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Contracting For Community Care : Strategies For Progress

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CONTRACTING FOR COMMUNITY CARE
STRATEGIES FOR PROGRESS

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PREFACE

The White Paper 'Caring for People' has stimulated wide ranging debate on the future of community health and social care. The King's Fund College has run a number of seminars and management development programmes intended to explore the implications of the White Paper in the context of other government policy and to look at the inherent management challenges.

In project paper No. 85 'Caring for people: local strategies for achieving change in community services', a number of implications of the White Paper are explored and a number of proposals made for effective inter-agency collaboration. That paper was the result of two seminars run at the King's Fund Centre and a series of management development programmes under the heading 'Achieving change in community services'.

A further booklet to be published by the King's Fund is a work book on quality assurance in long - term care; and a recent briefing paper published by the King's Fund Institute written by Virginia Beardshaw and David Towell covers assessment and case management.

This booklet is written by Christopher Hawker and Peter Ritchie, two independent consultants. They have considered carefully the issues of contracting for community care especially the "enabling" function of both health authorities and local authorities in developing a range of private and voluntary provisions. This paper fits neatly between the broad policy implications covered in 'Local strategies for achieving change' and the more detailed descriptions of assessment and case management covered in Beardshaw and Towell's booklet.

The aim of the present publication is to bridge that divide and offer some proposals at once strategic and detailed for the development of service and planning agreements within the "contract culture".

AUTHORS NOTE

This booklet has been developed from material originally collected to inform a training programme called 'Exploring the Contract Culture'; this course was commissioned by the Mental Handicap Nurses Association and funded through a Department of Health grant. The success of the course and the importance of the issues addressed prompted this fuller record.

The research work occurred during the period leading up to the publication of the White Paper 'Caring for People'; we have sought practice ideas that showed what our future services could be like and thus the issues that will have to be addressed by planners and practitioners over the next few years. Some changes have already occurred in the projects detailed here, not least in response to the nature of the government's final proposals. The material in the appendix can only demonstrate the impact of day to day practical concerns and limitations on the implementation of ideas; they should not be taken as an accurate record of the current state of affairs in any of these schemes.

We are very grateful to the MHNA and all those who spent time with us or sent papers which helped develop these ideas. We hope this distillation can inform future developments in the way that listening to people and reading about real projects has been the inspiration for what follows here. We firmly believe that learning should reflect upon, as well as inform, practical action.

The authors:

Christopher Hawker is currently researching the basis for 'User Management in Care Organisations' at the Centre for Applied Social Studies, University College of Swansea. His career has involved community development and project management in social welfare in both this country and abroad, and he assists with programmes at the King's Fund College from time to time.

Peter Ritchie is an independent consultant based in Swansea. He has a long involvement in working for people with learning difficulties. His recent work includes the development of innovative training approaches for the 'All Wales Strategy' developments in services for people with learning difficulties in West Glamorgan.

INTRODUCTION

The purpose of this booklet is to outline the issues that have to be addressed by service users, politicians and providers following the publication of the White Paper 'Caring for People' (HMSO 1989). The key questions raised by the White Paper are illustrated by some of the 'leading edge' work currently taking place in this country. This is complemented by experiences from North America where there has traditionally been a mixed economy of welfare.

Thus the following sections explore different dynamics in the development of human services within the new framework of 'caring for the 1990's.'

Section 1

CONTRACTS: THE AGENDA FOR COMMUNITY CARE briefly examines some of the factors that are influencing the move towards community based care for long term care groups. Key themes and issues embedded within the current proposals are developed.

Section 2

FACING UP TO THE CHANGES looks at current service systems and the effects of current government proposals.

Section 3

NEW STARTING POINTS locates key themes to the approach developed here.

Section 4

MANAGING IN THE CONTRACT CULTURE considers the organisational options for service development through variables that affect the outcome of any system changes. It highlights key opportunities for progress within the proposed framework for community care servlces.

Section 5

THE WAY AHEAD identifies two different paradigms for service design. One starts with the consumers (users) of services, the other stresses the development of the service system. The interaction between them is then considered.

The **APPENDICES** contain case studies of actual practice at the frontline of new developments in services in this country and North America, and suggest a lively range of real choices available to service users. These appendices detail work as it was in progress during the summer and autumn of 1989.

