ways of working, particularly trust and collaboration. There is also evidence that the lack of the necessary skills to operate in the new environment which people are identifying are significant demotivators. Furthermore, they are also likely to impact upon client care. The purchaser who understands the mechanics of the market and is good at balancing budgets may

understand little about the service s/he is purchasing. The impact of this on patient care has been highlighted earlier in terms of the constraints which average non-contingent costing impose. The evidence seems to suggest that at the moment because of the primacy of commitment to the client, voluntary agencies are absorbing this 'cost' but as many key actors reported at interview, they did not know how long they could sustain this type of resistance.

Another consequence of growth for many agencies is that the bigger the organisation the further away from the client those who campaign for their needs become. There are of course mechanisms for ensuring that the client's voice is heard, but in view of the interesting evidence about client involvement and notions of 'participation' which have emerged through this study, the distance from the client is important in the voluntary sector. One Director felt that it was important that he knew all clients and their carers by name and that they could 'drop in for a chat' if they were passing. However, the organisation in which he was working had grown dramatically in a decade from a service serving a small town and outlying districts to one which served the North of England. Clearly then this type of intimacy with his clients is no longer possible.

The presence of welfare entrepreneurs is also an interesting aspect of care for people with long-term care needs, particularly associated with Lipsky and Smith's (1990) new entrepreneurial agency but in fact evident in a range of organisational contexts. This type of provider certainly existed in some of the 27 agencies but was often found in the statutory agencies with which I worked. These were people who 'fixed' services, made things happen, creatively worked with what was there and overcame barriers to change. This entrepreneurialism often manifested itself by people either

'innovating by proxy' if they were based in an organisational environment where it was difficult to host a particular type of service. In these circumstances they might utilise the voluntary sector. More dramatically they would move from sector to sector to effect change. There was also evidence of statutory employees being seconded to stimulate the voluntary sector or to set up not-for-profit agencies to meet the aims of their policy (see the hospital closure case study-appendix B.).

(ii) Volunteer staff

Marshall (1996) argues that the notion that voluntary organisations are predominantly run by volunteer staff has no substance in fact. The figures in Chapters 5 and 6 show that many organisations in health and welfare are substantially underpinned by voluntary effort, although many of the organisations who are direct service providers for people with long-term care needs principally employ a paid workforce for their core tasks.

Volunteerism is also a significant force in health and social care and many services provide vital care for the relatively small outlay of a volunteer co-ordinator with some support. The work that the co-ordinator does for that service is, however, vital and a tip in the balance of what that person does may have far reaching ramifications. For example, in the work with the BRC HfH service one of the co-ordinators explained how crucial her support for the volunteer workforce was. The odd telephone call here, the visit to a volunteer or a friendly ear when they needed it was what helped to retain the volunteer when they were under pressure. A change in the balance of the co-ordinator's role in favour of meeting the information demands of funders means that this vital task is threatened. Currently the way around this is for the co-ordinator to give more of her personal time to enable her to fulfil the demands of support and accountability - this is

evidence of the 'personal costs of caring' identified by Russell et al (1996:407), a transaction cost which is especially costly to employees and might ultimately contribute to staff "burn-out" - a problem already particularly common in community care settings because of the often demanding nature of the personal care task (see Cambridge and Thomason, 1988; Knapp et al,1992; Allen et al, 1988; and Stenfert-Kroese and Fleming, 1989). Respondents in Russell and colleagues study had talked of the 'terrible distraction' associated with funding demands and the fact that you can 'lose sight of what you are here for'.

A second issue, and the most important one facing volunteering at the end of the 1990s according to Justin Davis Smith (1996), is the changing balance between paid and volunteer labour. He argues that the characteristics of volunteers are changing in the face of the contracting paid workforce. Parity between paid and unpaid staff is an issue which he argues needs addressing urgently.

Work with volunteers in the *HfH* scheme reveals the diverse characteristics, motivations and reactions to what they do. For example in our study of volunteer reactions to requests to monitor clients (Thomason and Mitchell, 1997) the range of reactions were almost as interesting as the reactions themselves, with some volunteers seeing the request to monitor as completely unproblematic and others feeling that it was a complete affront to the very essence of what it meant to be a BRC volunteer (a principal value being that of independeence).

(iii) Clients

In the day centre evaluation (see appendix A) the simplicity of what

most clients felt they needed was striking. For these clients the non-medical bias of that service - which looked at them holistically instead of seeing them in a fragmented way - was the vital contribution made by the voluntary sector.

There is some evidence from this study (cutting innovative services) that service diversity will be reduced as a result of the contract culture and this will impact particularly on the types of clients mentioned above. This is partly the result of the primacy of the cost-effectiveness rationale which, after a certain point, is to do with the primacy of cost because the overall problem of resource insufficiency mitigates against high cost services which are associated with high quality outcomes (see Knapp et al, 1997). This is compounded where other sectors have 'creamed off' less dependent clients who are less costly. There is also a very basic point which links what is happening to staff and what is happening to clients. A truism which emerged from a training officer in the Care in the Community programme which I feel has tremendous explanatory power was -"Happy staff, happy clients"- if staff have difficulty operating the system, as the evidence seems to be suggesting, then no matter what the rhetoric says about responsiveness and needs-led care, client care will be affected.

The aim of this section has been to consider the consequences of growth at different levels of organisational operation. An important finding as far as community care organisations are concerned is the potential impact on people. Organisations are made up of people, they provide services to people whose quality of life may be significantly impacted upon because of

an issue which is deemed to be small when it impacts at a higher level of the organisation. An example is the illustration cited earlier from the HfH service where a change in the balance of the co-ordinator's role in favour of meeting the information demands of funders meant that the vital task of co-ordination of volunteers is threatened. Currently the way around this is for the co-ordinator to give more of her personal time to enable her to fulfil the demands of support and accountability but this is recognised as a situation which cannot be sustained in the longer-term.The knock-on effect then is to jeopardise the volunteer base.

This is consistent with other evidence from the study which seems to suggest that at the moment, because of the primacy of commitment to the client, voluntary agencies are absorbing the cost of servicing funders information demands but as many key actors reported at interview, they did not know how long they could sustain this type of resistance.

The centrality of issues such as these to good quality community care are only apparent when looking at the impact of change in this focused way. An examination of what is happening to people, as attempted above, suggests that it is at this level that we need to address the consequences of growth. Other issues central to good community care, such as recognition that a more expensive service is not necessarily less cost-effective, can be addressed by the development of good quality purchaser-provider relationships. The advantage of examining the impacts of change at a number of levels is that it allows us to see clearly at what level problems are occuring. For example, these relationship issues emerge as clear indicators of what needs to be done and at what level of function if care is to be successful. The five conditions for effective professional work in community care cited by Hadley and Clough (1996:164) are useful in

seeking solutions to these problems.

7.4 REVIEWING THE FINDINGS

As I explained in the preface to this thesis the impetus for this work came from my interest in the development of community services as an alternative to long-term hospital care for people with chronic care needs associated with learning disabilities and mental ill health. In chapter 1, I argued that the choice of client groups posed particular challenges for these new services and I was particularly interested in the ways in which a range of agencies would handle these challenges. In the light of some of the interesting innovations I had seen in the voluntary sector, the theme of encouraging an enhanced role for the sector and the positive rhetoric which accompanied the mere mention of the term 'voluntary' in many circles made the choice of subject matter for this thesis timely.

The thesis then has focused in particular on public sector support for voluntary sector activity, the assumptions behind that support and the consequences for agencies , the services they provide and for clients of this support. Before I move on to the policy lessons which can be drawn from this work I revisit these central questions and draw together the key findings.

7.4.1 Assumptions and expectations(questions 1&2)

Central government's views on the contributions of voluntary and private sector providers of community care were set out clearly in the 1989 White Paper, Caring for People, and encapsulated in the 1990 NHS and Community Care Act. The expressed public sector expectations and assumptions which were likely to influence funding

emphasised choice, flexibility and innovation and cost-effectiveness. Although these assumptions were less enthusiastically shared by local and health authorities, they nevertheless ran through many of the observed actions of these other bodies. There were also expressed concerns mirroring Salamon's 'philanthropic failures' (concentrating on particularism, insufficiency and paternalism and amateurism).

Tables 5.8, 5.11, 5.12, 5.14 and 5.15 contain data collected in the DHA study which are helpful as we examine the range of myths about the sector. This attitudinal data supported the premiss that the voluntary sector was more responsive to consumer need. It also supported assumptions about its ability to be flexible although there was less unanimity about aspects of flexibility such as the extent to which it was rule-bound. Concerns about its ability to be responsive gathered during face-to-face interviews eg. 'the sector is too precious to be responsive in a strategic sense' contradict responsiveness claims and echo Salamon's negative rationales (1987).

Cost-effectiveness claims were also supported. The provision of high quality services was seen as a particular strength of the sector. There was less unanimity over whether those services were cheaper and overall the attitudinal data did not support the 'services are cheaper option'. Rather assumptions about the sector's greater expertise and capacity for flexible and high quality services supported the effectiveness claim, whereas the withdrawal of funds from high quality services contradicted this.

The perceptions checklist data gave less conclusive support for other assumptions about the sector's abilities. For example, it was difficult to establish whether the sector was more innovative than other sectors (the

perceptions checklist data was not particularly consistent here - see Table 5.12). And in terms of participation only 50% of respondents agreed with the proposition that it is easier to make one's views known in the voluntary sector, although service users were very positive in their response to this question, 71% agreed, and also 79% agreed that 'it is easier to get involved in the sector', which one might argue is really the measure which counts when looking at how participative a service is. The premiss that voluntary sector staff are motivated by a desire to reform society was another assumption which did not receive unanimous support.

Other data, face to face interviews in the DHA study and the hospital closure study revealed that organisations in the voluntary sector, when evaluating themselves, stressed expertise and ability to allow consumers a voice as key attributes. In contrast, the statutory sector cited ability to support the statutory sector and take the pressure off; advocacy; ability to respond at short notice and interest in non-mainstream services as attributes which they prized about the voluntary sector.

A key finding was that at the time of this research, the early 1990s, there was widespread 'goodwill trust' but not always 'competence trust' (Sako,1992).

7.4.2 Evidence on activities and performance (question 3)

How did the voluntary sector measure up to the assumptions held by public sector bodies?

The voluntary sector appeared to be responsive to consumer needs,

and offered specialised services which were not available to other sectors. Concerns were, however, expressed that choice might be narrowed by the contractual links being introduced to many areas of community care in the early 1990s.

The public sector assumption that the voluntary sector is more flexible and more innovative than other sectors proved impossible to test rigorously, which rather fits with Brodkin and Youngs' assertion that these beliefs may not be 'untestable empirically', but may well be 'empirically irrefutable - that is - not readily vulnerable to data' (1986:50). The attitudinal data relating to this was also variable, supporting some aspects of flexibility (such as responsiveness) but being less clear about how rule-bound the respective sectors were. The range of views suggested some support for Kramer's thesis that assumptions are based on 'invidious organisational stereotypes' (1987:241).

However, there was rich data to 'suggest' flexibility and innovation in both the statutory and voluntary sectors. One such body of evidence was the success of the demonstration projects, where the voluntary sector's ability to cut through inter-agency squabbles was crucially important. The voluntary sector had the capacity to provide the type of service which the statutory sector found difficult to provide at the time, such as round-the-clock care in the community or aspects of ordinary living. These are arguably best provided on a small scale or when you have refined networking abilities - which many voluntary organisations had.

Second, the consumer evaluations also demonstrated how important

flexible services were to the improvement of clinical symptoms. Voluntary agencies were taking the lead in three of the DHA areas and there was evidence about the statutory sector stimulating innovation in the other. Third, the Home form Hospital service illustrated how the voluntary sector can work at the leading edge of care, negotiating often 'thorny' issues at the interface of health and social care.

The cost-effectiveness assumption was examined with data on community mental health care for former long-stay hospital residents. Quality of care was highest in facilities run under consortium arrangements between the NHS and voluntary organisations, and there were also suggestions in the data that user outcomes were better in these facilities. However, costs were also highest under these care arrangements, leaving purchasers with a difficult trade-off between cost and quality.

The perception of potential for choice was supported by all sectors and the statutory sector counted interest in non-mainstream areas as a particular strength of the sector. Data from the North London Reprovision Study found evidence for a specialist role for the sector that may be interpreted as consistent with broadening the range of choice.

In terms of responsiveness to consumer need, the consumer evaluation demonstrated that service users felt involved, whether there was 'hard' evidence of involvement or not (by way of expressed mechanisms). Data collected about the nature of these services seemed to suggest a number of factors to explain this: different ethos, smaller size, variety of needs met, and - especially for mental health clients - services run in ways other than the 'medical model'. These data also support the distinctiveness argument

and in turn support James' treatment preference thesis (1987).

There was no firm evidence about concerns over loss of service diversity but signs that this might happen were provided by emerging evidence of funding cuts to 'effective' organisations, assumptions about particularism and agencies faring differentially in the new funding environment.

In conducting this work one of the most interesting findings and one which I want to argue is key to the future of inter-sectoral relations is how the different sectors view a range of issues. Whilst the perceptions checklist data overall shows little difference in the way respondents from the different sectors view some of the central myths about the voluntary sector and what it can do, some aspects of service provision are viewed quite differently. Some of the difference may be accounted for by the differing environments which organisations inhabit and the differing priorities and pressures people find themselves operating under.

However, a different problem comes from seeing the world through a different lens and the issues which arose around questions about participation were indicative of this. One of the respondents in the hospital closure study hit the nail on the head when he talked about 'beliefs being bred in to them.. *and being* ....so hard to overcome'. These issues, which I have put down to "cognitive dissonance" raised in the collection of work by Cooper et al (1996) amongst others on inter-professional working, are powerful obstacles to collaboration and a significant barrier to effective joint working.

Although many agencies prized their historical basis in mutuality it was clear that three-quarters of them now viewed themselves as service

providers, as did their statutory partners. On all measures they were seen as professional service providers with an ability to stay in touch with their clientele. This gave no support to claims of amateurism sometimes hurled at the sector.

There was evidence that organisations were fierecely guarding their campaigning role, a role viewed as essential by the statutory sector in the attitudinal data. The evidence for that political advocacy role was clear in the influence organisations were wielding by leading services in three of the areas and being influential in policy making and direction. There was a clearer positive response about the voluntary sector being good at promoting the work that it did.

7.4.3 Public sector support (question 4)

In 1990 43% of the revenue received by voluntary social services organisations came from the public sector. For mental health organisations the proportion was 58% and for learning disability organisations 73%. These high percentages grew over the next five years, emphasising the tremendous reliance of voluntary organisations in the community care field on public sources of finance.

7.4.4 The effects of public support (question 5)

Many concerns have been expressed about the impacts of public funding of this magnitude on the voluntary sector. Fears relate to the changes that this funding forces upon voluntary organisations (for example, making them more bureaucratic and pushing up their administrative costs.) There is the danger of loss of autonomy and independence, the erosion of comparative advantage, and paradoxically, perhaps - a greater degree of

financial insecurity. The evidence did not support all of these concerns, although it was clear that the new community care environment posed many new challenges for voluntary agencies which were explicated further by looking at the impacts at different levels of analysis.

7.4.5 Implications

Public sector bodies generally express a great deal of trust for voluntary organisations in the community care field. This trust is based more on 'goodwill' than on established competence. This is not to say that the voluntary sector is a poor provider of care, rather that voluntary providers of services need to demonstrate to the public bodies that potentially fund them that they can deliver high quality services at an affordable price.

The dangers of financial insecurity for these providers are potentially acute. Many contracts offered by public authorities are short-term, individualised (i.e., spot contracts, not block contracts) and with little scope for adjustment in response to unforeseen contingencies. As they gain in confidence in their providers, public sector purchasers should be trying to change the contractual form to give voluntary and private organisations greater security, and to allow them to invest in care quality improvements for the future. Partnership arrangements between the public and voluntary sectors can be very successful. "Partnership" is an over-used word but correctly describes the kind of model that would work well in the complex mixed economy of care.

7.4.6 Success factors

A major theme in this thesis has been the diversity of forms and activities

which is the contemporary voluntary sector. Whilst there is no doubt that the switch from a grant aid culture to a contract culture impacts on agencies, what can be said about the relationship between agency type and the effects of contracting? Can agency type be a predictor of funding success for example?

Russell et al (1996:407) contend that 'winners and losers' are beginning to emerge and describe how one agency fared particularly well in the new funding environment, growing exponentially over the five year period during which it was evaluated. However the predictors of success which they suggest embrace a broader field of influence than agency type (see discussion in chapter 6, page 6.35).

As I outlined in chapter 3 (p3.14), Mocroft and Thomason (1993) employed Lipsky and Smith's three-fold classification, developed in the US, to examine the English context. In the DHA study those organisations closest to the new entrepreneurial agency type have grown the most, but I would argue that there may be an alternative explanation to the one advanced about responsiveness to statutory need, although the very new agencies like the one used to close the hospital in Liverpool are becoming significant competitors. My alternative explanation is essentially about where the power lies in the changes. Those organisations in the study sample which have fared best appear to be those which were ready to capitalise on the changes to get the best for their clients. They were in a postion to do this because of their existing networks and because they were influential in terms of expertise, how alternative their service was or status in the local area. This was not unlike the findings in the study by Russell et al, (1996), where 'connectedness' was an important success factor in the funding stakes (page 404). However, not all agencies who

displayed these characteristics have grown as a result of the reforms and I would therefore contend that leadership style was inevitably an important additional 'success' factor.

7.5 WHAT ARE THE POLICY LESSONS TO BE LEARNED? (Question 6)

To many people it seemed that local and national decisions to run down long-stay hospital provision were often taken in the absence of an adequate appraisal of the likely consequences for service providers or budgets, and also without learning the lessons from similar decisions previously taken elsewhere. Encouragement of voluntary (and private) sector providers also often seemed to be based more on assumption than on information about what would result. Many policy and practice issues have been raised by these changes to the locus of long-term care. The evidence presented here has come from a range of sources and focused on two user groups - people with long-term mental health problems and people with learning disabilities. The evidence has been used to explore the assumed and actual roles of voluntary organisations, the rationales underpinning public sector support, and the resultant impacts.

What policy lessons emerge?

- Public sector bodies, and particularly purchasers of community care services, held quite firm views about the voluntary sector. These could be summarised in the early 1990s as considerable 'goodwill trust' but with some doubts about 'competence trust'. Purchasers need to ensure that the former does not blind them to the failings of competence (in the delivery of high quality, effective services of the kind wanted by users). Voluntary sector providers need to improve and/or more effectively demonstrate their abilities in this field.

• Many of the concerns expressed by people in the voluntary social service sector about the impacts of public funding (its growth and formalisation) were hard to reconcile with the available evidence at the start of the decade. Loss of autonomy and goal deflection appear not to have been serious problems. However, over time some difficulties have emerged in these areas.

• One of the main difficulties is potential financial insecurity, itself a consequence of local authorities' preferences in some 'care markets' for short-term spot contracting with limited scope for contingency adjustments. Over time some purchasers (but not many) have shown a willingness to move to purchasing approaches and contracting arrangements and payment types which do not leave so much of the 'risk' resting on the providers and which encourage them to invest in future quality. Many local and health authorities strongly support the voluntary sector's role in community care but have been slow to introduce the kinds of contractual arrangement which protects it.

• 'Partnership' and 'collaboration' are over-used words, but they describe the kind of relationship which many voluntary organisations say they want with public sector purchasers of their services. However, many have been reluctant to accept the levels of accountability and transparency that such arrangements inevitably seem to require in the more overtly competitive and performance-monitored environment of the late 1990s mixed economy of care. This is not only to do with the fear and reality of the transformation effects on organisations and what they do, but also because of the different value base in many voluntary bodies which espouses a very different agenda than the one initiated by statutory

partners. As Taylor (1996) suggests, voluntary organisations are extraordinarily adept at preserving this.

- In the case of the two client groups which were the focus of this work the voluntary sector does provide services which are distinctive and valued by clients. The importance of educating funders about the impacts of issues such as average funding and last minute renewal of funding on the service which agencies provide needs to be addressed if we are to develop sensitive funders and retain sensitive services.

- One apparently successful form of partnership has been the formal consortium arrangement between the NHS and voluntary organisations (housing associations) for former long stay psychiatric hospital residents. Although more costly than alternative arrangements, quality of care was of a high standard. This presents purchasers with a difficult trade-off.

- The maturing of some community care markets over recent years has been characterised in many localities by the establishment of 'preferred provider' lists. These arrangements may offer voluntary organisations many aspects of the kind of partnership environment that they desire.

- The challenge, of course, is for a voluntary sector provider to get close enough to its purchaser(s) to build up the goodwill ***and*** competence trust that help to keep transaction costs down, whilst not losing independence or flexibility.

7. 6 THE CONTRIBUTION OF THIS THESIS

The primary focus of this thesis has been to describe and evaluate the

role of the voluntary sector in the provision of care in the community for adults with long-term needs associated with learning disability and mental illness. Understanding the role and functions of the sector and why we care for clients in the way that we do is highly complex and cannot be understood simply by an analysis of legislative change. Money is a powerful incentive and it is clear that it has a major influence on the shape of the care we provide. Chapter 6 demonstrates this quite clearly and the Care in the Community Initiative, also an example of conditional monies, did so by facilitating a new care initiative. Money is enabling but it can also be constraining. The exciting thing which I feel this thesis has demonstrated is the different ethos which is evident in different sectors, an example of this being how far voluntary agencies said they would be prepared to go in sacrificing their raison d'etre at least at the time of this study. However, as this work has shown, the voluntary sector is shaped in part by the context in which it is operating. Money is one influence but the pressures for change are there in other forms; new directors who take things in a different direction, bids for new monies which subtly alter the range of activities the organisation is involved in. There is no doubt that for the vast majority of organisations financial insecurity is a constant issue and therefore that any new monies are a potential source of survival and change.