SECTION 1

CONTRACTS: THE AGENDA FOR COMMUNITY CARE

Introduction

Much will be said about the development of social welfare services for people requiring long term care [1] over the coming months and years. Two different ideological pressures are currently affecting these services all over the country. The first is the long standing move to 'dehospitalise' these services; the second is to shift service provision away from a local government base towards the independent sector. The report by Sir Roy Griffiths (1988), 'Community Care - Agenda for Action', was the first official synthesis of these ideologies. The government, having accepted the bulk of the recommendations, has now issued the White Paper 'Caring for People' (HMSO 1989) [2].

The 'sub-contracting' of care services to non-government agencies is seen as the key mechanism for improving the responsiveness and cost effectiveness of welfare services. This follows the government's review of community care practice in the Audit Commission report (1986) which criticised the efficiency and effectiveness of the system as a whole. Concerns included the enormous increase in expenditure in the 'free market' created in residential care in the private sector as well as the dominance of local authorities in other service fields.

These developments reflect wider government policy in limiting the role of local authorities in service provision. However, the 'corporate' welfare state is itself relatively recent and whilst the developments within it have undoubtedly contributed to a healthier society, it is not surprising to find that there is concern over the monolithic organisation of these services.

Pressure for change

Many of the changes that are now proposed have their roots in both older (pre 1972) service models and current debates on the decentralisation of service delivery. Other pressures which have informed these proposals include: [3]

- pressure from the private sector for a greater stake in central and local government responsibilities
- the closure of large institutional care settings and an inability of local authorities to fund new provision because of government pressure to reduce expenditure
- political changes, both right and left, with more agreement on 'pluralistic' provision of care and services
- promotion of improved standards in residential care argued in the Wagner Report (Wagner/NISW 1988)
- increasing awareness of the difficulties in providing decent services to individuals within the framework of large bureaucracies.

The White Paper attempts to balance these concerns by making the local authority responsible for planning and contracting for 'social care' services to independent organisations. The aim is to create a clear division between the 'purchaser'(local authorities) and potential 'providers' of services. The White Paper also makes clear that compulsory competitive tendering will not be extended to social services. However, a competitive ethos and discipline is still expected to shape the development of these services; thus providers should include both profit making and 'not for profit' agencies.

Targeting of resources will be achieved through assessing user's individual needs and designing individual packages of care that meet identified needs. For 'extensive' service users this will entail the appointment of a 'case manager' for each user, a move which reflects a more individualist approach to service 'consumers' and increasing user expectations for non-institutionalised services.

Many have welcomed these proposals as an important step forward in social welfare provision; but there are important concerns about the levels of funding to be provided for the new style services. However, even disregarding financial questions, these developments represent something of a 'double edged sword' at this stage. They can be used either dramatically to improve the autonomy and dignity of service users or further deny them choice and status in our crowded society. A key aim of the analysis here is to seek out the opportunities and mechanisms that can reinforce an ethos and practice in our services which genuinely benefits users.

1 People with learning difficulties, the physically disabled, the elderly & people with mental health problems.
2 Referred to as the 'White Paper hereafter.
3 We are indepted to John Burton for these points.

SECTION 2

FACING UP TO THE CHANGES

Proposals in practice

The effects of these proposals in practice are difficult to forecast other than the major consequences of the changes - a division between the funding and provision of care and an increase in the number of stakeholders in the system.

Contrasting views have emerged of what this will imply: opportunities exist in the transition from an over bureaucratic and sometimes insensitive system to one that is innovative and accountable to users as well as funders; but hard fought gains in the extent and coverage of social service provided under local authority supervision may be under threat; and services may be monopolised by groups who have either profit or management (rather than user) defined targets as their objectives.

The voluntary sector is taking these new opportunities seriously. Indeed some (such as Family Service Units, the NSPCC and indeed the WRVS) have been effectively 'contracted' to provide services for many years. Many national charities are setting up associated 'trading' agencies to bid for service contracts (and create some separation from their other functions) [4]. Some experience has been gained by a number of large voluntary organisations (such as the Apex Trust and NACRO) in collaborating with the Youth Training Scheme and Employment Training over the past few years. The private sector is preparing for the changes, too. A range of new and existing organisations are gearing up to take over services. Many 'professional' staff are also prepared to secure their futures as independent entrepreneurs in this field.

Warnings

However, some clear warnings are already available. Means and Harrison (1988) conducted a useful review of the Griffiths Report on which the current proposals are based. They argue that the report fails to address several key issues:

Power: It is suggested that the Griffiths proposals might offer greater choice but that professional staff retain their key powers.

Assumptions on gender and race: The important place given to family support in contrast to the single reference to racial difference suggests Sir Roy did not consider fully the effects his proposals might have in putting further constraints on women and ethnic minority groups.

Coherence: It can be argued the report is naive in separating medical, social and housing factors and that current systems could not work together effectively to provide a coherent service in their current form.

Means and Harrison also point out that housing policy would need to be strongly modified at both national and local level in order to accommodate the demands of community care. These criticisms extend to the White Paper.

Hurl (1984) too points out that independent welfare services do not necessarily act as an engine for change. Independent agencies have a clear interest in retaining the 'status quo' as their survival depends upon limiting change and the need for new investment. This is confirmed by Harding (1988) in her description of the independently managed services in the Netherlands. These studies indicate the clear danger that the pioneering stance of the voluntary sector could easily turn into a collusive corporatism of an independent sector.

Thus the White Paper does not in itself create greater consumer choice and power. Whilst it may generate a greater range of providers, this does not necessarily imply a greater range of services. The division between purchaser and provider could be used to advantage by users but in practice will be mediated by case coordinators or managers. The White Paper contains eight references to choice for, and the consultation and involvement of, service users. The strongest is at paragraph 3.4.10 where a duty is laid upon local authorities to establish procedures to receive complaints. Other references however merely indicate vague and undefined intentions, (compare, for example, the All Wales Strategy for People with a Mental Handicap.)

The White Paper has also failed to disentangle the scope for buck - passing between 'health', housing and 'social' care budgets. A failure both to 'ring fence' long term care monies in health authority budgets and clarify the joint finance system suggests that health authorities may be able to accumulate funds for acute services to the detriment of long term care. It is not yet clear whether replacement resources will be provided by central government to enable social services

4 On the other hand others are trying to restrain this impulse until legal, contractual, professional & financial matters can be more clearly identified.

departments to pick up caseloads from health authorities. ('Dowries' from health authorities for discharged patients remain.) There is also no use of funding mechanisms to provide incentives to develop community based systems instead of hospital based systems.

In spite of these caveats, the new proposals offer extremely important opportunities. A radical interpretation of the proposals is possible and realistic. This will depend upon adopting approaches that are not locked into pessimism or fear at the loss of status and power amongst some professional groups: opportunities to extend care will result in a new basis for social service and welfare systems.

SECTION 3

NEW STARTING POINTS

Introduction

Financial juggling can do something to change the basis on which services are provided. However it will be the means by which people are linked into those services and the way review mechanisms work to improve the whole package which will have the major impact on the quality of life for service users in the longer term.

Our starting point is that service systems should positively promote dignity, citizenship and self respect for all members of our society. These values can all too easily be subordinated within current service systems to 'professional' and administrative priorities. It can be argued that government policy continues to endorse a model of community care which focuses on the support needs of the individual and sees the problem as 'how best to fix the market so that those support needs can be identified and met in the most cost effective way'.

The main weakness is that the proposals continue to treat service users as passive third parties with the purchaser-provider contract determining payment and quality control on their behalf. In the current financial climate the interests of the purchaser will be to continue to seek economies of scale by fitting users to blocks of service; users, in the prevailing ethos of social welfare services, will continue to have no real power to change the situation either individually or collectively. On the other hand the White Paper is conciliatory in talking about a not-for-profit (independent) sector. In fact profit margins outside the residential sector are likely to be small and those within the residential sector could be squeezed as the local authorities start to use their purchasing power. Thus, much of this sector could become the locus for new service values. It is also clear that local authorities will still provide substantial services (except in residential care) which will help to generate choice, diversity and points of comparison for users.

Few would disagree that the dead hand of complacency, muddle and the cult of the lowest common denominator can take the life out of our state services. On the other hand privatised systems do not have the capacity to improve standards through competition because the 'buying power' of users is insufficient. In these two different systems users have no clear mechanism for improving the services they receive either individually or collectively. Thus we see the problem as how best to fix society so that it is competent to include as citizens all people who need additional support. We see the key role of services as catalysts of social change, not as sustainers of social casualties.

Keys to change.

The keys to change and development are expressions by users as to how they want to see themselves and how they are seen by others. If users do not want to get better then the service system will not be able to contribute to their therapy. On the other hand, if no attempts are made to offer alternative positive lifestyles then negative self images will prevail. This dilemma is built into current service systems. But how could a new system work to a vision and enhance dignity through a balance of framework, organisation and local action? Indeed how could the social welfare system seek to promote well-being as the very basis of its methods? These questions are the root of all that follows. They lead to three key objectives which should determine the future of social care:

1. For service systems to be effective, process should reflect outcome. If a system is to promote dignity, choice and self respect for users, these values should be reflected in the way the system is organised. Users must be central to system management and not peripheral.