It is, however, 10 years since the data collection took place for the work reported in this thesis. Organisations have undoubtedly changed in this time. As I mentioned earlier I am now a volunteer and trustee for a small (6 paid staff) local voluntary agency affiliated to a national advisory body and a network of similar groups. As someone who has worked in a range of settings I am struck by the

professionalism with which this organisation operates. The way it mobilises the large voluntary resource at its disposal (over 80 volunteers), the expertise that this pool of people has to offer, the knowledge and breadth of experience of the executive members about the organisation and the developments around it.

The organisation, I am told, is very different than it was before the new Director took up post - larger now, with more paid staff, bigger premises, more systems, more hi-tech. The discussions at Executive meetings are often very familiar (from the point of view of this thesis) - issues to do with professionalisation such as the meeting of core standards, the progress of funding bids, staffing issues, financially making ends meet, training. The point I want to make is that this organisation at least has a clear vision ahead. If there had been hot debates in the past about growth and the direction the organisation should go in, these are past. There is no-one on the Executive Committee who has been there longer than five years (although the organisation itself is 12 years old) which may be significant in terms of a clearly stuctured and revamped organisation.

Although these are personal observations I make them because I suspect many organisations have gone through this process since the time of my data collection and have emerged strengthened in ways which now meet the concerns of former critics. The other very important observation I wish to make is that although the organisation is transformed it is still significantly different from the statutory organisations with which it liaises to provide a service. It still retains its flexibility and client accessibility. Advocacy and the meeting of client needs are also of prime importance to this

organisation. But in addition it appears also to meet the needs of its staff. The importance of mission, which ten years ago agencies were urging should not be compromised, is still the guiding force of this organisation at least. For vulnerable people such as the groups which are the focus of this thesis then the voluntary sector does have something very distinctive to offer.

To return to the findings of this thesis, the work has found support for the notion that the voluntary sector is more responsive to consumer needs, and that the 'alternative' nature of the care that it has provided to people who would in former times have lived in hospital is valued. The importance of values at every stage of service provision has been an interesting finding and one which requires futher investigation. For example, it helps to explain the primacy of certain objectives over others in different sectors, the differing interpretations of the meaning of participative services and the 'othering' of those that are different which perpetuates the mythology around what the different sectors do. The breaking down of these powerful forces against collaborative work - which I believe to be at the heart of good community care - would help to reduce these examples of 'cognitive dissonance' which are such a powerful force against change. My work on the meaning of 'monitoring' to all actors in the HfH service was one contribution to this.

As I mentioned in chapter 2, considering that it is notoriously difficult to collect broadly comparable data about the voluntary sector, I would argue that a particular contribution of the work presented here has been the access which I was able to gain to a wide range of data. As a result of this I was able to gather a greater cross-section of views and

collect a fuller range of evidence about the achievements or otherwise of the purported attributes than I might otherwise have done. I fully acknowledge that the work therefore might be criticised for breadth at the expense of depth. However, the contributions made by the focused work with users, the hospital closure case study, the home from hospital evaluation and the TAPS study provided depth for important aspects of the work.

At the time of data collection the user-based work made a particular contribution not only to understanding what users felt they ***needed*** and valued but also to how that information could be accessed.

When the data was collected many of the hypothesised 'impacts' of enhanced statutory support were not evident. Funding environments have altered substantially since then and the 'presentations' of the various sectors have, I suggest, altered accordingly. For example, the presence of organisational infrastructure in the voluntary sector to suggest business acumen and "trustworthiness" is now an essential aspect of the 'funding game'. The baseline information for the Care in the Community study (1984-1988) and the breadth of data from this work would provide useful comparative data for a follow up study comparing the changing nature of voluntary sector care for people with long-term care needs associated with mental illness and learning difficulties. In view of the importance of the 'treatment preference thesis' for mental health service users, a study focusing in particular on the impact of change on this one aspect of the sector would be useful.

Appendix A

USER EVALUATION OF MENTAL HEALTH DAY CARE

This appendix contains a report of a user evaluation of day services commissioned by Warrington Social Services Department but produced to be accessible to the users who participated in the study.

APPENDIX A

A CONSUMER'S-EYE VIEW OF THE SERVICE PROVIDED AT WARINGTON DAY CENTRE

This report is a summary of the findings of a survey of consumer views conducted by Corinne Thomason of the Personal Social Services Research Unit, University of Kent, on behalf of Warrington Social Services and Making Space North West.

July 1991

PREFACE

My thanks to everyone who was involved in the production of this report in particular the people who use the day centre for their hospitality and friendship and also for sparing the time to talk to me and complete the questionnaires. I am also indebted to Ena Walsh and her team of staff for their help and to David Lyne for his guidance.

My thanks also to Maureen Weir and Lesley Banks who patiently and efficiently typed the report and to Nick Brawn who did wonders with the graphics.

And finally my thanks to David Whyte, Principal Officer Warrington Social Services, for giving me the opportunity to find a practical outlet for my research.

Corinne Thomason.

Front cover conceived and drawn by Tony Ryan.

CONTENTS

SUMMARY

Aims of the Study

The research was commissioned by Dave Whyte, Warrington Social Services Department, to provide a consumers eye view of the service provided at Warrington Day Centre. The results will contribute to an overall review of the service provided by the Centre.

Study Design

The aim of the study was to speak to a sample of Centre users specifically about their experiences of the service and more generally about their needs as a mental health service user.

The design was influenced by earlier work with users which revealed preferences for the suitability of different research tools and also pertinent issues for inclusion in the evaluation. The descriptive statistics are based on data collected from two different types of questionnaire.

Needs Associated with Mental Illness

The majority of respondents (82%) felt that attending the Centre helped to ameliorate the effects of illness. Individual responses to this question make interesting reading but warding off loneliness through social interaction and the therapeutic effect of spending time constructively were felt to be important for most people.

The main problems identified by interviewees were financial problems (38%). Surprisingly only one person specifically identified symptoms of illness as a major problem.

The range and individuality of needs which emerged was striking as was the simplicity of many needs, mostly reflecting practical assistance and social contact rather than medical intervention. Most respondents lived alone and the need for companionship emerged time and again as a reason for attending the centre, as a main problem faced by people (loneliness), as something which helps to ease the symptoms of illness and as one of the things that people most desired in their lives.

Service Range

As a corollary to needs identification, respondents were asked to consider if there was anywhere in Warrington where they could get the services they needed. Warrington Day Centre was cited by just over

half of the sample and a further 8% nominated Workspace. A quarter felt there was nowhere to meet their needs and the remainder did not know. No other service was identified as a way of meeting needs.

A third of all respondents did attend other day time facilities and half of these attended the Breeze-In and Orford groups occasionally, one on a regular basis. The other day services identified were the Day Hospital, Workspace, befrienders and the Drop in at the technical college. When asked to consider how they would spend their time if the day centre did not exist the overwhelming response was - 'there is nothing else to do in Warrington'. In the absence of the day centre the majority of respondents perceived structure and social contacts as being largely removed from their lives.

Detailed Views of the Service

The sample included people who attended the centre on a fairly regular basis be it once a week or every day. People attended on average 4 times per week and the mean time since first attendance was two to four years.

Two-thirds of the sample said they would like to attend more often. Other commitments and restricted opening hours were cited as the principal constraining factors. It was not clear from the responses whether patterns of attendance would change if the centre did open later i.e., would people come in later, would there be a different mix of people?

Travel by bus was the most favoured form of transport to the centre with an average journey time of fifteen minutes. The cost of travel would appear to be a heavy burden on people with limited incomes, average fare falling between 50 pence and £1, a third of the sample paid more, between £1 and £1.50 per day. However, only 16% of the sample identified financial reasons as a constraint on further attendance. Respondents viewed this rather matter of factly as a necessity, probably in view of the fact that the fare into the town centre would need to be found whether this included a trip to the day centre or not.

Respondents said that they attended the day centre for a number of reasons but the need for companionship and to form relationships predominated. However, a close second was the satisfaction of a complex array of practical needs ranging from support and help to money savers in the form of cheap midday meals, tea, coffee and free

laundry and washing facilities.

When asked to consider principal likes and dislikes about the centre, not surprisingly the benefits of coming to the centre corresponded closely to the principal reasons for attendance and to needs identified by users. Over half of the sample said that there was nothing to dislike about the centre, a quarter had individual personal grievances and 20% felt the centre shut too early in the evening.

When asked to rate different aspects of service delivery the responses suggested a high level of satisfaction with the service. Staff and food scored particularly highly, although, location, activities, other users also came out well.

Suggested improvements tended to revolve around extending and structuring activities and extending opening hours.

The majority of respondents (82%) felt involved in the running of the centre, although fewer (65%) felt they were consulted or that their comments were listened to or acted upon.

In terms of facilitating participation, over half of the sample felt that they were encouraged by staff to say how the centre is run and are regularly invited to meetings. 41% of people felt they could put their views across at meetings and there were no suggestions for how meetings could be improved.

The nature of the data however, suggests that this aspect should be interpreted with caution. There was a significant non response rate for these questions and discrepancies between some of the answers suggested that there were interpretative difficulties or at least that user perceptions were at variance with the author's/service providers view of the area under investigation.

WARRINGTON DAY CENTRE
- A USER PERSPECTIVE

1. INTRODUCTION

Warrington Day Centre Project has been running for 10 years with the aim of enhancing the quality of life of adults who have or are suffering from any form of mental illness. It is an independent registered charity and is promoted by two voluntary agencies: Making Space North-West (for the support of schizophrenia sufferers and their families) and Warrington Association for Mental Health (MIND), and two statutory agencies: Warrington District Health Authority and Warrington District Social Services Department. This document presents the results of a survey of user views conducted in July 1991.

Context for the Research

Cheshire County Council provides funding through a contractual agreement with the Warrington Day Centre Project. From time to time Warrington Social Services must monitor the performance of its contractees and to this end is currently involved in an evaluation of the Day Centre on behalf of the Social Services Committee. An important part of this evaluation is feedback from mental health service users.

Involvement of PSSRU

Corinne Thomason of University of Kent was asked to undertake 10 structured interviews with day centre users based on Version 1 of the questionnaire (appended). Also, in order that users would have the opportunity of giving spontaneous feedback Version 2 (appended) was made freely available for completion. The information from the questionnaires was to be analysed and presented in report form for incorporation in the larger scale evaluation to give an indication of users views.

Aim of the Evaluation

The results of the evaluation will be used for three things:

1. It will provide important information for a review of the day centre by Warrington Social Services.
2. It will contribute to a piece of work being conducted by Corinne Thomason at the University of Kent about the strengths and weaknesses of services provided by statutory/independent agencies.
3. It will form the basis for discussion between users of the centre and staff about what type of service the centre will offer in the

future.

Outputs will include a report for social services for inclusion in their own evaluation; second an accessible report for distribution to users which in conjunction with verbal feedback from the author will form a useful focus for discussion about the shape of the service.

And finally the findings will contribute to a chapter for a piece of work the author is conducting on service mix, agency links and service outcomes funded by the ESRC. The chapter is one of a series reporting empirical results, but will focus particularly on user perspectives of what agencies provide in a mixed economy with the emphasis specifically on voluntary/statutory differences. It will examine the ability of agencies to provide services which allow participation, choice and self-determination. It will also deal with consumer preferences and attitudes towards the range of services on offer and try to reason out user justifications for what suits them.

2. METHODOLOGY

DESIGN AND CONDUCT OF THE STUDY

As a key aim of the research is to discover what a range of users think of the service they receive it was important to ensure that the design allowed for maximum participation and freedom of expression.

The author drew on three sources of experience and information when considering the design:

1. The large literature on client survey techniques (for review see Thomason 1991, Booth et al 1990).
2. Previous work conducted with users by the author (Thomason 1989, Renshaw and Thomason 1988, Knapp and Thomason 1991).
3. Advice from mental health service users and workers in Warrington re preference and appropriateness of types of research.

This exercise raised a series of issues which were influential in the study design:-

User Characteristics

Many mental health service users crave anonymity and are uncomfortable/suspicious about information being kept about them. This often means that the collection of information via an official

looking questionnaire which will be difficult. Care also needs to be given to the type of information collected. Questions about diagnosis etc may be deemed inappropriate by some people who may well prefer to participate anonymously, if at all.

On the other hand, some people welcome the opportunity to talk at length about what is happening to them and prefer a face to face interview rather than a postal questionnaire or something which is distributed at the day centre, for example.

Techniques

A completely open-ended technique may achieve flexibility but suffer from lack of structure which makes it difficult to report findings in a rigorous way allowing for comparison between issues and some measure of their relative importance.

Which Questions?

Regardless of which technique is selected it is important to ask the 'right' questions and to use the 'right' language in framing these. For example, people may not see themselves as service recipients or as mental health service users and so it is important to be sensitive to these facts in the design.

In this case this potential difficulty was addressed by including a preparatory stage in the design. The author spent several days in the Centre in the Autumn of 1990 observing the routine and activities and talking to staff and users about the Centre to discover what the relevant issues were and what users/staff preferences/attitude towards research.

The results of this exercise revealed that users were happy to participate and preference was for a range of measures so that as many people could be involved as possible. The eventual design reflects this.

Problems Associated With Data Collection

It was anticipated that the negative experiences of many of the interviewees as people who had been segregated/stigmatised might influence their perception of the research (Atkinson, 1988; Ritchie et al, 1988). In particular, they might harbour fears about the purpose of the research, think that it was designed to check on them to trick them or to catch them out. Therefore the research needed to take account of these factors to minimise refusal to participate or feelings

of 'no obligation to do so'. In addition an interviewee might be reluctant to talk about problem areas, if assurances are not given.

From the service providers viewpoint there may also be barriers to progress. There may be reluctance to allow access to clients because of strong philosophical considerations, lack of record keeping systems or concerns about what the research will be used for and how the data will be interpreted.

THE DESIGN IN PRACTICE

Research with users in the mental health field is fraught with difficulty, particularly when it is out of a different mould than the numerous traditional mechanically based, highly quantitative studies, and more importantly when it is reliant on information provided by users rather than a carer or significant other.

In addition this research was to be conducted in an environment which is by design anything but a traditional institution. The environment and regime are such that any information about users is treated in a highly confidential way. There is no record keeping system, no formal care planning or treatment histories. Documentation is kept to a minimum i.e. people sing in each time they attend and information regarding client addresses etc. is only kept where a client has expressly requested this. This does not mean to say that staff do not have a profile of peoples needs and preferences, they do. It is, the mode of collection which differs i.e. 'getting to know you approach rather than a formal assessment. The atmosphere of the Centre and client expectations about how they will be treated therefore preclude formal structured data collection even if this were deemed appropriate.

Having said this the preliminary visit and user consultation over the research did circumvent some of the anticipated problems. Also explanations about how the information would be used and assurances of anonymity and confidentiality undoubtedly contributed to a low rate of refusal (2.5%) when individuals were approached.

Consultation with users and staff at the day centre coupled with previous experience with these groups and also a review of methodologies used by others (Le Touze and Pahl, 1989; Atkinson, 1988; Simons et al, 1989) led me to the position that best quality information is only gained by using a variety of methods. The numbers are too small and too ad hoc to make sense of a strictly

scientific model and the response problems incurred from people who often do not comply or comply in a restricted sense for reasons of suspicion or inability to understand or communicate may reduce the numbers further. Also traditional style scientific methods are often inappropriate for people who have often been through the system and either have a set reaction to being questioned in terms of letting the interviewer know what they 'feel' they want to her or have taken a decision not to comply. Whatever the reasons my experience is that poor quality information is obtained.

As the chief aim here is to tease out perspectives and real reasons for use this mix of methods is acceptable and worked well. Many of the national advocacy agencies are now assisting with evaluations of services, particularly because of the problems of getting people to speak honestly about their needs (Calnan 1988). There is now a growing appreciation that good quality information and high response rates are closely correlated with sensitive questionnaire design. (Wyngaarden,1981; Leedham, 1988).

Sensitive in a number of ways. First, sensitive to the experiences and abilities of the interviewees i.e. informal interviews with clients before the questionnaires are designed to elicit key issues and those in receipt of services are ideally placed to know what the issues are (Allen 1991) and test out preferred style of evaluation.

Third, useful to those you hope will participate. People are much more likely to respond if they feel there could be direct benefits for them. So discuss ways in which the work could improve services in an area. Therefore time was spent with staff and clients to get a feel for topics of interest to them, key issues and level of ability of clients.

Questionnaire Design

In terms of questionnaire design a number of factors had to be faced. The aims of the research are such that eliciting consumer views is paramount. However, there are a number of problems associated with collecting data from clients with mental health problems and learning difficulties which have been well-documented (Walker, 1989; Atkinson,1988; Wyngaarden, 1981; Simons et al, 1989).

Lowe and de Pava found that Yes/No questions produced high rates of response and although their validity is of doubtful significance their inclusion was valuable in opening up discussion. They also found that clients were encouraged by easier questions to attempt answers to

more complex questions.

Similarly to Wyncaarden, Lowe and de Pava found that freedom to change slightly the format of questions, whilst retaining their original intent, was useful and aided clients' comprehension of what information was being requested. In addition they found that the use of the prompt, (anything else), as suggested by Sigelman et al (1981), was of value in eliciting fuller responses. Table AA.1 below compares the two versions of the user questionnaire.

Table AA.1
Comparison of two user questionnaires

Components	Version 1	Version 2
Personal details	Not essential but help to identify:- name age gender	Where do you live What type of support Main problems/wishes Characteristics/ professional involvement
You and the Centre	Attendance, how long, what's good about it, who referred	What like most/least Improvements?
What the centre offer	Who is it for, comment on range of things, other day time activities, what offer:	Much reduced version
How the Centre is organised	Participation, choice, roles, confidentially	Much reduced version
Help	To what extent is Centre source of help?	Much reduced version
Alternatives	Choices? and what prevents it	Much reduced version
Your situation	Consumer groups? Needs, to what extent being met - could centre help?	What do you need?
Additional optional information	Characteristics of consumer - hospital admission - type of accommodation - medication - work	

The questionnaires focus mainly on clients' needs as a mental health user, their experience of the particular service in question and other services in general. It is also designed to uncover the interface between the two and collect information as specialisation, participation, consumerism, self-determination.

Version 1 of the questionnaire is more structured and explicitly covers a number of topics. Version 2 has a looser structure and it is anticipated will raise the same areas but is unstructured so as not to constrain the respondent.

The two questionnaires are quite different. Version 2 is much shorter and is mainly concerned with needs, services and if the two coincide. In this case the respondent is much freer to voice their own opinions without too much structure. I feel this lack of bias to be vital as the research is looking for a genuine consumer viewpoint untainted by imposed categorizations. Such a questionnaire is however difficult for some people to complete hence version 1 has a mix of open-ended, unstructured questions along with some multiple-choice type items which some clients prefer.

Other researchers (Wyngaarden, 1981) have also found that simply-phrased open-ended questions, and scope to rephrase questions while maintaining original intent, tends to spark a response.

During the preparatory stage I used unstructured interviews to get good quality information about what services people actually use. A key element in this is that people often do not perceive services in the way that a researcher going into an area perceives them. Generally people really don't know what you mean when you refer to services as such unless you're talking to a professional and yet by exploring it in this way it of course is very obvious that the users are the people that know better than anyone else which "services" are around and what they do.

The earlier work with clients was also useful to build up a rapport. Without exception once trust had been built up people were more than willing to complete questionnaires for me. I used these exploratory and most informative visits to build up a picture of the facility and the types of people who used it and designed the questionnaire accordingly. I was also then able to target key individuals who I felt would advocate on my behalf in getting respondents to complete the

questionnaires and left behind an image of myself rather than a distanced professional who took for granted that people would complete forms. As someone who is interested in what the facility itself was trying to achieve and would use the information responsibly. I felt strongly that it was important not to reinforce any negative experiences inherited from years of being in the system.

From each of these visits I constructed a brief report of the facility, its aims and objectives, people using the facility and a very general idea of what the people thought about it and used this information to construct a questionnaire which was designed to achieve a two fold aim. One to inform my research and collect valuable information to feed into my work on consumer related rationales and secondly to be a useful tool for the service itself in collecting information about consumer satisfaction. Without exception my presence in all of these facilities generated interest from senior professionals in the service, who in the current climate were trying to look at quality and consumer satisfaction and assess services in some way and in return for their co-operation I have always been willing to co-operate in any way that I could.

Profile of Participants

The data collection was conducted during the first week of July and day centre users were made aware beforehand of the purpose of the research. Questionnaires were made freely available both before and after the research had taken place to encourage as large a sample as possible.

Although a primary aim was to discover what a sample of current users felt, the evaluation could not ignore the fact that there could be other mental health service users who elected not to use the day centre for specific reasons. An attempt was made to capture the views of these people by distributing questionnaires via mental health social workers. However, no questionnaires were returned as a result of this exercise.

The information on which this report is based comes from four sources; informal interviews with users and staff of the day centre, Breeze-in scheme and other mental health professionals, an analysis of relevant documentation, completed questionnaires, and participant observation of the day centre and Breeze-in group.

Thirty completed questionnaires were received in all, 18 or Version 1

and 12 of Version 2. Nine people completed both questionnaires. The descriptive statistics are mainly based on the responses to Version 1 of the questionnaire but where there are similarities between the questionnaires the sample is expanded to 21. Table AA.2 below profiles the participants in this study. The week of the data collection was described as an 'average week'. Average daily attendance was 28 which compares with 32 and 29 for the weeks before and after the collection. A profile showing the characteristics of the participants is shown below.