2. Systems should be designed which are themselves therapeutic. They should actively prevent the segregation in hospitals, hostels and nursing homes of people who need support. Instead they should promote and reinforce normal lives, helping to sustain people in their own communities and networks.

3. Reinvestment is necessary in the community that is supposed to care; as Heginbotham (1990) has suggested this should be through both the funding of specific community based support services and the widening of knowledge and tolerance in our society that means that 'normal' communities includes people who are 'different'.

What opportunities lie in the re-shaping of services along new lines to promote these goals? We argue here for an 'organisational' approach to meet the challenge of these changes. The total welfare 'system' will have to respond to the introduction of new service delivery methods.

SECTION 4

MANAGING IN THE CONTRACT CULTURE

Elements of a managed system

This section considers the management options for future community based welfare services where whole or part services are 'contracted out' to other organisations. It illustrates the areas in which very careful and well informed decisions should be made as our services shift in new management directions based on the 'culture' of the contract.

The welfare system is viewed as having several key elements: Value Bases, User Roles, Financial Arrangements, The Service System (including Service Organisation and Professional Roles) and Review and Dvelopment Systems.

These are linked together as shown in Figure 1. These elements are the crucial components that must be considered in any 'system' change.

Value Bases

The arrival of the 'contract culture' reopens the debate about the values that should inform community based care approaches. Recently these have been informed by some degree of choice, normalisation (in mental handicap), consumer involvement and local community acceptance.

The new questions raised by recent proposals are:

1 how much should we spend on care,i.e how much are users 'worth'?

2 what balance of state and non-state provision will make the best use of this money and generate diversity and healthy competition? This could be called the 'ecology' of the system.

3 what place should user power take now and in the future?

Service systems can hold a range of positions on these values and attempt to satisfy all three in an effective balance. On question 1, there would seem to be some consensus on the need for an increase in financial resources to match the real needs of users; on question 2, the White Paper itself now argues for a change in the way services are provided. It is the final question which remains to be addressed.

Users quite naturally have diverse perceptions of what they want from care. The contract culture contains potential for a range of new roles for organisations in the private and voluntary sector. This could be exploited by consumers to continue to extend the range of services yet further; and could include traditional forms of care as well as more radical approaches.

Such diversity can be applied to different points in the service system. (Fig. 2)

Fig. 1

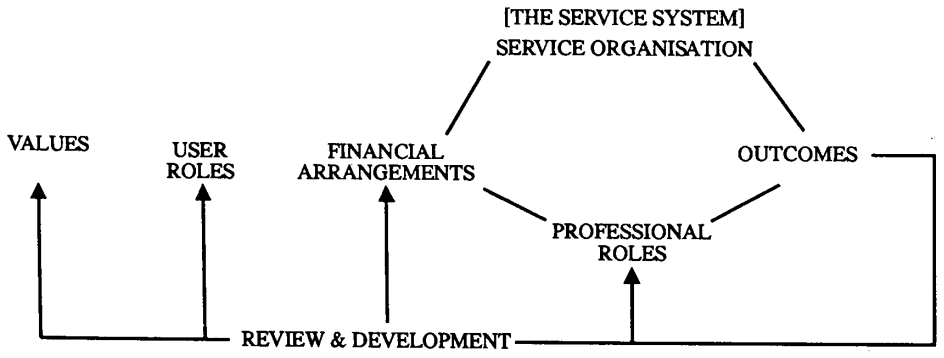


Fig. 2

NOW		POSSIBLE FUTURE
See Selves as Disabled / Desire for Conventional Service	USER VIEWS	See Selves as Citizens /Demand for Social Change & Individual Support
Caring, Altruistic, Victorian	SOCIAL PERSPECTIVES	Modern, Individualistic, Holistic
Part of the System	PROFESSIONAL VIEWS	Struggling to Develop Autonomy for Users
Incorporated Provision	POLITICAL OPTIONS	Tolerance, Diversity, "Green" Solutions

The contract culture allows for all these values to surface in the various decision making processes. It also, theoretically, allows for them all to be met if the 'system' can withstand diversity and take risks. The contract culture may extend this diversity but it will still be limited because of a need to set minimum standards. It is important to identify what factors might inform any 'minimum standard' and what forces might suggest the longer term directions in which the services should move

Figure 3 locates service design options within a values framework

Developments below the horizontal axis depend upon crossing a 'threshold' level of financial resources: this is the 'bottom line' of a system that can contain the diversity sought by the White Paper. Once this point is reached then value statements are the keys which determine service outcomes.