Table AA.2
Characteristics of people interviewed

TOTAL NUMBER INTERVIEWED	40
Interview type	
Informal discussion	15
Questionnaire 1	18
Questionnaire 2	12
Sample upon which descriptive statistics are based	18
Gender	
Female	5
Male	13
Age	
25 - 29	1
30 - 39	3
40 - 49	6
50 - 59	6
Over 60	2
Living arrangements	
Own house/flat	3
Council house/flat	8
Private rented accommodation	1
Accommodation managed by Making Space	4
Adult fostering	2
Alone	
With others	12
- family	
- other people	4
	2
Services received	
Psychiatrist	12
G.P.	9
CPN	3
Health visitor	1
Social Worker	6
Depot injection	5
Outreach	2
Last hospital admission	
This year	3
last year	3
2 - 5 years	6
More than 5 years ago	6

AIMS AND OBJECTIVES

Who is the centre for?

Figure AA.1 shows a range of views about who the centre is for.

Figure AA.1
Who is the centre for?

SERVICE PROVIDER VIEW

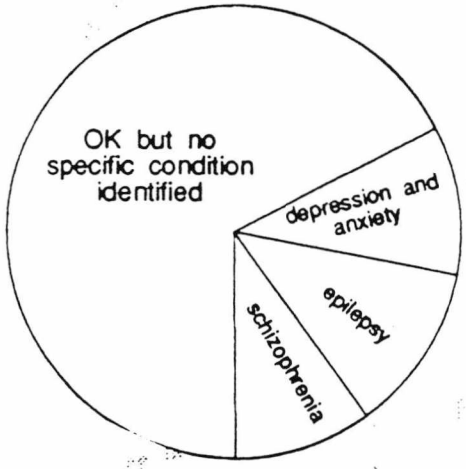
'The centre is for people who have suffered from a mental illness and for those who are isolated, lonely or depressed. There are lots of thing to do and there is plenty of room to sit and chat over a cup of tea or coffee. ...You can do as little or as much as you like.'
(advertisement)

USER VIEW

Who is the centre for?

The range of responses is depicted in the background to this figure.

How do you fit in with that?



One of the best ways of looking at what the Centre offers is to examine what it says about itself. The following extracts are drawn from publicity material and written aims and give a clear view of the objectives the project of the project and the service design.

The day centre publicises its service in an informal way suggesting maximum choice and flexibility in service delivery to a whole range of potential customers:-

> 'The centre ..... is for people who have suffered from a mental illness and for those who are isolated, lonely or depressed ..... There are lots of things to do and there is plenty of room just to sit and chat over a cup of tea or coffee ... You can do as little or as much as you like'
> (advertising poster).

Informality and openness also applies to day to day administration and admission procedures:-

> 'The day centre adopts a completely informal and open referral system with no forms to be completed, no strict selection criteria or personal files. We have no formal treatment plans but this does not mean there is no improvement in many of the individuals. This his explained by the fact that the day centre accepts individuals as they are and that the friendly, informal atmosphere is acceptable to quite severely damaged people who can attend on their own terms.'

Minimal pressure exists in the form of a programme of structured activity to ensure that people are free to do as little or as much as they want:

> 'People who attend the centre often us it as a base for establishing social contacts with people choosing how much company and activity they need.
>
> People may take the opportunity to take part in a whole range of recreational, educational and social activities. These are changed regularly to suit the needs of the people attending the centre but include:

> literacy classes, handicrafts, cooking and budgeting classes, welfare rights information, swimming, relaxation and a host of other activities. Not all activities take place in the centre and full use is made of local provision, e.g. local swimming baths, local College of Further Education. All the activities are entirely optional and no-one is forced to join in the activities. Most people often need time to soak up the atmosphere and activities available before joining in.'

However a more structured programme does exist;

> 'The day centre also operates structured activities where more formal, therapeutic groups operate. Potential contributors to the structured day centre programme make offers to the organiser who presents the offer to a panel. Sessions are run by professionals or volunteers so the structured programme needs no day centre staff. Groups that have contributed to the structured programme include: social skills training, womens' groups, relaxation. Not everyone who attends these sessions need to attend the centre for other activities but may be known to either the statutory or voluntary agencies.
>
> (Aims of Warrington Day Centre).

In November of last year, a new project aimed at providing employment for people with psychiatric illness began called Workspace. It is located next door to the day centre and deals with the reprocessing and resale of clothing. People are employed doing a variety of jobs.

CENTRE USAGE

Table AA.3 below shows frequency of attendance by length of attendance. A third of participants attended every day and over attended three or more times per week. If we look at length of attendance 72% of these interviewed had been attending the Centre over 2 years, 22% over 7 years.

Table AA.3
Frequency of attendance at day centre

Frequency Of Attendance By Time Since First Attendance

Years Since First Attendance	Number of Days Per Week						
	6	5	4	3	2	1	%
7 - 10 years	1	3	-	-	-	-	22
4 - 7 years	-	-	-	-	1	-	6
2 - 4 years	3	-	1	1	-	3	44
1 - 2 years	1	-	-	-	-	-	6
less than 1 year	1	-	1	2	-	-	22
Total (n)	6	3	2	3	1	3	
Total %	33	17	10	17	6	17	

When asked about whether they were happy with frequency of attendance or whether they would prefer to attend more or less 64% of respondents said they would like to attend more often. No-one said they would like to come less often.

When constraining factors were identified (see Box AA.2) they tended to fall into four categories:

Box AA.2
Constraints on further usage

CONSTRAINTS ON FURTHER USAGE

Financial	16%
Personal	38%
Centre closed	23%
None	23%

When people provided a reason for not attending the centre more, individual reasons tended to predominate for example:

> 'I would like to come more but I don't have the time sometimes because of seeing relatives or other appointments'.

Other people cited reasons such as lack of confidence or panic attacks. Two people lived too far away from the town centre to make attendance more than once a week feasible. Three people who were already attending the centre 6 days per week indicated that they would like to attend more if the centre was open. These people felt particularly that the centre closed too early in the evening. From the responses it was not clear whether patterns of attendance would change if the centre did open later i.e. would people come in later, would you get a different mix of people?

TRANSPORT

Figures AA.3-AA.6 look in detail at how users travel to the Centre, how long it takes, what it costs them and whether or not they consider getting to and from the Centre a problem.

Almost three-quarters of all participants did not consider transport to be a problem. Most people travelled by bus (39%) others either walking (28%) or travelling by care (22%). Only one person gad their own car others had a lift to the Centre. Equal numbers travelled by train or bicycle (6%).

The average journey time was fifteen minutes and 70% of all participants had a travel time of twenty minutes or less.

When it came to cost of travel a third of participants paid travel costs in the range £1 - £1.50 per day with the average fare falling between 50p and £1. Another third of all participants had free travel either because there was no cost involved or fares were reimbursed or paid from another source.

In view of the low level of income of most users, and the cost of transport experienced by most the author had expected to find that the cost of attendance was felt to be a constraining factor mitigating against more frequent attendance. However, this did not appear to be the case as we can see in Figure AA.6 and Box AA.7. When questioned further about this some interviewees responded that if they didn't attend the day centre they would have to pay to go into town anyway and so the cost was viewed more or less as a necessity.

TRANSPORT

Figure AA.3

How long does it take?

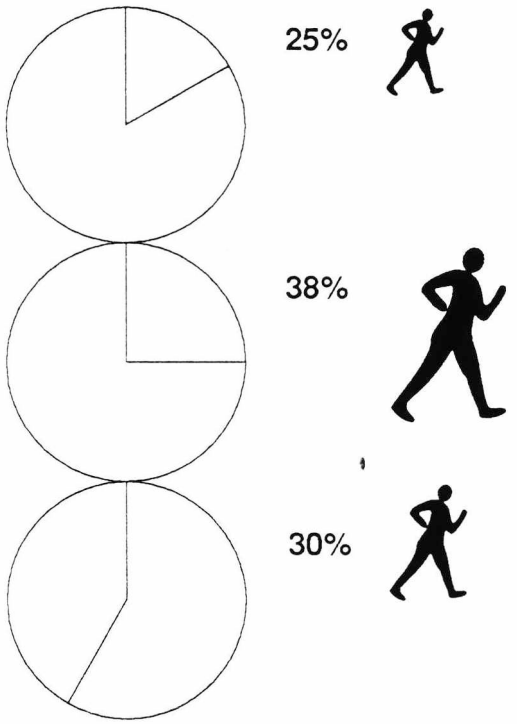


Figure AA.4

How do you get here?

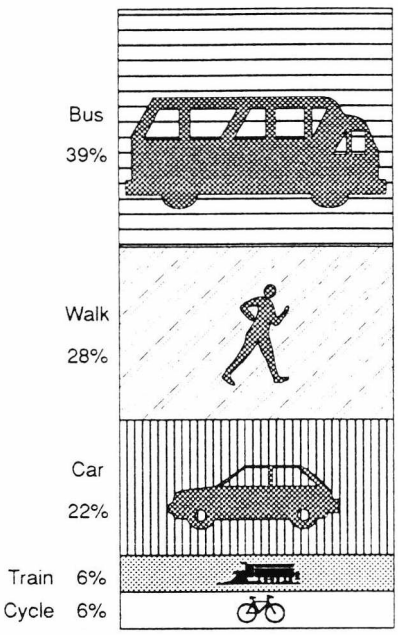


Figure AA.5

Is it a problem?

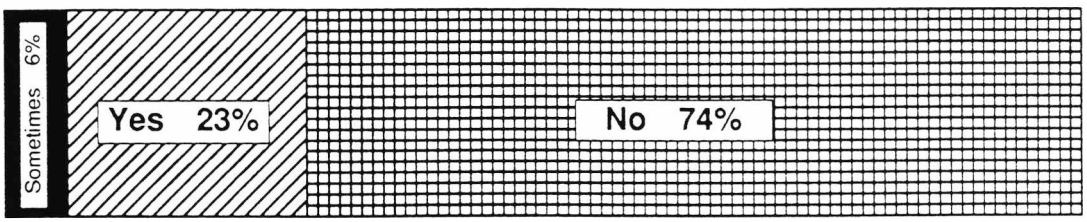
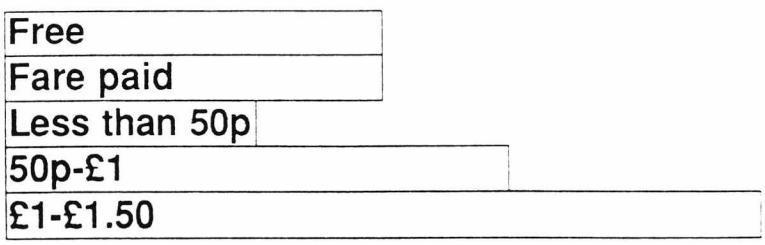


Figure AA.6

How much does it cost?



REASONS FOR ATTENDANCE

When questioned about reasons for attending the day centre (Box AA.7) a variety emerged but these can be broadly attributed to the following categories:-

Box AA.7

REASONS FOR ATTENDANCE

REASON	%
Relationships/companionship	44
Practical reasons	38
To structure time/routinization of everyday life/work	18

Relationship Needs

The satisfaction of our need for social contact with others emerged as the most cited reason (50%). This was expressed in a number of ways but company and companionship or for a talk or chat with friends emerged most often. Sometimes this was expressed in terms of problem areas of a person's life which the interviewee was trying to address, i.e. to ease loneliness, I couldn't sit on my own all day. Many of these reasons overlap with the next most popular category, practical needs.

Practical Needs

Many people attended the day centre for pragmatic reasons (38%), some specific to easing the symptoms of their illness (6%) but generally illness was little mentioned. There was an understanding that the environment was such that this did not need to be explained. More importantly that support could be readily enlisted, from peers, staff at centre, staff of Making Space and via liaison with outside agencies. Help with problems and support were mentioned by 12% of the sample. If we compare the response to this broad question with the response to more specific questions about who helps you, we see an interesting contrast here where althoughthe majoeity of people feel day centre staff are their main source of help this is not identified as a main reason for attendance at the centre which supports the earlier assertion about unwritten rules. Cheap tea, coffee, meals and access to washing and laundry facilities were mentioned by 15% of the sample and perhaps not surprisingly exclusively, by male participants. The money saving aspect of this facility was only mentioned by one

participant although the responses to other questions reveal the importance of financial savings to most people in the sample.

Structure, Routine and Work

The final category is the need for structure and routine in our every day lives. For many of us this is imposed by work outside the home and/or caring for a family. Most people who have a mental illness are unable to work because of their disability (Thomason, 1989) and they often live on their own without people to care for or to care for them. 18% of the sample mentioned the need to impose some structure on their lives as their primary reason for attendance. 99% of the total were employed by Workspace but others saw the centre as 'something to do', 'it passes the time', 'it gets me out of the house'.

4.ASSESSMENT OF SERVICE IN DETAIL

Likes and Dislikes

Interviewees were asked to focus on specific aspects of the service delivered by Warrington Day Centre first is a general way by contemplating likes and dislikes and more particularly by rating different aspects of the service. Suggestions for improvements were also invited (Figure AA.8).

Box AA.8

Areas of service highlighted by users as 'good'.

FRIENDSHIP
- building up networks
- I like to have a chat with people
- it helps to talk over problems

SPENDING TIME IN A CONSTRUCTIVE WAY
- if it wasn't for the day centre I would stay in bed all day
- I enjoy the activities
- I can work here
- an opportunity to get out of the house

PRACTICAL HELP AND SUPPORT
- staff will always help in any way
- I can do my washing
- saves on electricity
- I get my meals here

PERSONAL BENEFITS
- stops me being bad tempered
- helps me feel more confident
- I like it here/enjoyment

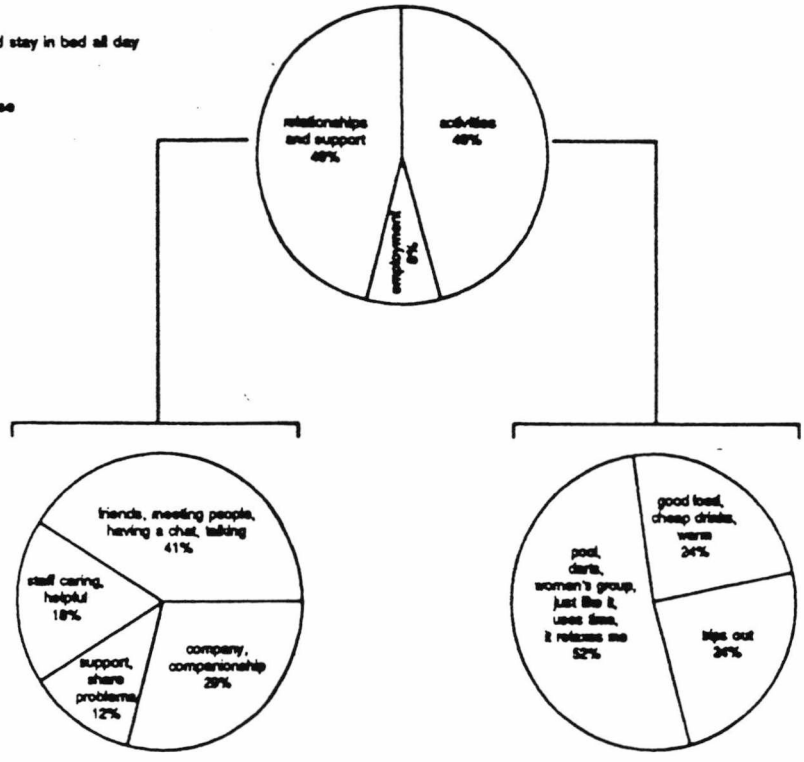


Table AA.5

Views on different aspects of service delivery

Interviwees were asked to consider a number of aspects of service delivery and rate them on a five point scale from very good to very poor (Table AA.5).

Aspect of Service Delivery	Very Good	Good	OK	Poor	Very Poor
Food	8	8	1	-	-
Location	8	4	3	-	-
Facilities	9	5	3	-	-
Activities					
in centre	6	8	3	-	-
outside	7	8	1	1	-
Building	6	9	2	-	-
Staff	11	4	2	-	-
Other Users	4	11	2	-	-

Only one respondent used a 'poor' category to describe any aspect of the service and this was in respect of activities outside the centre. All aspects were rated as very good, good or O.K., which at one level suggests that users are generally highly satisfied with all aspects of the centre. If we examine the highest scoring aspects in the very good and good categories we find the following (Table AA.6):-

Aspect of Service Delivery	Very Good (%)	Good (%)
Staff	63	
Location	50	
Facilities	50	
Other users		69
Building		69
Food		50

Table AA.6

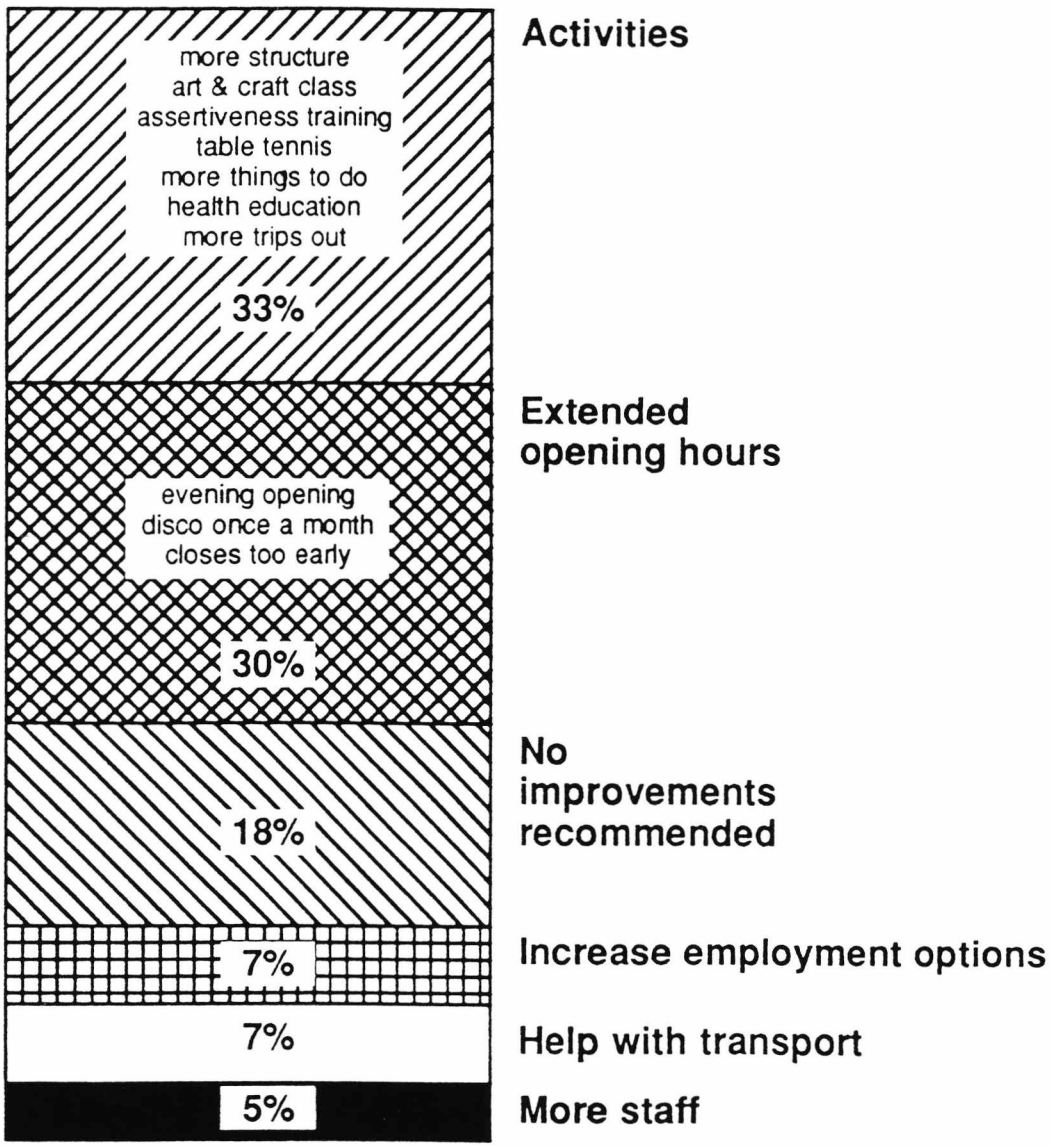
Further examinantion of positive responses to service delivery

A relative assessment can be made by looking at aspects which were rated O.K. A quarter of respondents used this category to describe the location of the centre and the activities conducted in the centre. This ties in with financial problems identified by respondents and the fact

that most people have to travel to attend the centre and the lack of structure(Figure AA.9).

Figure AA.9

IS THERE ANYTHING YOU WOULD LIKE TO SEE IMPROVED?



What People Value and What They Need

Interviewees were asked a number of questions designed to elicit information about what is important in their lives, what are the main problems they face and what services the feel they need. A supplementary question asked interviewees to consider whether there was anywhere in Warrington which offered the services they felt they needed.

Areas of peoples lives identified as most important (See Box AA.10) were not dissimilar to what most people would select, good health, family relationships, to lead a meaningful life, support and structure in one's life and leisure pursuits.

Interviewees were asked to reveal what they would wish for if they were given three wishes. This question was posed in an attempt to get people to think outside their situation. The responses were most interesting (Box AA.11) and although several people asked for unattainable goods up to play for Wimbeldon or to win the pools, the majority of people wished for ordinary things. It is interesting to note that mostly they were the solutions to the main problems identified in Box AA.12 overleaf.

Box AA.10

What are the most important things in your life?

HEALTH
- to feel well

RELATIONSHIPS
- family/children
- friends
- a partner/woman

THINGS SPIRITUAL
- to have a meaningful life
- religion

SUPPORT
- day centre
- accommodation

LEISURE
- ciggies/alchohol
- recreation/games/TV

Box AA.11

If you had three wishes what would they be?

RELATIONSHIP	42%
to get married	
a good relationship	
not to be lonely	
more company	
good friend	
EMPLOYMENT	13%
to have ajob	
HEALTH	11%
good health	
to be well again	
FINANCIAL	21%
to have money, not too much	
to win the pools	
more money	
OTHER	13%

Box AA.12

WHAT ARE THE MAIN PROBLEMS THAT PEOPLE FACE?

Financial	38%
Loneliness	38%
Skill-related	19%
Illness related	6%

Although people answered this question (see Box AA.12) in quite different ways the problems encountered by people who have a mental illness are similar and can be attributed to four basic areas, financial, isolation and loneliness, skills related and illness related.

Perhaps surprisingly only one person specifically identified symptoms of illness as a major problem, although one could argue that the effects of illness comprise the remainder of the sample. Difficulty making ends meet, and shortage of money were mentioned regularly as was loneliness. Skill related problems tended to revolve around daily living skills like cooking, domestic work etc.

Interviewees were asked to consider what services they felt they needed. Most respondents identified more than one source of help. Box AA.13 considers the range of responses under three headings.

Box AA.13

What services do you feel you need?

MEDICAL
- -psychiatrist
- doctor

SOCIAL
- companionship
- outings
- somewhere for week-ends

PRACTICAL
- community transport
- help with washing, ironing, sewing
- outreach
- staff at W.D.C.

Box AA.14

Is there anywhere in Warrington which offers the services you need?

Warrington Day Centre	64%
NO	23%
DK	15%
Workspace	8%

The responses were varied and only on one occasion was a specific need mentioned more than once (this being companionship). This indicates the range and individuality of needs, but also the simplicity of many of the needs, mostly reflecting practical assistance and social contact rather than medical intervention. Interviewees were also asked if there was anywhere in Warrington where they could get the services they needed, (Box AA.14).

Just over half of all respondents named Warrington Day Centre and a further 8% nominated Workspace. Almost a quarter of the sample felt there was nowhere to meet their needs and 15% did not know.

Box AA.15

WHAT TYPE OF HELP DO YOU NEED WHEN YOU ARE ILL?

Talking	47%
Medical	31%
Soliture/rest	11%
Activity/skills	11%

Respondents were asked what type of help they needed when they were ill (Box AA.15). Medical help did not emerge as the primary need when people felt unwell. Reassurance was mentioned by 2 interviewees but someone to talk to whether it be a relative, friend, professional was felt to be the most helpful. Four people particularly identified staff of Warrington Day Centre as their primary source of help when they felt unwell.

Medical help normally referred to altering medication. One interviewee made it clear that medical help for her did not equate with Winwick Hospital, although their was an acceptance by most people that medical help might include an admission to hospital if they were very unwell. This emerged particularly from those who suffered from epilepsy.

Activity was also felt to be therapeutic during a period of feeling unwell, although one person specifically mentioned the development of specific skills such as confidence building and assertiveness training as helpful.

To try to gauge whether attendance at the centre helped to ameliorate the effects of illness, interviewees were asked to consider if attendance

helped often, sometimes or never, all responses fell into the often or sometimes category, 82% feeling that attendance helped them often. Participants identified a number of ways in which attendance helps those with mental health problems. Box AA.16 lists these under five broad headings:-

Box AA.16

In what ways does attending the centre help your illness?

EASING SYMPTOMS

- I feel much better
- I get less depressed
- pacing has diminished

PERSONAL

- it eases loneliness
- I have friends to talk to
- it helps me to be more active

SPENDING TIME MORE CONSTRUCTIVELY

- fills the days when I have little money to spend
- gets me out of the house
- helps to keep me occupied

PRACTICAL HELP

- meals save me money and so I have less to worry about
- the additional money from my job at Workspace makes a big difference

APPROACH TO LIFE

- I forget about my own troubles
- I don't dwell as much

In general respondents listed more than one way in which attendance helped but warding off loneliness through social interaction and the therapeutic effect of spending time constructively were important benefits for the majority of people leading to improved well-being. Individualised comments are shown below (Box AA.17).

Box AA.17

In what ways does attending the centre help your illness?

I take my tablets here, keep warm and get all my meals

male 50's, living alone, suffering from schizophrenia

It gives me confidence, makes me feel I am doing something special

male 30's, living with family, suffering from anxiety

It definitely helps me. It is more sociable here than going out to the pub

female 44, living alone and suffering with depression

It helps me to keep an open personality

male 50's, living alone

Without doubt! When I first came I couldn't speak, had no feelings, coming here has completely changed that

male 57, living alone, suffering from schizophrenia

The centre is a marvellous thing. There is always someone to talk to and to ask for help

woman 46, living alone, suffering with epilepsy

Yes a lot. There is always something going on. If I was at home I would lie in bed and get bored. It gives me something to do

male 30's, living with family, with challenging behaviour

Participation

In a previous survey (Deepwell, 1990) representation of user interests emerged as an area which required attention. In that study almost half of the sample felt they had no say in the running of the centre. However, in a follow up question less than 25% said that they would want more say.

As this study was conceived to uncover what users felt about the service, it was obviously important to discover what channels people had for communicating their needs both informally and formally.

If we look at the aims of the centre expounded in Section 3 above user participation featured high on the list of priorities. A key question for the evaluation therefore was to assess to what extent users felt they had an opportunity to participate in the way the centre is run, the type of service it delivers and the day to day running of the project. In order to do this we needed to look not only at management structure and how decisions' are taken but also at regime, how people are encouraged and facilitated to participate and most importantly how users perceive the outcome of this process.

Initially participants were asked to consider a number of questions about participation in general (Box AA.18).

Box AA.18

Expressed feelings of participation in the centre

Do you feel involved in the running of the centre?

Often	29%
Sometimes	53%
Never	18%

Are you consulted when decisions are made about the centre?

Often	41%
Sometimes	24%
Never	29%
Not appropriate	6%

Do you feel your comments are listened to and acted on?

Yes	47%
No	20%
Sometimes	13%
No response	20%

As we can see in response to a general question about involvement 82% of respondents felt involved in the Centre sometimes or often. However fewer felt that they were consulted when decisions were made about the Centre, (65%) and roughly the same proportion felt that their comments were listened to and acted upon.

However there are some discrepancies within the figures which suggest that interviewees may have misinterpreted the questions. For example only 18% of the sample said that they never feel involved in the running of the Centre and yet as many as 29% said they were never consulted when decisions were made. An additional 6% said that the running of the Centre was not to do with them - 'the staff do that'; 'We put thing forward and they tell us if it is accepted'; 'Decisions aren't up to us, we shouldn't tell them how to run it we haven't got the right'.

To investigate this area further participants were asked additional questions to see what measures were taken to facilitate participation (Box AA.19).

Box AA.19
User involvement in the centre

Do you feel encouraged by staff to say how the centre is run?

Yes	53%
No	12%
Sometimes	12%
No response/not appropriate	23%

Are you invited to meetings concerning the centre?

Yes	53%
No	24%
Sometimes	18%
No response	5%

Do you feel able to put your point of view across at meetings?

Yes	41%
No	12%
No response/not appropriate	47%

Have you any suggestions as to how meetings can be improved

No	50%
No response	50%

Equal numbers of respondents (53%) said they felt encouraged by staff to say how the Centre is run and that they were invited to attend meetings concerning the Centre. There seemed to be some confusion over the meetings and how often they took place. Several people referred to the fact that meetings 'used to happen more regularly but don't get to hear about them any more'. However when I questioned staff about regularity this had not altered although location had. The meetings were no longer held in the main lounge of the Centre but in a smaller room. Three people mentioned that they didn't bother with user reps.

When asked about the meetings, themselves, what they were about and whether users felt they could speak freely and put their view across, 41% clearly felt that they could. Of the 12% who said they could not this was attributed to lack of confidence and inexperience e.g. 'I keep on being interrupted', 'I can't get a work in'.

There were no suggestions for how the meetings could be improved, although only half of the sample responded to this question.

Interviewees were also asked to consider whether the Centre had any members of staff and users equally, if any areas of the Centre were 'out of bounds' and if so if they agreed with this.

In terms of rules people were fairly equally divided between positive and negative responses. The main rule which emerged was no alchohol, other people mentioned no smoking in Workspace. Where users felt rules were in force they were applied equally to staff and users.

With regard to areas of the Centre which were out of bound. Half of the sample were unaware of any restrictions others pointed to:

> 'the office if staff aren't there because there are private papers'
>
> 'the kitchen during the day in case anything goes missing'
>
> 'the offices upstairs'

Two of the questions were only answered by half of the sample.

5. MENTAL HEALTH SERVICE CONTEXT

Warrington day centre is an integral part of the network of provision in Warrington for the mentally ill. The day centre has close links with Warrington Community Care and residents of both Park Court and Bewsey House are regular attenders at the centre. Residents of Cheshire Social Services Salisbury House also are made welcome at the centre and some are frequent visitors to the day centre.

In addition the provision of the day centre relieves the pressure on other members of the family and neighbours. The day centre provides friendly and confidential support to both the sufferer and family.

Other Day Care Activities

We have already observed when looking at peoples' perceived needs that no other service is identified as a way of meeting needs. However, other services do exist namely The Orford Group and Breeze-In. People were asked directly if they ever attended either of these groups or any other service.

Box AA.20

Other day care activities used by participants

	SOMETIMES	OFTEN
The Orford Group	2	1
Breeze-In	2	1
Drop-In Technical College	1	-
Day Hospital	1	-
Befriender	2	-
Workspace	-	4

The majority of people had not heard of these groups. Three people attended the groups one on a regular basis. Other activities were identified as described in Box AA.20.

Box AA.21

What would you do if you did not attend the centre?

WHAT WOULD YOU DO IF NOT ATTENDING THE CENTRE?	
Don't know	44%
Stay at home	22%
Go for a drink	17%
Go to the day hospital	11%
Voluntary work	6%

Respondents were asked what they would do if they didn't attend the centre (Box AA.21). The overwhelming response to this question was that there was nothing else to do in Warrington. Responses varied from 'I'd be lost, I don't know, there's nowt to do,' to 'I'd vegetate, I'd walk around the streets, I'd lounge about'. Other people just felt they would be stuck at home, with their problems, watching TV, or staying in bed all day. In the absence of the day centre the majority of respondents perceived structure and social contacts being largely removed from their lives. Others envisaged resolving this by seeking other sources of occupation and social contact either in the pub, at the day hospital or doing voluntary work.

Drinking as a solution, apart from it's doubtful health effects, is also severely constrained by lack of money. Resort to the day hospital would seem like a backward step for many of the day centre users but also in practice access is rationed and likely to become more scarce in the future.

DISCUSSION

A very clear message which has emerged from this study is just how important the service provided by Warrington Day Centre is to the people who use it, and also its key role in mental health service provision in the district itself.

The findings also suggest a high degree of satisfaction with the service which the day centre provides and a close correlation between the benefits experienced by users and the principal needs identified by users themselves.

The regime is deliberately flexible and therefore rather different from the service offered in centres run by agencies elsewhere and although a minority of people would have preferred more structure, on balance informality seems to be the key to the centres' success.

The data suggests that users perceived needs and aspects of service delivery which they find most helpful in their every day lives, may be multi-faceted but are relatively simple, and can largely be met by having somewhere to go, someone to talk to and something to do. By simply enabling these things to happen opportunities are created for meeting more specific needs. For example, having somewhere to go gets a client out of the house, thereby structuring daily life. It enables that person to meet other people, thereby satisfying relationship and social contact needs. Engagement in activity may be pleasurable,

increase self-esteem and ameliorate the debilitating effects of illness. Thus it is possible and indeed highly likely that a service offering every day support is preventing the need for large scale medical interventions.

On the face of it then the service appears to be offering a very simple service and yet it is able to respond to a wide range of need.

Although as a matter of principle no records are kept about people, the staff appear to know the clients well to the extent that informal case management is taking place. The author spent a total of ten working days in the centre and observed clients and staff talking to each other and dealing with a wide range of problems. Staff are certainly perceived as the access point for all manner of help from housing needs, to advice on benefits, the effects of medication, and feelings. My view is that they respond to these needs and wear a number of hats, advocate, friend, nurse, counsellor and they do access specialised services where possible.

The key question appears to be not whether the centre is providing the right service - it most clearly is, but how can it be facilitated to continue to do this and how can that support be extended to cover the times when the centre is not open.

Sunday opening is being considered for a trial period and appears to be successful but it is not clear what the effects of extended opening in the evenings would be in terms of patterns of attendance, would people come in later and/or change of clientele. An extension of service in this direction is obviously not cost neutral and would have staffing implications.

Extending the service by buying activities and specialised help into the centre would seem to be a practical way forward and would build on recent successful examples of collaboration between the day centre organiser and officers from other services. However, this type of development would need to be handled with caution to retain the benefits of a flexible service and minimise the dangers of transforming the service in such a way that the users would perceive it as serving professional interests rather than their own good quality consultation is an obvious safeguard here.

The very central location of the centre is one of its key strengths and enables people to utilise it in a very flexible way and in conjunction

with other community facilities and although the centre is specifically aimed at people with mental health problems. The centre seems to successfully interpret this in a very broad way so as to make the centre accessible, yet no-one seems to be inappropriately placed. This gives the centre a strange aurora in that it does not feel like a special, segregated facility and yet there is also a feeling of safety or haven if you like.

A small caveat here is that the centre is more accessible to men both in terms of environment and activities. This is a common problem faced by this type of centre. The introduction of a women's group has demonstrated that there is a demand for support from a significant number of women who feel the day centre service in general is inappropriate for them. This needs further investigation.

The results regarding travel to the centre were interesting, particularly the approach to the cost of travel, as the cost of travel is often identified as a constraining factor when looking at rates of attendance. However, this did not appear to be the case here, despite the high transport costs relative to income.

Having said this, subsidised travel would be of practical help in view of the fact that financial problems featured large in peoples' lives.
However, if a subsidy was possible it would have to be offered in a way which did not encourage dependence, limit choice or demean people. For example, one can safely say at the moment that the high levels of attendance at the centre are not distorted by people being bussed into the centre, reimbursed for travel once they arrive or delivered to the door by professionals. A bus pass would seem appropriate and should be investigated.

RECOMMENDATIONS
The centre should continue to provide the high quality service it is currently providing.

The results of this study suggest that further thought be given to the following:

1. Subsidised transport for mental health service users.

2. Extended opening hours, particularly evenings.

3. An extended range of activities.

4. Further discussion with users about ways in which participation can be facilitated.

5. Special attention to the ways in which the service can be made more sensitive to the needs of women.

6. Continued liaison with other mental health professionals to bring services into the centre.

Corinne Thomason
July 1991.

REFERENCES

Allen, C. (1990) Welfare Indicators in Health and Social Services, towards a greater recognition of the role of qualitative methods in informing resource allocation decisions. MA dissertation, UKC.

Atkinson, P. (1988) Research interviews with people with mental handicaps, Mental Handicap Research, 1(1), 75-90.

Booth, T. (1983) Residents' views, rights and institutional care, in Fisher, M. (ed) Speaking of Clients. Social services Monograph:research in Practice University of Sheffield.

Calnan, M. (1988) Towards a conceptual framework of Lay evaluation. Social Science Medicine, 27(9), pp. 927-933.

Cambridge (1991) Methodology paper for the Care in the Community Five Years on study.Unpublished PSSRU Discussion paper

LeTouze, S. and Pahl, J. (1989) A consumer survey on people with mental handicaps - project outline. CHSS, UKC.

Le Touze, S. and Pahl, J. (1990) A consumer survey among people with learning disabilities. CHSS University of kent.

Leedham, I. (1988) Methodology discussion paper, unpublished. PSSRU, University of Kent at Canterbury.

Leedham, I. (1989) From mental handicap hospital to community provisions. Ph.D Thesis, PSSRU, UKC.

Ritchie, Morrisey and Ward. (1988) Keeping in touch with the talking. Report of the special actions project, SCPR.

Sigelman, C.K., Schoenrock, C.j. Winer, J.L., Spanhel, C.L., Hromas, S.G., Martin, P.W., Budd, E.C. and Bensberg, G.J.(1981) Issues in interviewing mentally reatarded persons: an empirical study, in R.H. Bruiminks, C.E. Meyers, B.B. Sigford and K.C. Lakin (eds) Deinstitutionalisation and Community Adjustment of Mentally Retarded People, AAMD Monograph No. 4, American Association of Mental deficiency, Washington, DC.

Simons, K., Booth, T. and Booth, W. (1989) Speaking out: user studies and people with learning difficulties, Research, Policy and Planning, 7, 1, 9-17.

Walker, R. (1989) Who would like to know why: qualitative research and the policy maker. Research Policy and Planning, 7(2).

Wyngaarden,M. (1981) 'Interviewing mentally retarded clients: issues and strategies', In R.H.Bruininks, C.E. Meyers, B.B. Sigford and K.C. Lakin (eds) Deinstitutionalisation and Community Adjustment of Mentally Retarded People, AAMD Monograph No. 4, American Association of Mental deficiency, Washington, DC.

Appendix B

HOSPITAL CLOSURE CASE STUDY

This appendix contains an internal report produced for Liverpool Health Authority which details discussions around the closure of Olive Mount Hospital. It contains some evaluative material produced as part of the review of the closure process.

CLOSING A HOSPITAL - A CASE STUDY

INTRODUCTION

This report is based on a case study of the dynamics of the closure of a mental handicap hospital in Liverpool and the subsequent creation of an agency to assist that closure. The report gives an insight into the justifications for setting up an agency to facilitate closure and the effects on all participating actors including clients. The study is of particular interest as the development is happening in an area known for its strong voluntary tradition and highlights well the differences, the similarities, and conflicts between the old style voluntary agencies and emerging voluntary organisations set to up to further specific statutory sector objectives.

BACKGROUND

Research Aims

This case study is interesting, not only because the strategy closed a hospital, but also because it largely used a single agency to achieve this end. There are other elements which make this particular example a good focus for evaluation. All developments are set against a backcloth where 'strong voluntary tradition' is writ large and where the health authority concerned promotes itself as 'being in partnership' with a plethora of managing agencies (LHA 1990).

These twin elements are practical illustrations of two of the dominant themes of social policy in recent years, the emphasis on mixed economy and concerted attempts at dehospitalisation. What happens in practice when these themes conjoin in a strategy for service development? How does the service in practice reconcile service principles, policy change and political expediency? What weights are attached to different and often conflicting factors when decisions are being made, i.e. needs of users, organisations, staff, availability of finance, type of service? And what impact do other extraneous factors have, for example maintaining the status quo, regional and national policy direction and as we will see, an important element in this case, time constraints? [1] Finally, what lessons emerge for the efficacy of recent developments in community care policy from this experience?

Service developments are complex animals and it is sometimes difficult to see clearly which factors are most influential in determining a way forward. This is an attempt to do so by bringing a variety of perspectives to bear on the evidence and interpreting it in the light of these different views.

As someone interested in voluntary/statutory sector links and the basis on which they are formulated, the closure of Olive Mount Hospital presented me with the opportunity to examine the process of change in great detail. The closure was particularly opportune as it happened in the middle of my study period and compared with other closures was very fast (15 months from start to finish). I was particularly interested in casting light on which factors most influenced a closure strategy? For example I was interested in answering the following questions:

1. Whose needs does the development meet?

2. What are the emerging issues for future consideration?

3. Does practice conflict with the objectives outlined in the white paper?

4. What are the implications for the further development of a mixed economy of care?

Methodology

The analysis is based on a review of planning documents, publicity material, correspondence, observation at an all-day meeting involving all the key players and individual interviews.

The brainstorming day had two main aims:

1. To examine the history and politics behind the development and the resourcing of the strategy pre November 1989.

2. To explore the management of change issues which arose from the implementation of the strategy post November 1989.

The brainstorming day was recorded on tape and pictorally on flip chart paper. Information gathered on the day was used to a) inform

the face to face interviews which followed b) as a source for comparison with the data which emerged from the indepth interviews and c) as opportunity for reflection and pooling of information.

Face-to-face interviews were then conducted with thirteen of the key actors. The interviews lasted approximately ninety minutes and were loosely structured around a number of themes:

1. The interviewees role in the strategy.

2. What factors guided the strategy?

3. What have been the key successes and failings of the strategy?

4. What is the history of joint working in Liverpool?

5. Whose needs did the strategy meet (prioritise) relatives, staff, health authority, clients?

6. What is the nature of the voluntary sector in Liverpool?

7. What are its characteristics, strengths and weaknesses and why did the health authority opt for a new 'breed' voluntary when a range of organisations already existed?

8. Anticipated problems/issues for the future?

Information was also drawn from a series of formal interviews with key actors from the social services department of Liverpool City Council and with senior members of voluntary agencies involved in services for people with learning difficulty in Liverpool.

Service Development

The National Development Team visit in January 1989 provided a dramatic push for change in the organisation of services for people with learning difficulties in Liverpool (NDT 1989). Commenting on services in Liverpool which he described as 'starting from a low baseline' - Derek Thomas, the Director said, 'many of its services are traditional in style, large scale and very separate from the life of the community'. The team supported proposals to develop much more local services using ordinary housing and developing programmes that emphasise the importance of employment and a range of leisure and educational opportunities. However the Director also urged that this should be done in partnership with the local authority's other departments and with the health authority and the many voluntary agencies in the city. 'There is, he suggested, a window of opportunity for a joint strategy, it must not be missed'. At this stage the team recognised that there was considerable overlap in the stated aims of the various agencies and that there was a great potential for reaching a common service philosophy. But at that time the agencies were working separately, the social services department were preoccupied with the closure of and redevelopment of New Hall hostels and the health authority were tentatively making plans for the closure and reprovision of services at Olive Mount Hospital.

In the voluntary sector there were some interesting examples of small scale Care in the Community projects funded with joint finance money and managed by agencies such as L'Arche, Barnardos, LPSS, Brothers of Charity. As far back as 1984, as part of the Care in the Community initiative MENCAP Homes Foundation and Liverpool Housing Trust had worked successfully with Liverpool health authority to bring twelve people out of Olive Mount Hospital to live in three, four bedroomed houses in the Old Swan district of the city. However, despite these examples there was no co-ordinated approach to care for people with learning difficulties and the NDT made the development of a single inter-agency strategy one of its central recommendations. The SSI (1989) also endorsed this view in the following recommendations after its visit two months later. This was taking place in the context of no widely acknowledged philosophy or value base for the development of services for people with learning difficulties in Merseyside and with a health authority which appeared to give greater emphasis to procedures and financial safeguards than to ensuring that the professional medical and paramedical service needs of patients/tenants were being met. There were particular deficiencies in relation to the services supposedly available through CMHTs such as psychology, physiotherapy and speech therapy.

LMHF should seriously consider initiating a comprehensive inter-agency review involving as many staff as possible and with representation including health, education and day care. The aim should be to appraise what has been achieved; to build on what is positive, and to identify past pitfalls and difficulties with a view to drawing up an action plan to remedy problems and avoid the repetition of similar experiences in future projects.

Policy Direction

Caring for People also had a major influence on the development of the closure plan for Olive Mount and although the need for speedy resettlement by April 1991 in order to maximise benefits was made irrelevant by the delays in implementation, financial expediency did act as a stimulus. However there are other recommendations in the community care policy which are pertinent to this development, and to our evaluation. The recommendations themselves are based around a number of admirable principles these being: to provide a range of services, concern for carers, the promotion of case management practice and needs' assessment, maximum use of the mixed market of provision to widen choice, the qualification and responsibility of various agencies, and value for money. The intentions made explicit in the following extracts from the community care white paper are vital to a consideration later on in this chapter of whether policy and practice coincide in this case.

> The government wishes to promote further progress within available resources and is exploring how this can best be done. In particular, it wishes to encourage a provision of services to individuals, developed from a multi-disciplinary assessment of their needs made with proper participation with the individuals concerned, their families and other carers. (2.15)

> When these new forms of service are sufficiently developed people with a mental handicap should only be in NHS

facilities when they have medical or nursing needs which cannot be practicably be met by other than such facilities. There will be an increasing need for an appropriate range of health care to be available both through general and hospital practice, domiciliary services, and specialist services. There will continue to be an important role for those such as consultants in the psychiatry and mental handicap with particular knowledge and experience of treating patients with a mental handicap. (2.16)
Nor should community care be seen as the prerogative of public services. People like to take responsibility for their own needs wherever possible. We are fortunate in having a thriving voluntary sector, and a rapidly growing private sector. The government believes that people welcome this mixed provision of care, and that it encourages innovation, diversity, proper attention to quality and the interests of consumers. ----- (2.21)

The government will expect local authorities to make use wherever possible of services from voluntary, 'not-for-profit' and private providers in so far as this represents a cost-effective care choice.... (3.4.1)

Stimulating the development of non-statutory service providers will result in a range of benefits for the consumer, in particular:. a wider range of choice of services;. services which meet individual needs in a more flexible and innovative way;. competition between providers, resulting in better value for money and a more

cost-effective service. The government envisages however, that the statutory sector will continue to play an important role in backing up, developing and monitoring private and voluntary care facilities, and providing services where this remains the best way of meeting care needs. (3.4.3)

THE STRATEGY - *Key Influences and Determining Factors*

Background

On the 8th November 1989 Liverpool Health Authority received formal approval for the resourcing of its strategy for the development of services for people with profound learning difficulties. With the pressures imposed on both Mersey Regional Health Authority and Liverpool Health Authority from the implications of the Government's White Paper 'Caring for People' which was at that time scheduled for implementation in April 1991, and the need to reduce bridging finance for the hospitals double running costs to an absolute minimum, the resources were received only on the condition that the closure was fast tracked and achieved by December 1990. What follows provides some insight into the planning processes which have gone on and how the strategy was implemented within such a tight timescale.

The planning process (Autumn 1987 - November 1989)

Letter from Region November 1989 concerning availability of funding for mental handicap strategy, the total cost limitation of which was a total capital requirement of £4.6 million and a revenue bridging of £7 million. The letter contained a number of conditions abiding by which the funding will be made available.

In 1988 the strategy looked like this:

1. Ordinary housing would be provided for 60 residents with day care services in the community.

2. Six 8-bed nursing homes would be provided within the relatively new wards and a 40-place day unit on site.

In early 1989 MRHA requested that the strategy be re-examined to see whether or not the provision of more places off the hospital site could be afforded. Protracted negotiations took place which led to financial approval and a service model which satisfied O'Brien's five accomplishments and satisfied the principles which had been endorsed by the National Development Team and MRHA's 'A Framework for Living'.

Aims

The elements of the strategy as finally agreed in March 1990 were:

1. 26 x 3 person group homes in the community with intensive levels of staff support.

2. 17 adult fostering placements.

3. A 14 place nursing home.

4. A specialist support service for people with challenging behaviours and/or psychiatric problems.

5. The expansion and development of the community support teams.

6. An FE Pilot Project at South Mersey College now known as a study link project.

Practical issues

A strategy implementation core group was set up in April 1989 to meet weekly to address some of the practical issues of implementation which were:

1. How are the futures of staff best secured.

2. How can the commitment of staff be best secured during change.

3. How can 26 properties and, at that time 2 nursing homes, be purchased, adapted and equipped.

4. How is reliable information on the needs of the residents to be obtained.

5. How do we develop and refine the financial model.

6. How do we train up staff to work in the new services.

7. How do we obtain senior support and commitment to the strategy.

8. How do we try to allay the very natural anxieties of relatives.

9. How to persuade staff to switch to the three shift system in the

houses.

Aims Reviewed

When asked to describe the key aims of the strategy those interviewed seemed to be divided about whether the principal aim was the process of hospital closure or whether the hospital closure was simply a means to an end, that is providing a service for people in ordinary accommodation in the community. Without exception the interviewees responded to a question about principal aims in terms of hospital closure. Not all added to this the corollary of developing a community based service to replace this. All interviewees also mentioned re-location into ordinary houses in the community but there was a difference of opinion as to whether closure was due to the political will to go for an ordinary life philosophy or whether the strategy was finance-driven. One interviewee commented that the closure was just a means to an end and that the key objective was to move people to the community within the five accomplishments model and that their broader mission was to improve the infrastructure of services for people with learning difficulties in Liverpool. One interviewee commented another aim was to prove that the health authority could do it i.e. demonstrate functional autonomy.

The Mixed Economy of Care in Liverpool Post 1989

Liverpool has a strong philanthropic tradition across the spectrum of voluntary activity. The caring area is no exception to this. One of the first schemes to take people out of Olive Mount Hospital was spearheaded by Liverpool Housing Trust and MENCAP Homes Foundation, in collaboration with the health authority using joint finance monies.

Joint working in Liverpool has often been somewhat strained at the macro level although individual examples of collaboration at officer level have been productive. When asked about collaboration with other agencies the people involved in the strategy described a situation of paralysis mostly attributed to political constraints and shortage of money where the SSD was concerned and disorganisation and preciousness over admission as well as unwillingness to diversify where the voluntary sector was concerned. Only a few people felt that it was down to lack of ability of officers in the local authority. Although there was an awareness that the SSD was preoccupied with closure of its own large institution, New Hall hostels.

As we will see, there is an element of conflict here in what was practice pre 1989 and post hoc justifications after the new strategy had been formulated.

An interesting aspect of joint working in Liverpool is the flow of key individuals between services, in particular, the movement of social services staff to health either via change of job or secondment and perhaps crucially the secondment of one of these people to the new managing agency which was largely used to close the hospital.

It undoubtedly follows that this continuity aided implementation and led to clarity of purpose, single mindedness as well as being a stimulus and drive (a Senior Social Workermoved deliberately to make it happen) so even in a city renowned for its strong left wing principles and hence one might expect opposition to a sector which could be in competition for jobs the voluntary sector has thrived.

In fact, interviews with key personnel in all sectors suggested that in recent times it had continued to thrive directly because of poor relations between health and social services. Both agencies being happier to work with the voluntary sector than each other.

The health authority in particular worked extensively with the voluntary sector to move people out of hospital in its Care in the Community programme. In a document publicising its Care in the Community initiative (LHA 1990) it describes the mode of service delivery as being working 'in partnership with six managing agencies from the voluntary sector together with five housing associations to provide forty two small group homes, one small nursing home, eight professional fostering placements and two family placements. The agencies with which the health authority works are MENCAP, Brothers of Charity Services, AHP Group Services Ltd., L'Arche Liverpool, Barnardos North West, Liverpool Personal Service Society and CIC. 'By the end of 1990/91 over three hundred and thirty five places will have been developed for people with learning difficulties who previously lived in long-stay hospital in the north-west, a total of seventy three small group homes, two nursing homes, nineteen family placements and eight professional fostering homes will be operational in the Liverpool health authority Care in the Community initiative'.

Key Determinants of Strategy

As the health authority developed their strategy there were a number of pre-conditions that needed to be taken into account.

1. Hospital staff would have to be redeployed in order to release capital.

2. To fund community services adequately (_ higher) health managers wished to make use of DSS allowances.

3. Health managers wished to place people in ordinary housing, no more than 3 clients per house, and implement a pre-specified day care model.

4. The policy regarding community placements and benefits outlined in the white paper (before the delays) meant that the strategy would need to be implemented quickly or this source of additional funds would not be available.

Choice of Managing Agency

Crucial to the choice of Community Integrated Care (CIC) as an agency to operationalise the strategy was the failure of joint working with the health authority, the unwillingness of the voluntary sector to make maximum use of benefits for philosophical reasons, the offer of substantial additional monies from Region provided the hospital closed quickly and the NDT visit which highlighted a way forward for service development.

A key determinant of the decision of the health authority to use a voluntary organisation other than those of which they had experience were the perceptions of the sector held by health service managers.

When asked to consider the strengths and weaknesses of organisations the following emerged.

1. Health authority had 'fingers burned' on a previous occasion where voluntary agency staff had been highly critical of health service staff. This did not bode well for dealing with staff sensitively during de-commissioning.

2. Not willing to maximise DSS benefits for philosophical reasons.

3. No confidence in structures of organisations. NO managerial culture/need support.

4. Not able/willing to manage such a large scale project.

5. Agencies seen as too inflexible to bend to preferred service model or to move quickly.

6. On the positive side the voluntary sector is viewed as a valuable critic of the state, usefully raising pertinent issues in service development.

When asked to compare the two largest voluntaries in this field with CIC, health service managers scored all agencies highly on innovation but the other agencies win on quality and how needs led services are but CIC scored more highly in the value for money stakes. (See Table AB.3).

When members of the voluntary sector were asked about their own

priorities in the design of services the following emerged:

- needs led services
- high quality services
- innovation in service delivery
- value for money

We can see that health service managers perspective of voluntary sector and voluntary sector aims coincide but the priorities attached by each sector to these different considerations are at variance. Health authority managers felt that CIC as a single agency was more cost effective and because of the ordinary life model and the diversity within that, there was more chance of people getting what they want. But services are not allocated on the basis of need.

The perspectives of all sectors was in fact relevant here as an attempt was made via the joint working framework to set up a trust to manage the closure but agreement could not be reached Table AB.1 indicates the perspectives revealed in interviews with key actors. They provide valuable insights into the broader scene in which this decision was made.

Health now view SSD as not seizing the opportunity because of the constraints imposed on them but feel that despite the polemics at the time they are secretly pleased that the scheme went ahead as it will improve the infrastructure.

SSD predict that the likely scenario for the future is that traditional voluntaries will be involved in philanthropy and NFPO in service

delivery. The creation of CIC is viewed as an amalgam of convenience and that its independence is certainly under question.

Table AB. 2 documents responses to a questionnaire to elicit beliefs about the sector. The table shows responses from actors in each of the sectors and the final column for actors who were involved in the strategy. It is interesting to note that where there is unanimity over characteristics across the sectors, responsiveness to consumer need for example, responses from actors involved in the strategy do not support this.

Equally when questioned about how rule-bound the voluntary sector is responses across the sectors largely supported the suggestion that the voluntary sector is less rule-bound. However less than half of the people questioned in the sample strategy supported this assertion.

There was more convergence of views over whether or not the voluntary sector deals with non-urgent need. The majority of people disagreed with this statement.

THE MANAGEMENT OF CHANGE - *The Process Reviewed*

The Management of Change (December 1989 - February 1991)

In December 89 there were 123 residents living at the hospital and 197.89 whole time equivalents of 250 people working at the hospital. By February 1991 the strategy had been completely implemented bar the refurbishment of Wavertree Lodge and the Post Grad Villa for beds for the special support service for people with learning difficulties and psychiatric problems and/or challenging behaviours. This could only

be done in April 1991 when the capital had become available.

Reflections on the Strategy

A key focus of the brainstorming day and individual interviewees was to get people to consider the enabling factors and barriers to change, the successes and failures of the strategy.

Enabling Factors

Discussion in the wider groups threw up the following. From a planning point of view Mersey Regions 'A Framework for Living' published in 1987 provided a clear vision of what a service should look like, this was reinforced by the NDT's recommendations in 1989. There was agreement that Olive Mount was not the place to provide a service for people, that it was a 'bad bin' and it was imperative that it should close. On the financial side the collapse of the programme budget in 1987 meant that projects needed to be self-financing if they were to go ahead and the re-distribution of ring-fenced monies by Region meant that each district knew what monies were available. The strategy employed by region to encourage closure viz à viz targetting specific hospitals with additional cash and the deadline for boarding out payments imposed by the white paper recommendations were also incentives/enablers. Key personnel at all levels of the strategy were mentioned time and again for their experience, commitment to change and tireless efforts.

Barriers to Change

A number of barriers to change emerged. Internal to the hospital many of the barriers were those familiar to other hospital closures (see Cambridge & Thomason (1989) for full explanation). In brief

staff re-deployment could have been potentially explosive and staff needed to be persuaded that the strategy was the best for the clients, relatives, themselves. Previous turbulent history of community care schemes made the idea lack credibility, irrespective of the potentially more invasive difficulty of institutionalised staff - institutionalised attitudes. There was also a them and us culture surrounding the relationship between management and staff and families which led to a certain amount of distrust. The hospital was described as being run by 'a mafia style' force resulting from a well organised union and 'surrendered management'.

Successes and Failings

Each interviewee was asked to consider the key successes of the strategy and conversely its key failing/drawbacks.

A number of themes emerged from this line of questioning, sometimes an element associated with success also had a down side so was also mentioned as a negative. Therefore it seemed useful to consider the positives and negatives side by side with a thematic framework (see Table AB.4). The table is fairly self-explanatory and illustrates well that most of the themes had negative and positive influences on these success of the strategy. These interpretations are self-evaluatory but also have their counterparts expressed by members of outside agencies.

Achievements of the task featured time and again in face to face interviews coupled with statements eluding to joint working, 'we all came through it together', 'there was a certain Dunkirk spirit'. Also the feeling that all the key players had invested a lot in providing that

it could be done and were immensely proud of their achievement.

Many of the responses were very similar even down to the use of common language which may be a result of the very close bond people formed as a result of meeting weekly and being heavily dependent on one another to make the strategy achievable. Cohesion was a strong theme partly because of the fear of failure perhaps. The alternatives were just too awful.

Commitment to closure and that it was the 'right thing to do' also came through strongly. 'We weren't precious about it we just improved the quality of life.

When considering strengths and weaknesses of the strategy different emphases were placed on different elements by various actors. The strategy sample can be divided roughly into four categories

medical
managers
practitioners
people co-opted from other agencies

There were some elements which were common to all groups however, commitment to task, sense of achievement, gruelling effect on everyone, improved quality of life. However, although there tended to be unonimity about process and task related issues, views differed over ideology, personnel and user related issues. Most of the negative responses were explained using the time constraint factor. For example, it was a push led closure not a people led closure and there

was no time to properly assess clients (Table AB.5).

There is no doubt that skill and rugged determination were felt to be key factors in managing to avoid major industrial relations problems and opposition from parents but there was also an honest acceptance that it could have gone the other way and a certain amount of relief was expressed over this.

Contributors who I have categorised from outside agencies tended to hold more reservations about the speed at which decisions were taken. They, in particular, pointed a less rosy picture of how smoothly staffing issues were handled. They certainly expressed a certain amount of stress and anxiety amongst staff, not revealed in discussions with managers of the strategy. 'Staff regarded the move as the best of a series of not very attractive options'. Although managers went some way to acknowledging this by saying that the strategy was handled with the minimum of staffing problems. Staffing issues were handled well in the circumstances.

The time factor also emerged in the common language mentioned earlier. Several people mentioned phrases like 'off the blocks', 'whirlwind of change', the official documentation uses the term 'fast tracking', 'we were carried along by our peers when we were at a low ebb', 'quick death, no chance to draw breath'.

Importantly on the negative side that speed did adversely affect decisions, although people were ambivalent about this. Decisions over placements, cost of houses, little time for consultation, no choice for those left, disappointment over nursing home.

Future Issues

Interviewees were asked to consider what, in their view, the key issues for the future were. Several people commented that the 'real task' was just beginning and that a lot of work lay ahead. Specifically there were areas that interviewees felt lay unresolved, first service quality. Interviewees felt it important that quality objectives be set to ensure that standards remain high. One could argue that it is rather surprising that the health authority have proceeded with this major change in direction without first ensuring that this safeguard was in place. Day services also need to be organised as there are no coherent plans for activity makers.

Concern was expressed about the managerial competence of CIC. There was already evidence of inefficiency in the slow production of financial accounts by head office. This is interesting as one of the key reasons given for not using existing agencies was the perception of them as inefficient and lacking in managerial acumen.

Major problems also lay ahead with staff as they switch from sleep-ins, lose protection money and the service settles down and has to deal with cover for leave due to sickness, holidays, turnover etc. (Sickness has been negligible to date.)

It was also felt to be important for CIC to become more independent and develop its own identity which somewhat contradicts feeling expressed earlier in the strategy about the benefits of maximum control over the managing agency.

WHY CIC

'We never felt the authority were the best able to do it. We knew that other people could do it better'.

At the heart of this study is the need to discover why services take the shape of the form that they do.

The white paper talks at length about choice for clients, service design built around client need, but purchased with a mind to cost-effectiveness which I choose to interpret here as good quality options, with positive outcomes at the lowest possible costs. The white paper also implies that there should be a range of options to offer choice to users whose needs will be diverse but in the knowledge that this diversity will not be forthcoming within the existing system, it acknowledges the positive contribution other sectors can make and encourages use and stimulation of the independent sector (private and voluntary agencies).

In order to achieve the long awaited benefits for users in terms of diversity, appropriateness and high quality options it was seen as a pre-condition of what it should be, knowledge of about what the sectors do, can do and what the outcomes are.

Table AB.1

AGENCY PERSPECTIVES ABOUT THEMSELVES AND EACH OTHER

	Health	Vol	SSD
Health	Commitment to close hospital. Ability to do it + expertise	Too precious. Disorganised. Not cost-effective. Not flexible. Good at raising issues	Political constraints. Lack of ability. New Hall hostels. Never do anything
Vol	Finance driven. Doubtful philosophy. Lack of ability of managers. Treat CIC differently.	Diverse. Unco-ordinated. Critical of each other. We have expertise.	No money. Supportive of vol sector. Pre-occupied with New Hall.
SSD	Trying to off-load service Pre-occupied with hospital closure - finance driven. Money available/CIC amalgam of convenience, less constrained.	Positive. Supportive - strong and versatile. Can help to respond in current climate.	Moving towards acceptance of mixed economy. Opposition to private sector.

Table AB.2

PERCEPTIONS OF VOLUNTARY SECTOR

Question	Voluntary		Health		SSD		Strategy Sample	
	POS	NEG	POS	NEG	POS	NEG	POS	NEG
More responsiveness to consumer need	100%		100%		100%		60%	30%
Less qualified staff	60%	20%	100%		60%	30%	40%	50%
Less rule-bound	80%	20%	100%		60%	30%	40%	40%
Deals with rare needs	40%	20%		100%	60%	30%	40%	30%
Deals with non urgent need	20%	60%	50%	50%	60%	30%	30%	55%

Table AB.3

ASSESSMENT OF MANAGING AGENCIES BY HEALTH AUTHORITY

	CHARACTERISTICS	
AGENCY TYPE	ADVERSE	FAVOURABLE
Innovatory organisation	• Articles of association limit work to people under 25	• Type of service valued
Christian Community	• Grown to optimum size • Preference for more able residents • No potential for secondment because of spiritual approach	• Service valued
Large religious based organisation	• No potential for secondment • Heavily involved in re-development of own service • Doubt over philosophy	• None identified
Traditional organisation	• Conditions of service divergent • Heavily involved in relocating people from other hospitals	• Some potential for secondment • Good at keeping to schedule
Well established Social Services agency	• Busy with full programme relocating people from other hospitals	• Philosophically in tune • Specialise in boarding at family placements • Proven track record
New style offshoot of traditional national organisation	• Opposition to full use of DSS monies • Poor reputation with hospital staff due to past insensitivity • Previously requested additional monies • Preference for larger units • Staff unwilling to be seconded • Conditions of service different • Likely to be working with SSD on another large closure	• Philosophical approaches commendable • Management structure solid
Community Care Trust	• None identified	• Clearly demonstrated understanding of strategic needs of health authority • Willingness to implement strategy and policy • Will accept staff without pre-conditions • Single agency will allow control to meet tight deadline

Table AB.4

REFLECTIONS ON STRATEGY

Category	Positive	Negative
Task	Achieved aim. Proved ability. Commitment to closure	Continuity of care suffered.
Ideology	Improve quality of life and infrastructure. High quality/ordinary housing. Only 14 in nursing home	14 in a nursing home, no choice for those left. Push led closure not people led
Process	Camaraderie, ownership of change. Broke the rules. Short timescale - encouraged achievement - focussed team - kept to time Massive commitment and input. Service developer acted as co-ordinator and interviewed to clear blockages. Managers had good track record.	Service developer - pet rottweiler / pollyannish attitude. Getting over standing orders. Split duties on supply side. Short timescale - too fast for day services - delay in housing meant schedule illogical - no chance to draw breath - keeping to time major headache for housing manager.
Personnel	Staff with us no IR problems. Vast experience combined to effect change. Cohesion in whirlwind of change. Dunkirk spirit. Training programme.	Gruelling effect on staff. Core team experiencing doubt about own futures. Conflicts with host agencies.
Users	Families with us. A lot of work with families and users. Only one move.	Neighbours - could have had more chance to prepare. Push led closure. No time to properly assess clients.
Costs	A lot of money double the dowry plus capital from region.	Payed more for property to secure it. Personal - worked nights + weekends.

Table AB.5

WHOSE NEEDS DID THE STRATEGY MEET?

Type of Staff	Relatives	Clients	Staff	Authority
anagerial staff	2	1	3	4
linical	3	4	2	1
PSS	3	2	4	1
ousing and supplies	2	1	3	4
ersonnel and training	3	1	2	4
ursing	3	1	2	4
nancial	2	1	3	4
C	4	2	3	1

Appendix C

EXCERPTS FROM QUESTIONNAIRES USED IN THE DHA STUDY

This appendix contains selected pages from the questionnaires used in face-to-face interviews with respondents from voluntary and statutory agencies.

(The questionnaires are not complete but the pages presented are illustrative of the types of questions asked. Complete questionnaires are available on request.)

AREA: | REFERENCE: NHS/ | DATE:

VOLUNTARY SECTOR ACTIVITY AND PUBLIC SECTOR SUPPORT IN CARE IN THE COMMUNITY

Questionnaire for representatives of Health Service Agencies

This work is funded by the Economic and Social Research Council and conducted by Corinne Thomason and Professor Martin Knapp, Personal Social Services Research Unit, University of Kent at Canterbury (telephone 0227 764000).

Typeset at the PSSRU by JD 1991

TO THE INTERVIEWEE

This questionnaire has been designed to gather information about the organisation of services for people with long term care needs associated with mental health problems/learning difficulty in your area.

It specifically aims to explore how agencies work together to provide services and to what extent and on what bases you work, in conjunction with voluntary agencies, to provide services.

Please do not feel constrained by the areas covered in this schedule, they are not definitive. Additional information in the form of planning documents, strategy papers etc. are most welcome.

Thank you for your co-operation.

Corinne Thomason
Research Felllow
Personal Social Services Research Unit
Cornwallis Building
The University
Canterbury
Kent CT2 7NF

Tel. No. (0227) 764000 Ext. 3875

INTRODUCTION

I would like to get a general picture of services for people with mental health problems/learning difficulties in your area.

I am therefore interested in having quite a wide-ranging discussion which might cover some or all of the following:- overall strategy, service mix, inter-agency relationships, consumer participation in service delivery, preparation for the contract culture, monitoring and regulation. More specifically I would like to hear your views on the relative strengths and weaknesses of the different sectors in service provision.

This interview is therefore designed to allow for a semi-structured discussion around a number of key themes with a more structured component vis à vis perspectives on the voluntary sector.

1. Mechanisms for de-hospitalisation.
2. Who are key people in other agencies?
3. Which agencies provide what types of services for people with mental health problems in your area?
4. Inter-agency relationships.
5. Finance.
6. Consumer participation in service delivery.
7. Assessing consumer need.
8. What are the relative strengths and weaknesses of the different sectors in your area?
9. What preparations have been made with respect to *Caring for People*?
10. Any other research?

AREA: | REFERENCE: SSD/ | DATE:

VOLUNTARY SECTOR ACTIVITY AND PUBLIC SECTOR SUPPORT IN CARE IN THE COMMUNITY

Questionnaire for representatives of Social Services Agencies

This work is funded by the Economic and Social Research Council and conducted by Corinne Thomason and Professor Martin Knapp, Personal Social Services Research Unit, University of Kent at Canterbury (telephone 0227 764000).

Typeset at the PSSRU by JD 1991

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NOTE TO INTERVIEWER

1 This questionnaire can either be used in its full form, if time allows, or by selecting different modules. Each part is complete in its own right.

2 **People with mental health problems/learning difficulties** – both of these terms have been used throughout this questionnaire. Please make it clear to the interviewee which client group is the focus of the study in each research area

TO THE INTERVIEWEE

This questionnaire has been designed to gather information about the organisation of services for people with long term care needs associated with mental health problems/learning difficulty in your area.

It specifically aims to explore how agencies work together to provide services and to what extent and on what bases you work, in conjunction with voluntary agencies, to provide services.

Please do not feel constrained by the areas covered in this schedule, they are not definitive. Additional information in the form of planning documents, strategy papers etc. are most welcome.

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This interview is therefore designed to allow for a semi-structured discussion around a number of key themes with a more structured component vis à vis perspectives on the voluntary sector.

A. STRATEGY

1. Do you have any strategy/planning documents regarding people with mental health problems/learning difficulty?

2. How old is this document? Have there been substantial revisions and how has it changed from earlier documents?

3. What are the key factors which influence your policy towards these client groups?

4. What are the main problems for service development and do you expect them to continue?
   (N.B. changes in specific funding, increased demand, effects of other agency services etc.)

5. What are your key aims in relation to these client groups?

B. WHITE PAPER

1. What in broad terms has been the local response to the proposals in the white paper?

2. How have you prepared for implementation - lead officer - project group - external consultancy?

3. What priorities have emerged from the local change agenda?

4. What key changes are being proposed locally and within what time scale?

5. What has been the response to proposal for change and your implementation strategy from:

   a) local authority members

   b) your own staff and staff groups

   c) other local agencies

   d) users and user groups

6. In practice what effect will the delayed implementation have in the immediate future/in the long term future?

7. What do you expect to be the main issues associated with the shift to enabling role (challenges, difficulties, opportunities)?

8. How much potential - in terms of ability and willingness - is there within the non-statutory sector to take on a larger service providing role?

9. What do you feel the effects of an enhanced role will be on:

   a) voluntary organisations

   b) users and carers

   c) your authority

C. CONSULTATION

1. Which district health authorities cover your area?

2. Which other SSDs does your DHA serve?

3. How are users and their representatives currently consulted about service provision?

4. Will current arrangements for collaboration with other agencies and users alter substantially as a result of the white paper proposals?

5. How do you propose to increase participation and choice by service users and enhance support for their carers both in the process of implementation and thereafter?

6. With regard to the mental illness specific grant, have you identified any priorities for how this could be spent?

7. Have you taken part in discussions about this?

8. Is your authority willing to make the appropriate financial contribution?

9. What will the money be used for?

D. PURCHASING, CONTRACTING AND BUDGETING

1. Is there already a mixed economy of care in your area?

2. Can you give me any examples of recent switches from provider to purchaser role?

3. What has been your authority's experience of tendering and contracting?

4. What lessons are there from these experiences?

5. Are you financial information systems geared up to dealing with the purchaser role?

6. Do you feel there are any services which do not lend themselves to contracting, if so which ones?

AREA: | REFERENCE VOL/ | DATE:

VOLUNTARY SECTOR ACTIVITY AND PUBLIC SECTOR SUPPORT IN CARE IN THE COMMUNITY

Questionnaire for members of Voluntary Organisations

This work is funded by the Economic and Social Research Council and conducted by Corinne Thomason and Professor Martin Knapp, Personal Social Services Research Unit, University of Kent at Canterbury (telephone 0227 764000).

Typeset at the PSSRU by JD 1991

NOTE TO INTERVIEWER

This questionnaire can either be used in its full form, if time allows, or by selecting different modules. Each part is complete in its own right.

Not all sections may be appropriate for some organisations. For example, a ***service-providing*** agency may not have a membership (section C) as such or use volunteers. The questionnaire is broad-based to be sensitive enough to the different characteristics of a diverse set of organisations, but where a line of questionning is clearly inappropriate to that organisation, proceed to another section.

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This ESRC funded research project has been running since January 1989 and is due to finish in April 1992. It forms part of a larger programme of research into the Mixed Economy of Care hosted by the Personal Social Services Research Unit. The research is directed by Professor Martin Knapp and Corinne Thomason who are, respectively, Deputy Director and Research Fellow at the Personal Social Services Research Unit, University of Kent at Canterbury. For further information about the work telephone Canterbury (0227) 764000.

The work aims to describe and evaluate the roles of the voluntary sector in the provision of care and support in community settings for people with long-term needs. In particular it will:

1. Examine the expectations and assumptions held by the respective sectors about their own and each other's roles in provision.

2. Describe public sector support for voluntary organisations (funding, assisting, kind, tax advantages, etc. both nationally and locally).

3. Assess the validity of the expectations and assumptions about the roles using empirical evidence from four district health authorities where the work will be based, and finally draw policy conclusions about the strengths and weaknesses of the sector in the 1990s in the context of the White Paper proposals.

TO THE INTERVIEWEE

This questionnaire has been designed to gather a wide range of information about your organisation and what it does. It specifically aims to explore the ways in which you contribute to the mix of community services for people with long-term care needs in your area and uncover to what extent and on what bases you work in conjunction with statutory agencies to provide services. Please do not feel constrained by the areas covered in this schedule, they are not definitive. Additional information in the form of planning documents, strategy papers etc. are most welcome.

Thank you for your co-operation.

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A. TYPE OF ORGANISATION

1. How old is the organisation?

2. What are its aims and objectives?

3. Who does it serve?

4. Which category best describes your organisation?
   a. Service providing
   b. Mutual aid
   c. Politically motivated
   d. Other

4a. If ***service providing*** - which of the following statements best describes the type of service you provide?
   a. Supplementary/extension to existing services
   b. Alternative to existing services
   c. Specialised service
   d. Other

4b. If ***mutual aid*** – which of the following best describes why there is a need for your organisation and what it does?
   a. No service exists already
   b. The statutory service which exists is not applicable
   c. The existing service is not caring enough
   d. The existing service lacks the expertise to deal with need in question
   e. Other

4c. If ***politically motivated*** – which of the following best describes your activities?
   a. Client advocacy
   b. Political lobbying
   c. Critical dimension
   d. Other

B. ACTIVITIES

5. What proportion of time does your organisation spend on the following activities?
   a. Fund raising
   b. Support to members
   c. Research
   d. Campaigning and lobbying
   e. Liaising with other agencies
   f. Administration
   g. Other

6. How many projects is your organisation working on at the moment?

7. How does this compare with 5 years ago?

8. What is the relationship of your work to that of local government (complimentary/same)?

9. How frequently are written reports of your work prepared and who receives them?
   a. Members
   b. Subscribers
   c. Grant providing agencies
   d. Others to whom your organisation has obligations

C. MEMBERSHIP (if appropriate)

10. How many people belong to your organisation?

11. What proportion are
    a. Service users
    b. Someone close to the user
    c. Officials
    d. Professional people
    e. Nominees of other bodies
    f. Interested members of the public

12. Is membership increasing/remaining steady/decreasing?

13. Do you target membership on any particular group?

14. Have you any indication of the loyalty/keeness of your membership? For example
    a. Numbers attending general meetings
    b. Numbers attending conferences
    c. Numbers subscribing to your Newsletter etc. or on your mailing list

Appendix D

PERCEPTIONS CHECKLIST

PERCEPTIONS CHECKLIST

A questionnaire to examine views about the contribution of the voluntary sector to community services for people with learning difficulties (mental handicap)

This checklist has been designed to capture the views of a wide range of people about the nature of the voluntary sector's contribution to services for people with learning difficulties.

I am aiming for an overall impression rather than long answers and therefore it has been deliberately compiled in a manner which is quick and easy to complete (it should take you no longer than five minutes).

The work forms part of a three year study funded by the ESRC which aims to describe and evaluate the roles of the voluntary sector in the provision of care and support in community settings for people with long-term needs. In particular the full study will examine the expectations and assumptions held by the respective sectors about their own and each others' roles in provision. It will assess the validity of the expectations and assumptions about these roles using empirical evidence from four district health authorities.

If you would like to know more about this work or would be interested in the outcome of this survey please contact either myself, Corinne Thomason, or Professor Martin Knapp, at the address shown below — or telephone Canterbury (0227) 764000 ext. 3875, ext. 7552 or ext. 7555.

Corinne Thomason
Research Fellow
Personal Social Services Research Unit
Cornwallis Building
The University
Canterbury
Kent CT2 7NF

March 1991

PSSRU
UNIVERSITY OF KENT AT CANTERBURY

The PSSRU is the largest social care research unit in the UK. Its programme of studies focuses particularly on services for elderly people, children in care, and the resettlement of long-stay hospital patients in the community. Research studies are funded mainly by the DHSS, and by other government departments, the Economic and Social Research Council, charitable trusts and international social welfare organisations. Social policy research at the University of Kent, where the Unit is based, was recently rated as 'outstanding' by the University Grants Committee. The Unit has published over 700 discussion papers and has its own book series (published by Avebury/Gower) as well as a freely available Bulletin. Further information: Anne Walker (0227 764000 ext. 7672).

PERSONAL SOCIAL SERVICES RESEARCH UNIT
Cornwallis Building, University of Kent at Canterbury, Canterbury, Kent, CT2 7NF, UK
Telephone: 0227 764000 Telex: 965449 Fax: 0227 764327

Views about the voluntary sector and learning difficulty (mental handicap)

(Please complete this *quickly* by ticking the appropriate box. It should take no longer than five minutes.)

1 Services run by the voluntary sector are more responsive to consumer needs than statutory services

☐ True ☐ False ☐ Don't know

2 Services run by voluntary organisations are mainly staffed by unpaid volunteers

☐ True ☐ False ☐ Don't know

3 Services run by voluntary organisations are cheaper because organisations are smaller

☐ True ☐ False ☐ Don't know

4 Services run by voluntary organisations are organised by people with similar needs to those catered for by the services they provide

☐ True ☐ False ☐ Don't know

5 The voluntary sector gets its money from fund-raising

☐ True ☐ False ☐ Don't know

6 Most members of staff in the voluntary sector tend not to have professional qualifications

☐ True ☐ False ☐ Don't know

7 The voluntary sector provides services which are different to those of the statutory sector

☐ True ☐ False ☐ Don't know

8 The voluntary sector is less bound by rules than the statutory sector

☐ True ☐ False ☐ Don't know

9 People working in the voluntary sector are keen social reformers

☐ True ☐ False ☐ Don't know

10 The voluntary sector is good at promoting what it does

☐ True ☐ False ☐ Don't know

11 Services run by voluntary organisations tend to cater for unusual needs

☐ True ☐ False ☐ Don't know

12 It is easier to make your views known in voluntary run services

☐ True ☐ False ☐ Don't know

13 Services run by voluntary organisations are cheaper because staff are unpaid

☐ True ☐ False ☐ Don't know

14 Voluntary sector run services are not as organised as statutory services

☐ True ☐ False ☐ Don't know

15 Services run by voluntary organisations tend to be short-term projects which disappear after a year or so

☐ True ☐ False ☐ Don't know

16 The voluntary sector deals with non-urgent need

☐ True ☐ False ☐ Don't know

17 Only statutory services can be relied upon to provide comprehensive care

☐ True ☐ False ☐ Don't know

18 There are no checks on standards of service in the voluntary sector

☐ True ☐ False ☐ Don't know

19 It is easier to get involved in services run by voluntary organisations than those organised by the statutory sector

☐ True ☐ False ☐ Don't know

Information about the person completing this form

1	I am clear which organisations provide what services in my local area	☐ Yes	☐ No
2	I am/have been a service user	☐ Yes	☐ No
3	I do/have worked in a voluntary run service		
	• as a volunteer	☐ Yes	☐ No
	• as a paid staff member	☐ Yes	☐ No
4	I do/have worked in the statutory sector		
	• in the health service	☐ Yes	☐ No
	• in a local authority	☐ Yes	☐ No
5	I do/have worked in the private sector	☐ Yes	☐ No
6	I have professional experience in the following fields:		
	• medical	☐ Yes	☐ No
	• nursing	☐ Yes	☐ No
	• social care	☐ Yes	☐ No
	• social work	☐ Yes	☐ No
	• administration	☐ Yes	☐ No
	• other	☐ Yes	☐ No

7 I am aged

- under 20 ☐
- 20-29 ☐
- 30-39 ☐
- 40-49 ☐
- 50-59 ☐
- over 60 ☐

8 Gender

- I am male ☐
- I am female ☐

9 I would describe my current work as being

- a carer ☐
- a service manager/provider ☐
- an administrator ☐
- other ☐

Thank you

REF: /

Appendix E

USER QUESTIONNAIRE.

Evaluation of Warrington Day Centre
Users' evaluation

The Warrington Day Centre has now been open for ten years. In an effort to constantly improve services, we have decided to take part in an evaluation to find out what services the centre provides, who uses it, and the opinions of people who use the centre or are associated with it.

As a user of our service, your view of what the centre provides is crucial and therefore your assistance in the completion of the attached questionnaire would be appreciated.

The results of this survey will be used for three things:

1 *It will provide important information for a review of the day centre by Warrington Social Services.*

2 *It will contribute to a piece of work being conducted by Corinne Thomason of the University of Kent about the strengths and weaknesses of services provided by statutory and independent agencies.*

3 *It will form the basis for discussion between users of the centre and staff about what type of service the centre will offer in the future.*

The information is confidential and you need not give your name if you do not wish to. Your response will not be seen directly by anyone at the Centre. Responses will be collated into a report by Corinne Thomason of the University of Kent. The report will then be used as a discussion document to inform service development. Copies of the report will be available for all the participants and Corinne Thomason will present the results at a meeting in the Centre in August 1991.

User questionnaire

1 Personal details

1.1 Where do you live (area)? _____

1.2 In which type of accommodation are you living?

- ☐ in own home
- ☐ in relative's home
- ☐ social services hostel or group home
- ☐ accommodation managed by Making Space
- ☐ other residential accommodation
- ☐ hospital
- ☐ private lodgings

1.3 Do you live on your own? _____

1.4 What type of support do you have? _____

1.5 Who helps you? _____

1.6 Do you have a job? _____

1.7 What are the main problems you face? _____

_____

1.8 Who helps you with these? _____

1.9 Do you see any of the following professionals?

- ☐ Psychiatrist
- ☐ GP
- ☐ CPN
- ☐ Social worker
- ☐ other

1.10 When were you last in hospital? _____

1.11 Is there anything that worries you a lot? _____

_____

1.12 What are the most important things in your life? _____

_____

1.13 If you had three wishes what would they be? _____

_____

_____

2 Services

2.1 What services do you feel you need? _____

_____

2.2 Is there anywhere in the Warrington district which offers the services you feel you need? _____

_____

2.3 Who is the Warrington Day Centre for? _____

_____

2.4 How do you fit in with that? _____

_____

2.5 How often have you used the centre in the last year _____

2.6 What do you most like about coming here? _____

_____

2.7 What do you like the least? _____

_____

2.8 Are there any aspects of your illness which you feel are better since you have been coming to the centre?

_____

2.9 In what ways does it help with your illness? _____

_____

2.10 If you didn't come here where would you go? _____

_____

2.11 What improvements would you like to see in the way the centre is run or the service that is offered?

_____

_____

Please feel free to provide any further comments on the centre itself, your experience of mental illness, or any other relevant material and please feel free to represent in picture form how you feel.

Thank you.
Corinne Thomason, March 1991

Please return to Corinne Thomason, Research Fellow, Personal Social Services Research Unit, University of Kent at Canterbury, Canterbury, Kent, CT2 7NF, in the envelope provided.

Appendix F

LOCALITY STUDIES
(CROSS-NATIONAL PROJECT QUESTIONNAIRE)

SURVEY OF VOLUNTARY ORGANISATIONS

The information supplied is anonymous and will remain confidential.

If you require further information in completing the questionnaire please contact Jeremy Kendall, PSSRU (0227 764000, ext 7637) or Martin Knapp (0227 764000, ext 7552). Please return the completed questionnaire in the envelope provided.

SECTION 1: ABOUT YOUR ORGANISATION

LEGAL STRUCTURE

1 What is the legal structure of your organisation? (tick one)

- ☐ Trust
- ☐ Unincorporated association (i.e. with a constitution, but no legal personality)
- ☐ Company limited by guarantee
- ☐ Company limited by share capital

Corporation established by:

- ☐ Statute (please indicate the appropriate Act of Parliament) . . . . . .
- ☐ Royal charter
- ☐ Ecclesiastical decree

- ☐ Charity whose trustees body is incorporated under the *Charitable Trustees Incorporation Act 1872*
- ☐ Organisation registered under the *Friendly Societies Act 1974*
- ☐ Organisation registered under the *Industrial and Provident Societies Act 1965*
- ☐ Other (please specify) . . . . . .
- ☐ No legal structure

CHARITABLE STATUS

2 Is your organisation charitable in law?

☐ Yes ☐ No (tick one)

If YES, please tick the appropriate box below, and complete as indicated

- ☐ Charity registered with the Charity Commission
  Charity registration no. . . . . . .
- ☐ Charity exempted from registration
- ☐ Charity excepted from registration

NOTE: Your organisation may be an excepted or exempted charity, but you may still be voluntarily registered with the Charity Commission. If this is the case, please the tick the appropriate two boxes, and supply the registration number.

3 Which of the following best describes your organisation? Please tick ONE box only.

- ☐ Charity
- ☐ Voluntary organisation
- ☐ Government body
- ☐ Business
- ☐ Quango (non-departmental public body)
- ☐ Other (specify) . . . . . .

ACTIVITY

4 What specific services and activities apply to your organisation? Please tick all the boxes that apply.

- ☐ Culture and arts
- ☐ Recreation
- ☐ Fundraising body (e.g. Lions, Rotary clubs)
- ☐ Pre-school activities
- ☐ Primary and secondary education
- ☐ Higher education
- ☐ Adult and continuing education
- ☐ Other education (e.g. development education)
- ☐ Research
- ☐ Hospital
- ☐ Hospice
- ☐ Nursing home
- ☐ Mental health
- ☐ Health promotion and education
- ☐ Complementary medicine
- ☐ Other health
- ☐ Social services
  - ☐ physically disabled
  - ☐ HIV / AIDS
  - ☐ substance abuse
  - ☐ children and families
  - ☐ young people / youth
  - ☐ women
  - ☐ men
  - ☐ elderly people
  - ☐ other . . . . . .
- ☐ Environment (including animal welfare)
- ☐ Community hall activities
- ☐ Community development
- ☐ Economic development
- ☐ Housing
- ☐ Employment and training
- ☐ Civil rights
- ☐ Black and ethnic minorities
- ☐ Pressure group / lobbying
- ☐ Advice services / financial or legal services
- ☐ Crime prevention
- ☐ Rehabilitation of offenders
- ☐ Victim support
- ☐ Consumer protection
- ☐ Grant-making trust
- ☐ Local development agency
- ☐ International / third world
- ☐ Business or professional association
- ☐ Trade union
- ☐ Other (specify) . . . . . .

5 What is the major area of activity of your organisation? (By 'major activity' we mean the activity to which the greatest percentage of your expenditure is devoted.) Please select ONE from the above list which best describes your major activity. . . . . .

6 Does your organisation have a bar or social club?
☐ Yes ☐ No (tick one)
If YES, is it a separate legal entity?
☐ Yes ☐ No (tick one)

7a Is your organisation an umbrella body for other groups?
☐ Yes ☐ No (tick one)

7b Is your organisation affiliated to an umbrella body or bodies?
☐ Yes ☐ No (tick one)
If YES, please state the main body to which you are affiliated . . . . . .

8a Is your organisation a headquarters or parent organisation with local branches?
☐ Yes ☐ No (tick one)
If YES, how many branches do you have:
NO. OF BRANCHES . . . . . .

8b Is your organisation the local branch of a headquarters or parent organisation?
☐ Yes ☐ No (tick one)
If YES, what is the name of your headquarters or parent organisation?
NAME: . . . . . .

9 In what year was your organisation formed?
YEAR . . . . . .

CATCHMENT AREA

10 How would the geographical area served by your organisation best be described? (Tick the ONE best response, and name the area below):
- ☐ Neighbourhood (smaller than local or health authority areas)
- ☐ Local authority area: district, London or metropolitan borough
- ☐ Local authority area: county council, metropolitan county or Greater London
- ☐ District health authority area
- ☐ City-wide
- ☐ Region
- ☐ Several regions
- ☐ National area
- ☐ International area
- ☐ Other (please specify) . . . . . .

Area name . . . . . .

REMUNERATION

11 How is your management committee or governing board remunerated?
(Please tick as many as apply)
- ☐ unpaid (voluntary)
- ☐ paid expenses only (voluntary)
- ☐ specific fees for specific services
- ☐ salaried
- ☐ by honoraria
- ☐ occasional payment (over and above expenses)
- ☐ other (please specify) . . . . . .

. . . . . .
. . . . . .

In the sections which follow, by '1990' we mean the financial year which ended on some date in 1990.

SECTION 2: THE PEOPLE IN YOUR ORGANISATION

12 How many people either worked for your organisation as trainees, or as paid employees (core and project funded, permanent and temporary), or were involved in it as volunteers, in 1990?

	1990
Employees – full-time	
Employees – part-time	
Trainees – inc. YT, ET	
Volunteers – inc. gov. board	

13 On average, how many hours per week were your PART-TIME paid workers employed in 1990 (core and project funded, permanent and temporary)? If actual figures are unavailable, please estimate.
Hours per week
Total for all part-time workers . . . . . .
Average per worker . . . . . .

14 On average, how many hours per week did all your volunteers together work for your organisation in 1990? Again, if actual figures are unavailable, please estimate.
Hours per week . . . . . .

15 What was the total membership of your organisation in 1990?
No. of individuals . . . . . .
No. of organisations . . . . . .

SECTION 3: POLICY ADVOCACY/CAMPAIGNING

16 In the past year has your organisation taken part in any lobbying or campaigning activities (i.e. active promotion of, or resistance of particular local, central or European government programmes or policies)?
☐ Yes ☐ No (tick one)
If YES, what proportion of the total staff time of your organisation was devoted to these activities? Please tick the appropriate box.
- ☐ 25% or more of staff time
- ☐ 10-25% of staff time
- ☐ 3-9% of staff time
- ☐ Less than 3% of staff time

17 Has your organisation ever been criticised for either campaigning too much, or for not taking part in enough campaigning? If so by whom?
(Please give details) . . . . . .
. . . . . .
. . . . . .

SECTION 4: FINANCIAL INFORMATION

18 Please fill in the table below with as much detail as possible. Ideally we would like to know the amount, but if this is not possible, please give us an informed estimate for as many categories of income as possible. **We realise that completion of this question may be difficult, especially for small organisations, in which case please send us a copy of your accounts for 1990.**

INCOME		1990
Central government	– grants	
	– contracts	
Local government	– grants	
	– contracts	
Social security and housing benefit		
Donations from	– Individuals	
	– Companies	
	– Foundations (*grants and other contributions by grant-making trusts and community foundations*)	
	– Federated funds (*contributions by collective fundraising, organisations Telethon, Children in Need appeal, etc.*)	
Fees and charges to users for services – *client charges and fees for social care and other mission-related services*		
Sales of products and business income – *proceeds from products and services that are ancillary to the primary activity ('mission') of the organisation, as well as proceeds from for-profit subsidiaries and trading income*		
Transfers *from parent organisation*		
Endowment and investment income – *interest on savings and temporary cash investments; dividends and interest on securities; net rental income; and capital gains*		
Other operating income – *including membership fees*		
TOTAL OPERATING INCOME *(sum of all income elements above)*		
Income from	– Sale of fixed assets, and sale of investments	
	– Loans taken out and other sources	
TOTAL INCOME		

19 Please give your total operating ***income*** for the financial year which ended in 1989: £ . . . . . .

20 Please give your total operating ***expenditure*** for the financial years which ended in
1989: £ . . . . . **1990:** £ . . . . . .

21a Is your organisation registered for VAT? ☐ Yes ☐ No (tick one)

21b If **YES**, what was the total VAT your organisation paid on its inputs in 1990?: £ . . . . . .

21c If **NO**, how much VAT do you estimate your organisation paid in 1990: £ . . . . . .

22 Has the recent increase in VAT affected your organisation? ☐ A lot ☐ Not much ☐ No (tick one)

23 If you received any in-kind contributions in 1990 (including all non-monetary donations apart from time, for example donation of office space, material, vehicles etc.), what is your best estimate of its value in pounds sterling? £ . . . . . .

24a Did your organisation receive relief on your local rates in 1990? ☐ Yes ☐ No (tick one)

24b What percentage relief was received? (note that mandatory relief for charities is 80%): . . . . . %

SECTION 5: POLICY ISSUES

25 What are the major problems confronting your organisation at the present time?

Below we list some possible problem areas. Please indicate by circling the appropriate number which are *very important* (3), *quite important* (2), or *not important at all* (1) in your organisation.

Not important 1	Quite important 2	Very important 3

What are the major problems confronting your organisation in relation to funding?

A	Inadequate private funding	1	2	3
B	Inadequate or declining central or local govt support	1	2	3
C	Increased reliance on fee income	1	2	3
D	Increased reliance on sales and business income	1	2	3
E	Excessive dependence on the public sector (government)	1	2	3
F	Replacement of government sector grants with contracts	1	2	3

What are the major problems confronting your organisation in relation to staff?

G	Difficulties recruiting staff with appropriate skills	1	2	3
H	Low salaries and benefits	1	2	3
I	Excessive professionalisation of staff	1	2	3
J	Inadequate resources for training	1	2	3
K	Difficulties in supporting front-line staff	1	2	3
L	Difficulties in attracting volunteers	1	2	3
M	Difficulties managing volunteers	1	2	3
N	Insufficient income to afford enough staff	1	2	3

What are the major problems confronting your organisation in relation to government policies?

O	UK tax laws that do not sufficiently encourage giving	1	2	3
P	Excessive UK government pressures	1	2	3
Q	Lack of clear UK government policy direction	1	2	3
R	Responsibilities shifted from the government sector	1	2	3
S	Government restrictions on policy advocacy/campaigning	1	2	3
T	Pressures from political factions	1	2	3
U	Dealing with the European Community	1	2	3
V	Burden on voluntary committee members from increased legislation and regulation	1	2	3

Are any of the following problem areas for your organisation?

W	Competition from private (for-profit) businesses	1	2	3
X	Limited public awareness of your organisation	1	2	3
Y	Limited public awareness of the needs which your organisation addresses	1	2	3
Z	Ethical issues in fundraising	1	2	3
AA	Other ethical issues	1	2	3
BB	Lack of co-operation with local government	1	2	3

THANK YOU FOR YOUR CO-OPERATION.
PLEASE RETURN THE COMPLETED QUESTIONNAIRE IN THE ENVELOPE PROVIDED.

Appendix G

HOME FROM HOSPITAL STUDY

Job Title: Previous occupation s:
Length in post: Funding Agency ies

BRITISH RED CROSS SERVICE CO-ORDINATORS

The evaluation of the Home-from-Hospital Schemes by the Nuffield Institute Trust (1996) hints at some of the pressures which are likely to impact on schemes as financial pressures increase, eg the ability to demonstrate value for money and effectiveness in the shape of indicators, such as quality of service and speed of discharge (Waddington & Henwood, 1996). Pressure on beds is likely to lead to pressure on discharge services, which could have consequences for the work of Home-from-Hospital Co-ordinators, when they collaborate with statutory services.

The word 'monitoring' has been used as an adjunct to evaluation, apparently taken to be the overview offered to funders of schemes, with standard procedure being to have an advisory and support group as part of this system. However, the word has now come to some schemes as a notion of monitoring clients.

The following questions are seeking your views on this area and your time and effort in completing this questionnaire would be appreciated.

1. To whom or to what body are you primarily responsible?

2. Do you feel that it is important that your service is accountable? Yes/No
3. If so, in what ways and to whom?

4. How would you describe your relationship with your funding agency/agencies?

5. Why do you think that the health authority/social services/other agencies are funding your service?

Job Title: Previous occupation s:
Length in post: Funding Agency ies

6. Is your service independent of your funding authority? Yes/No
7. If so, what characterizes its independence?

8. What type of tasks are you asked to perform by funding agencies when commissioned?

9. How do you know if your service is effective?

10. How could anyone/any organisation indicate how they thought your service was performing (either positively or negatively)?

11. What type of tasks would you not perform and why?

12. What type of tasks do you perform but feel uneasy about and why?

Job Title: Previous occupation s:
Length in post: Funding Agency ies

13. With which agencies are your most important relationships?

14. Why do you think this is?

15. How do you feel that other agencies perceive your role?

16. How do clients see the service?

17. Do you see yourself as being part of the voluntary sector?

18. What special attributes does a service run by the British Red Cross have?

19. What do you think are the special attributes of the service that you provide compared to other voluntary organisations?

Job Title: Previous occupation/s:
Length in post: Funding Agency/ies:

20. What is the most important characteristic of the service that you provide?

21. What are the major problems that you encounter in the work that you do?

22. What hinders you when performing your job?

23. What helps you to do your job?

Please add any other comments that you feel are relevant to the issue but which are not covered by this questionnaire:

Thank you very much for completing these pages. The information will give an 'at the sharp end' report on some of the issues facing BRC co-ordinators at the moment, at the NCVO's Conference in September 1997. Liz Mitchell, HfHL, Cheshire

References

REFERENCES

Allen, C. (1990) Welfare Indicators in Health and Social Services, towards a greater recognition of the role of qualitative methods in informing resource allocation decisions. MA dissertation, UKC.

Allen, I., Hogg, D. and Peace, S. (1992) Elderly people: Choice, participation and satisfaction, Policy Studies Institute, London.

Allen, P., Pahl, J. and Quine,L. (1988) Staff in the Mental Handicap Services: A Study of Change. Health services Research Unit, University of Kent at Canterbury.

Anheier, H.K. and Seibel, W. (1990) The Third Sector: Comparative Studies of Non Profit Organisations. Berlin: Walter de Gruyter & Co.

Atkinson, P. (1988) Research interviews with people with mental handicaps, Mental Handicap Research, 1(1), 75-90.

Audit Commission (1986) Making a Reality of Community Care, HMSO, London.

Aves, G. (1969) The Voluntary Worker in the Social Services. London: Bedford Square Press.

Baldwin, S. and Twigg, J. (1991) Women and community care - reflections on a debate in Women's Issues in Social Policy. - eds. Maclean, M. and Groves, D. Routledge, London.

Barclay Committee (1982) Social workers: their role and tasks. NCVO, Bedford Square Press.

Beck, B.M. (1970) The Voluntary Social Welfare Agency: A Reassessment. Social Service Review. 44, pp.147-154.

Beecham, J., Knapp, M., Schneider, J., (1995) Policy and Finance for Community Care in the New Mixed Economy in Collaborative Community Mental Health Care, Watkins, M., Hervey, N., Ritter, S., and Carson, (eds) J. Edward Arnold, London.

Beechey, V. (1987) Unequal Work. Verso. London.

Benedict, R. (1973) Unpublished lecture. in Maslow, A. H. The Farther Reaches of Human Nature. Harmondsworth: Penguin, *pp. 207-19.*

Ben-Ner, A. (1986) Nonprofit Organisations: Why Do They Exist in Market Economies? The Economics of Nonprofit Institutions. Rose-Ackerman, S. (ed.) New York: Oxford University Press.

Ben-Ner, A. (1987) Nonprofit Collectivist Organisations. The Nonprofit Sector: A Research Handbook. Powell, W.W. (ed.) New Haven: Yale University Press.

Ben-Ner, A. and Gui, B. (eds.) (1993) The Nonprofit Sector in the Mixed Economy. Michigan: The University of Michigan Press.

Ben-Ner, A. and Van Hoomissen, J. (1993) Nonprofit organizations in the mixed economy: a demand and supply analysis. in Ben-Ner, A. and Gui, B. (eds.) The Nonprofit Sector in the Mixed Economy. Michigan: The University of Michigan Press.

Bernard, J. (1990) Innovation in a Local Authority Social Services Department: Content, Context and Process. MA dissertation, Polytechnic of East London.

Billis, D. (1996) Who Cares Whether Your Organisation Survives? Voluntary Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press Ltd., pp.222-236.

Billis, D. and Harris, M. (1996) Introduction: Enduring Challenges of Research and Practice. Voluntary Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press Ltd., pp.1-12.

Bolton, M. Leggett, D. and Thorne, M. (1994) Shifting the Balance: The Changing Face of Local Authority Funding. London: NCVO Publications.

Booth, T. (1983) Residents' views, rights and institutional care, in Fisher, M. (ed) Speaking of Clients. Social services Monograph:research in Practice University of Sheffield.

Brenton, M. (1978) Worker Participation and the Social Service Agency. British Journal of Social Work. 8, pp.289-300.

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

Brodkin, E. and Young, D. (1986) Political Economy of Privatisation. Mimeograph, SUNY, Stony Brook.

Calnan, M. (1988) Towards a conceptual framework of Lay evaluation. Social Science Medicine, 27(9), pp. 927-933.

Cambridge (1991) Methodology paper for the Care in the Community Five Years on study.Unpublished PSSRU Discussion paper

Cambridge, P., Hayes, L. and Knapp, M. (1994) Care in the Community: Five Years On. Aldershot, Arena.

Caulcott, T. (1985) The voluntary sector in a cold climate. Local Government Studies, 11, pp. 16-17.

Challis, D. J., Chessum, R.,Chesterman, J. and Woods, R. (1988) Community care for the frail elderly: an urban experiment, British Journal of Social Work, 18 (supplement), 13-42.

Clark, C.L. (1991) Theory and Practice in Voluntary Social Action. Aldershot: Avebury.

Cmnd 3703 (1968) Report of the Committee on Local Authority and Allied Personal Services (The Seebohm Report). London: HMSO.

Cmnd 4683 (1971) Better Services for the Mentally Handicapped. London: HMSO.

Cmnd 6233 (1975) Better Services for the Mentally Ill. London: HMSO.

Coates, D. (1990) Traditions of Thought and the Rise of Social Science in the United Kingdom. in Anderson, J. and Ricci, M. (eds.) Society and Social Science: A Reader. Milton Keynes: Open University Press, pp. 239-295.

Cooper, N., Stevenson, C. and Hale, G. (eds.) (1996) Integrating Perspectives on Health. Buckingham: Open University Press.

Davis Smith, J. (1996) Should Volunteers be Managed? Voluntary

Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press Ltd., pp.187-199.

Deakin, N. (1991) Government and the voluntary sector in the 1980's. Policy Studies, 12.3, PSI, London.

Deakin, N. (1996) What does Contracting do to Users? Voluntary Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press Ltd., pp.113-129.

De Beauvoir, S. (1972) The Second Sex. Penguin.

Department of Health and Social Security (1981) Care in the Community: A Consultative Document. London: HMSO.

Department of Health and Social Security (1983) Care in the Community. HC(83)6, LAC(83)5, London: HMSO.

Department of Health and Social Security (1983) NHS Management Inquiry (Griffiths Report). London: DHSS.

Department of Health and Social Security (1986) Collaboration between the NHS, local government and voluntary organisations: joint planning and collaboration. Draft circular, London: DHSS.

Department of Health and Social Security (1987) Public Support for Residential Care: Report of a Joint Central and Local Government Working Party (Fifth Report). Stanmore, Middlesex: DHSS Leaflets.

Department of Health (1990) Community Care in the Next Decade and Beyond. Policy Guidance. London: HMSO.

DiMaggio, P. and Powell, W. (1983) Institutional Isomorphism. American Sociological Review 48, pp.147-160.

Douglas, J. (1980) Towards a Rationale for Private Nonprofit Organisations. PONPO Working Paper 7, Yale University.

Douglas, J. (1983) Why Charity? The Case for a Third Sector. Beverly Hills: Sage.

Dreier, P. (1980) "Socialist Incubators." Social Policy, 11(May-June):29-34.

Ellman, M. (1982) Another Theory of Nonprofit Corporations. Michigan Law Review. 80, pp.999-1050.

Esping-Anderson, G. (1990) The Three Worlds of Welfare Capitalism. Cambridge: Polity Press.

Ferris, J. and Graddy, E. (1986) Contracting-Out: For What? With Whom? Public Administration Review. 46, 332-344.

Finch, J. (1984) The Deceit of Self-Help: Preschool Playgroups and Working Class Mothers. Journal of Social Policy. 13, pp.1-20.

Finch, J. and Groves, D. (eds.) (1983) A Labour of Love: Women, Work and Caring. London: Routledge & Kegan Paul.

Flynn, M. (1986) Adults who are mentally handicapped as consumers: issues and guidelines for interviewing. Journal of Mental Deficiency, Res. 30, pp. 369-377.

Flynn, M. and Common, R. (1992) Contracting for Care. York: Joseph Rowntree Foundation.

Forsythe, D.P. (1980) Humanizing American Foreign Policy: Nonprofit Lobbying and Human Rights. PONPO Working Paper 12, Yale University.

Frankenberg, R. (1979) 'Methodology: Social or Individual?', paper read at BSA/SSRC Methodology Conference.

French, D. (1992) The voluntary social welfare sector in Canterbury and Thanet. Discussion Paper 896, Personal Social Services Research Unit, University of Kent at Canterbury.

Gann, N. (1996) Managing Change in Voluntary Organisations. Buckingham: Open University Press.

Gladstone, F. (1979) Voluntary Action in a Changing World. London: Bedford Square Press.

Graham, H. (1983) Caring: A Labour of Love. in Finch, J. and Groves, D. (eds.) A Labour of Love: Women, Work and Caring. London: Routledge & Kegan Paul, pp. 13-30.

Griffiths, R. (1988) Community Care: Agenda for Action. London: HMSO.

Gronbjerg, K. A. (1982) "Private Welfare in the Welfare State: Recent US Patterns" Social Service Review 56 (March):1-26.

Gronbjerg, K. A. (1987) Patterns of Institutional Relations in the Welfare State: Public mandates and the Nonprofit Sector." Journal Of Voluntary Action Research, 16 (January-June):64-80.

Gronbjerg, K.A. (1990) Mangaging non-profit funding relations: case studies of six human service organisations. Conference proceedings of the independent sector Spring research forum, 15-16 March, Boston, Massachusetts, USA.

Gutch, R. (1992) Contracting Lessons from the US. London: NCVO Publications.

Hadley, R. and Hatch, S. (1980) Social Welfare and the Failure of the State. London: Allen and Unwin.

Hadley, R. and Clough, R. (1996) Care in Chaos. London: Cassell.

Hall, P., Land, H., Parker, P. and Webb, A. (1975) Change, Choice and Conflict in Social Policy. London: Heinemann.

Handy, C. (1988) Understanding Voluntary Organisations. Harmondsworth: Penguin.

Hansmann, H. (1980) The Role of Nonprofit Enterprise. Yale Law Journal. 89, pp.835-901.

Hansmann, H. (1987) Economic Theories of Nonprofit Organisation. The Nonprofit Sector: A Research Handbook. Powell, W.W. (ed.) New Haven: Yale University Press.

Harris, M. (1996) Do We Need Governing Bodies? Voluntary Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press Ltd., pp.149-165.

Harris, M. and Billis, D. (1996) Conclusion: Emerging Challenges for Research and Practice. Voluntary Agencies. Billis, D. and Harris, M.

(eds.) Basingstoke: Macmillan Press Ltd., pp.237-245.

Hatch, S. (1980) Outside the State. London: Croom Helm.

Hewitt, P.(1993) About time: The revolution in work and family life. IPPR/Riverws Oram Press. London.

Holman, B. (1993) A New Deal for Social Welfare. Oxford: Lion.

Holme, N. and Maizels, J. (1978) Social Workers and Volunteers. London: Allen and Unwin.

Hosking, D.M. and Morley, I.E. (1988) The skills of leadership. in Hunt, J.G., Baliga, B.R., Dachler, H.P. and Schriesheim, C.A. (eds.) Emerging Leadership Vistas. Lexington MA: Lexington Books.

Hosking, D.M. and Morley, I.E. (1993) A Social Psychology of Organising. Winchester: Harvester Wheatsheaf.

House of Commons (1985) Second Report from the Social Services Committee : Community Care with Special Reference to Adult Mentally Ill and mentally Handicapped People, London, HMSO.

House of Commons Public Accounts Committee (1988) Sixteenth Report: Monitoring and Control of Charities in England and Wales, HCP 116, Session 1987-88, London: HMSO.

Housing Corporation (1984) Circular 6/84, Housing Corporation, London.

Jackson, H. (1983) Developing Local Voluntary Action: Four Experimental Small Grants Schemes. Home Office Research Bulletin. 16, pp.51-53.

James, E. (1987) The Nonprofit Sector in Comparative Perspective. The Nonprofit Sector: A Research Handbook. Powell, W.W. (ed.) New Haven: Yale University Press.

James, E. and Rose-Ackerman, S. (1986) The Nonprofit Enterprise in Market Economies. London: Harwood Academic Publishers.

Jenkins, J.C. (1987) Nonprofit Organisations and Policy Advocacy. The Nonprofit Sector: A Research Handbook. Powell, W.W. (ed.) New Haven:

Yale University Press, London.

Johnson, N. (1981) Voluntary Social Services. Oxford: Martin Robertson.

Judge, K., and Smith, J. (1983) Purchase of Services in England. Social Services Review. 57, pp.209-233.

Katz, A.H. and Bender, E.I. (1976) The Strength in Us: Self-Help Groups in the Modern World. New York: New Viewpoints Books.

Kay, R.P. (1992) The metaphors of voluntary/non-profit sector organising. Cranfield University School of Management Working Paper, no. 13/92.

Kay, R.P. (1994) The artistry of leadership. Non-Profit Management and Leadership, 4 (3).

Kay, R. (1996) What Kind of Leadership do Voluntary Organisations Need? Voluntary Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press Ltd., pp.130-148.

Kendall, J. (2000) The Third Sector and Social Care for Older People in England: Towards an explanation of its contrasting contributions in residential care, domiciliary care and day care. Civil Society Working Paper Number 8: The Centre for Civil Society, London School of Economics. London.

Kendall J, Almond S, (1998) The UK Voluntary (Third) Sector in Comparative Perspective, PSSRU, London School of Economics.

Kendall, J and Knapp, M. (1996) The Voluntary Sector in the UK. Manchester: Manchester University Press.

Knapp, M.R.J. (1988) Inter-Sectoral Differences in Cost-Effectiveness: Residential Child Care in England and Wales. The Nonprofit Sector in International Perspective. James, E. (ed.) Oxford: Oxford University Press.

Knapp, M. (1995) Mental Health Care in the Voluntary Sector: Is there a Cost-Effectiveness Advantage?. PSSRU Discussion Paper 1177.

Knapp, M. (1996) Are Voluntary Agencies Really More Effective? Voluntary Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press Ltd., pp.166-186.

Knapp, M.R.J. and Missiakoulis, S (1982) Inter-sectoral cost comparisons: day care for the elderly, Journal of Social Policy, 11, 3, 335-354.

Knapp, M.R.J., Baines, B. and Fenyo, A.J. (1988) The Price Elasticity of Demand for Contracted-Out Residential Child Care. Discussion Paper 539, Personal Social Services Research Unit, University of Kent at Canterbury.

Knapp, M., Cambridge, P., Thomason, C., Beecham, J., Allen, C. and Darton, R. (1992) Care in the Community: Challenge and Demonstration. PSSRU, University of Kent at Canterbury. Aldershot, Ashgate.

Knapp, M., Hallam, A., Beecham, J. and Baines, B (1997) Private, Voluntary or Public? Comparative Cost-Effectiveness in Community Mental Healthcare. PSSRU Discussion Paper 1212.

Knapp, M., Koutsogeoergopoulou, V. and Davis Smith, J. (1996) Volunteer Participation in Community Care. Policy and Politics. 24(2), pp.171-192.

Knapp, M.R.J., Robertson, E. and Thomason, C. (1987) Public Money; Voluntary Action: An Economic Examination of Public Sector Support of the Voluntary Sector. Discussion Paper 500, PSSRU, University of Kent at Canterbury.

Knapp, M.R.J., Robertson, E. and Thomason, C. (1990) Public Money; Voluntary Action: Whose Welfare? in Anheier H and seibel W eds The Third Sector: Comparative Studies of Non-Profit Organisations, De Gruyter, Berlin.

Knapp, M. and Thomason, C. (1987) Contribution of the Voluntary Sector to Health Care. in Gretton and Harrison (eds.) Health Care UK 1987. Policy Journals.

Knapp, M.R.J., Hallam, A., Beecham, J. and Baines, B. (1999) Private,

voluntary or public? Comparative cost-effectiveness in community mental health care, Policy and Politics, 271, 25-41.

Knight, B.(1993) Voluntary Action, HMSO , London.

Korman, N. and Glennerster, H. (1990) Hospital Closure. Buckingham: Open University Press.

Kramer, R. (1979) Voluntary Agencies in the Welfare State: An Analysis of the Vanguard Role. Journal of Social Policy. 8, pp.473-488.

Kramer, R. (1981) Voluntary Agencies in the Welfare State. Berkeley: University of California Press.

Kramer, R (1985) "The future of the Voluntary Agency in a Mixed Economy." Journal of Applied Behavioural Sciences, 21:377-391.

Kramer, R.M. (1987) Voluntary Agencies and the Personal Social Services. The Handbook of Nonprofit Organisations. Powell, W.W. (ed.) New Haven: Yale University Press.

Kramer, R. et al. (1993) Privatization in Four European Countries. New York: M.E. Sharpe.

Kramer, R (1994) Voluntary agencies and the contract culture: "Dream or nightmare?' Social service review, 68,33-60.

Kramer, R (1990) Change and continuity in British voluntary organisations, 1976 - 1988, Voluntas, 1, 33-60.

Krashinsky, M. (1986) Transaction Costs and a Theory of the Nonprofit Organisation. The Economics of Nonprofit Institutions. Rose-Ackerman, S. (ed.) New York: Oxford University Press.

LeTouze, S. and Pahl, J. (1989) A consumer survey on people with mental handicaps - project outline. CHSS, UKC.

Le Touze, S. and Pahl, J. (1990) A consumer survey among people with learning disabilities. CHSS University of kent.

Leat, D. (1985) Making Sense of Grant Aid. Charity Statistics 1985-85. Tonbridge: Charities Aid Foundation.

Leat, D. (1988) Voluntary Organisations and Accountability. London: Policy Analysis Unit, National Council for Voluntary Organisations.

Leat, D. (1995) Funding matters, in Davis Smith J, Rochester C, Hedley R,(eds) An Introduction to the Voluntary Sector, Routledge, London.

Leat, D. (1996) Are Voluntary Organisations Accountable? Voluntary Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press Ltd., pp.61-79.

Leat, D., Tester, S., and Unell, J. (1986) A Price Worth Paying? A Study of the Effects of Government Grant Aid to Voluntary Organisations. London: Policy Studies Institute.

Leedham, I. (1988) Methodology discussion paper, unpublished. PSSRU, University of Kent at Canterbury.

Leedham, I. (1989) From mental handicap hospital to community provisions. Ph.D Thesis, PSSRU, UKC.

Leff, J. (1997) Care in the Community:Illusion or reality?, John Wiley and Sons, Chichester.

Lewis, J. (1993) Developing the Mixed Economy of Care : Emerging Issues for Voluntary Organisations, Journal of Social Policy,22,173-192.

Lewis, J. (1995) The Voluntary sector, the State and Social Work in Britain, Edward Elgar, Aldershot.

Lewis, J. (1996) What Does Contracting do to Voluntary Agencies? in Billis, D. and Harris, M. (eds.) Voluntary Agencies. Basingstoke: Macmillan Press Ltd., pp.98-112.

Lewis, J. and Glennerster, H. (1996) Implementing the New Community Care. Buckingham: Open University Press.

Lipsky M, and Smith S.R (1990) Nonprofit organisations, government and the welfare state, Political Science Quarterly, 104, 624-648.

Marshall, T.F. (1996) Can We Define the Voluntary Sector? Voluntary Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press

Ltd., pp.45-60.

Mellor, H. (1985) The Role of Voluntary Organisations in Social Welfare. London: Croom Helm.

Miller, A. (1988) Poverty Deserved? Birkenhead: Liver Press.

Mishra, R. (1984) The Welfare State in Crisis. Hemel Hempstead: Harvester Wheatsheaf.

Mocroft, I. and Thomason, C. (1993) The evolution of community care and voluntary organisations. in Saxon-Harrold, S. and Kendall, J. (eds.) Researching the Voluntary Sector, Vol. 1, Tonbridge: Charities Aid Foundation.

Moore, J. and Green, J.M. (1985) The Contribution of Voluntary Organizations to the Support of Caring Relatives. Quarterly Journal of Social Affairs. 1, pp.93-130.

Morgan, D. (1981) 'Men, masculinity and the process of sociological enquiry." in Roberts, H.(eds) Doing Feminist Research, Routledge, London.pp.83-113.

Morgan, J. (1984) The Voluntary Sector and the National Health Service. Yearbook of Social Policy. pp.107-121.

Offe, C. (1984) Contradictions of the Welfare State. Cambridge, MA; MIT Press.

Osborne, S.P. (1994) The Once and Future Pioneers? York: Joseph Rowntree Foundation.

Osborne, S. (1996) What Kind of Training Does the Voluntary Sector Need? Voluntary Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press Ltd., pp.200-221.

Owen, D. (1964) English Philanthropy 1600-1960, Harvard University Press, Cambridge, MA.

Parker, R. (1990) Care and the private sector, in I. Sinclair, R. Parker, D. Leat and J. Williams, The Kaleidoscope of Care: A Review of Research on Welfare Provision for Elderly People, HMSO, London.

Paton R. (1996) How are Values Handled in Voluntary Agencies? Voluntary Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press Ltd., pp.29-44.

Prochaska, F. (1988) The Voluntary Impulse. London: Faber and Faber.

Raftery, J, Robinson, R, Mulligan, J_A, Forrest, S. (1996) Contracting in the NHS Quasi-market, Health economics, 5, 353-362.

Renshaw, J., Hampson,R., Thomason, C., Darton, R., Judge, K. and Knapp,M. (1988) Care in the Community: The First Steps. PSSRU, University of Kent at Canterbury,Gower, Aldershot.

Richardson J (1995) Purchase of service contracting: some evidence on UK Implementation, NCVO, London.

Ritchie, Morrisey and Ward. (1988) Keeping in touch with the talking. Report of the special actions project, SCPR.

Roberts, H. (1981) Doing Feminist Research, Routledge, London.

Rodgers, B.N. (1976) Cross-National Studies of Social Service Systems. New York: School of Social Work, Columbia University.

Rosenbaum, N. (1982) Government Funding and the Voluntary Sector: Impacts and Options. Volunteerism in the Eighties: Fundamental Issues in Voluntary Action. Harman, J. (Ed.) Washington: University Press of America.

Rowe, A. (1978), Participation in the Voluntary Sector: The Independent Contribution. Journal of Social Policy. 7, pp.41-56.

Russell, L., Scott, D. and Wilding, P. (1996) The Funding of local Voluntary Organisations. Policy and Politics. 24(4), pp.395-412.

Sako, M (1992) Prices, quality and trust, Cambridge University Press, Cambridge.

Salamon, L.M. (1985) Government and the Voluntary Sector in an Era of Retrenchment: The American Experience. Paper presented at the Interphil II Conference, Venice, 1985.

Salamon, L.M. (1987) Partners in Public Service: Toward a Theory of Government - Nonprofit Relations. The Nonprofit Sector: A Research Handbook. Powell, W.W. (ed.), New Haven: Yale University Press.

Salamon, L M (1995) Partners in Public Service: toward a theory of government-nonprofit relations, in W.W. Powell (ed) The Non-profit sector: a research handbook, Yale University Press, New haven, Conneticut.

Salamon, L.M. and Anheier, H.K. (1993) A comparative study of the non-profit sector : purpose, methodology, description and classification, in Saxon-Harrold, S and Kendall, J (eds) Researching the Voluntary Sector, Vol 1, Charities Aid Foundation, Tonbridge.

Salamon, L.M. and Anheier, H.K. (1994) The non-profit sector cross-nationally. in Saxon-Harrold, S. and Kendall, J. (eds.) Researching the Voluntary Sector. Vol 2, Tonbridge: Charities Aid Foundation.

Salamon, L.M. and Anheier, H.K. (1996a) The Emerging Nonprofit Sector: An Overview. Manchester: Manchester University Press.

Salamon, L.M. and Anheier, H.K. (1996b) Defining the Nonprofit Sector: A Cross-National Analysis. Manchester: Manchester University Press.

Salamon, L.M. and Anheier, H.K. (1996c) Social Origins of Civil Society: Explaining the Nonprofit Sector Cross-Nationally. Working Paper of The Johns Hopkins Comparative Nonprofit Sector Project, The Johns Hopkins University Institute for Policy Studies.

Saxon-Harrold, S. and Kendall, J. (eds.) (1993) Researching the Voluntary Sector. A National, Local and International Perspective. Tonbridge: Charities Aid Foundation.

Saxon-Harrold, S. and Kendall, J. (eds.) (1994) Researching the Voluntary Sector. A National, Local and International Perspective. 2nd ed., Tonbridge: Charities Aid Foundation.

Schlesinger , M and Dorwart, R A (1984) Ownership and mental health services : a reappraisal of the shift toward privately-owned facilities, New England Journal of Medicine, 311, 959-965.

Schneider, J. (1996) Voluntary Organisations in Mental Health: The Impact of the 1990 Reforms. Discussion Paper 1128. PSSRU, University of Kent at Canterbury.

Schorr, A.L. (1970) The Tasks for Volunteerism in the Next Decade. Child Welfare. 49, pp.425-434.

Secretaries of State (1989a) Caring for People, HMSO, London.

Secretaries of State (1989b) Working for Patients, HMSO, London.

Seibel, W. (1990) Organizational behaviour and organizational function. in Anheier, H.K. and Seibel, W. (eds.) The Nonprofit Sector: International and Comparative Perspectives. Berlin: de Gruyter.

Seibel, W. and Anheier, H.K. (1990) Sociological and political science approaches to the third sector. in Anheier, H.K. and Seibel, W. (eds.) The Nonprofit Sector: International and Comparative Perspectives. Berlin: de Gruyter.

Shakespeare, P., Atkinson, D. and French, S. (eds.) (1993) Reflecting on Research Practice. Issues in Health and Social Welfare. Buckingham: Open University Press.

Shore, P., Knapp, M.R.J., Kendall, J., Fenyo, A. and Carter, S. (1994) The local voluntary sector in Liverpool. in Saxon-Harrold, S. and Kendall, J. (eds.) Researching the Voluntary Sector. Vol. 2, Tonbridge: Charities Aid Foundation.

Sigelman, C.K., Schoenrock, C.j. Winer, J.L., Spanhel, C.L., Hromas, S.G., Martin, P.W., Budd, E.C. and Bensberg, G.J.(1981) Issues in interviewing mentally reatarded persons: an empirical study, in R.H. Bruiminks, C.E. Meyers, B.B. Sigford and K.C. Lakin (eds) Deinstitutionalisation and Community Adjustment of Mentally Retarded People, AAMD Monograph No. 4, American Association of Mental deficiency, Washington, DC.

Simons, K., Booth, T. and Booth, W. (1989) Speaking out: user studies and people with learning difficulties, Research, Policy and Planning, 7, 1, 9-17.

Steinberg, R. (1986) Labour Economics and the Nonprofit Sector: A Literature Review. Virginia Polytechnic Institute and State University.

Stenfert-Kroese, B and Fleming, I. (1989) Staff's attitudes and working conditions in community-based groups of homes of people with learningdifficulties, unpublished paper, School of Psychology, University of Birmingham.

Taylor, M (1990) New Times, New Challenges, National Council for Voluntary Organisations, London.

Taylor, M. and Lewis, J. (1993) 'Contracting: what does it do to voluntary and nonprofit organisations', unpublished paper.

Taylor, M. (1995) Voluntary action and the state, in Gladstone, D. (ed) British Social Welfare: Past, present and Future, university College london Press, london.

Taylor, M. (1996) What are the Key Influences on the Work of Voluntary Agencies? Voluntary Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press Ltd., pp.13-28.

Taylor, M and Lansley, J (1992) Ideology, and welfare in the UK: the implications for ythe voliuntary sector, Voluntas, 3,2 153-74.

Taylor, M and Kendall, J (1996) History of the Voluntary sector in Kendall J and Knapp M. R. J., The Voluntary sector In the UK, Manchester University Press, Manchester.

Taylor, M., Langan, J., and Hoggett, P. (1995) Encouraging diversity: voluntary and private organisations in community care , Arena, Aldershot.

Taylor, M and Lewis, J (1993) Contracting:what does it do to voluntary and non-profit organisations? paper presented at NCVO conference, London, July.(Unpublished).

Taylor-Gooby, P. and Lawson, R. (1993) Markets and Managers. Buckingham: Open University Press.

Thomason, C. (1991) A User Eye view of a mental Health Day Service. Warrington Social Services/Making Space, North West.

Thomason, C. (1991) Olive Mount Closure - A Study in the Process of Change. Liverpool Health Authority.

Thomason, C. and Mitchell, E. M. (1997)Designing Good Quality Discharge Systems or Passing the Buck? Paper (unpublished) presented to the 3rd researching the Voluntary sector Conference, University of the South Bank, London.

Titmuss, R.M. (1974) Social Policy: An introduction. London: Allen and Unwin.

Ungerson, C. (1987) Policy is Personal: sex, gender and informal care. London: Tavistock.

Van Til, J. (1988) Mapping the Third Sector. United States: The Foundation Center.

Von Abendorff (1990) Paper presented to PSSRU methodology working group.PSSRU, University of Kent at Canterbury, Canterbury, Kent.

Waddington, E. and Henwood, M. (1996) Going Home. London: British Red Cross.

Walker, R. (1989) Who would like to know why: qualitative research and the policy maker. Research Policy and Planning, 7(2).

Webb, S. and Webb, B. (1912) The Prevention of Destitution. London: Longman.

Weisbrod, B.A.(1975) Towards a theory of the nonprofit sector, in E. Phelps (ed.) Altruism, morality and economic theory, Russell Sage, New York.

Weisbrod, B.A. (1977) Toward a Theory of the Voluntary Nonprofit Sector in a Three-Sector Economy. The Voluntary Nonprofit Sector. Weisbrod, B.A. (ed.) Lexington: D.C. Heath.

Weisbrod, B.A. (1982) Assets and Employment in the Nonprofit Sector. Public Finance Quarterly. 10, pp.403-426.

Williams, F. (1989) Social Policy: A Critical Introduction. Cambridge:Polity.

Wilson, D. (1996) How do Voluntary Agencies Manage Organisational Change? Voluntary Agencies. Billis, D. and Harris, M. (eds.) Basingstoke: Macmillan Press Ltd., pp.80-97.

Wistow, G., Knapp, M.R.J., Hardy, B. and Allen, C. (1994) Social Care in a Mixed Economy. Buckingham: Open University Press.

Wistow, G., Knapp, M.R.J., Hardy, B., Forder, J. and Kendall,J. (1996) Social Care Markets: Progress and Prospects. Buckingham: Open University Press.

Wolfenden, Lord (1978) The Future of Voluntary Organisations. London: Croom Helm.

Wyngaarden,M. (1981) 'Interviewing mentally retarded clients: issues and strategies', In R.H.Bruininks, C.E. Meyers, B.B. Sigford and K.C. Lakin (eds) Deinstitutionalisation and Community Adjustment of Mentally Retarded People, AAMD Monograph No. 4, American Association of Mental deficiency, Washington, DC.

Young, D.R. (1987) Executive Leadership in Nonprofit Organisations. The Nonprofit Sector: A Research Handbook. Powell, W.W. (ed.) New Haven: Yale University Press.