Fig. 3

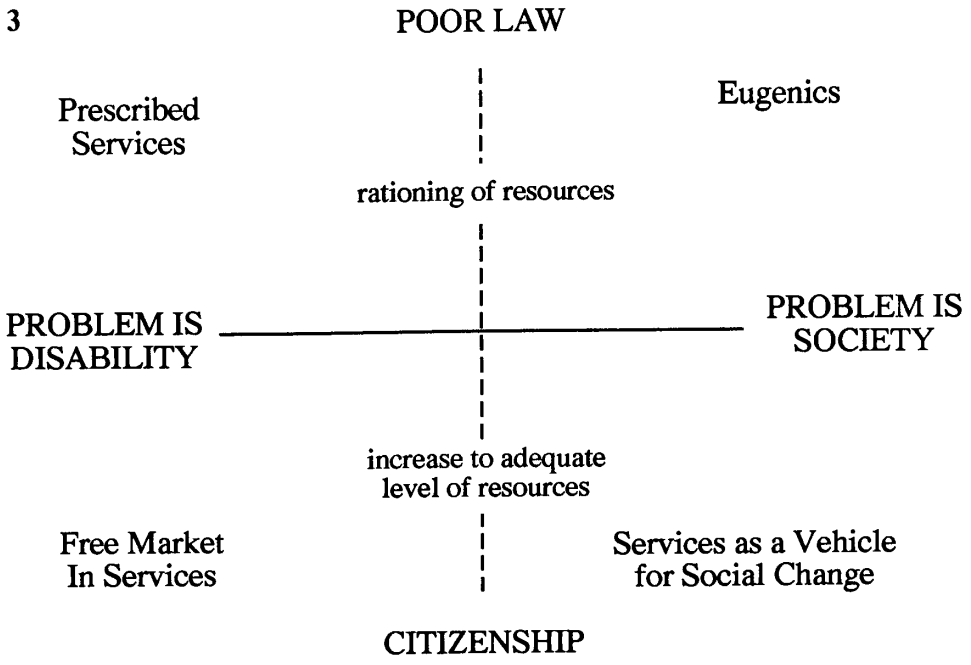
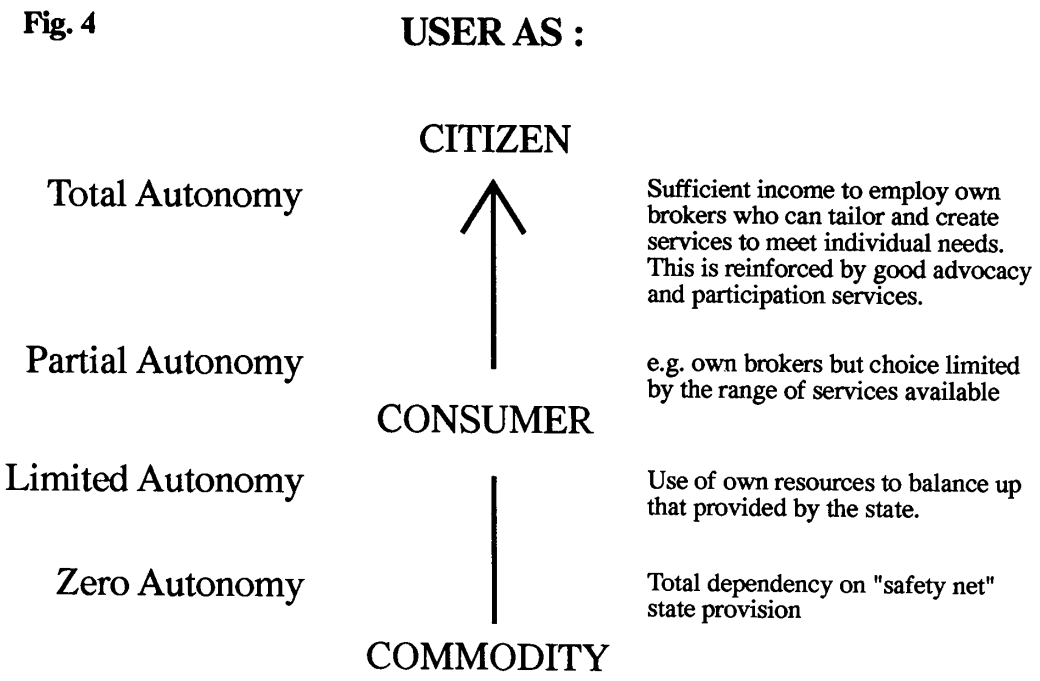


Fig. 4



User Roles

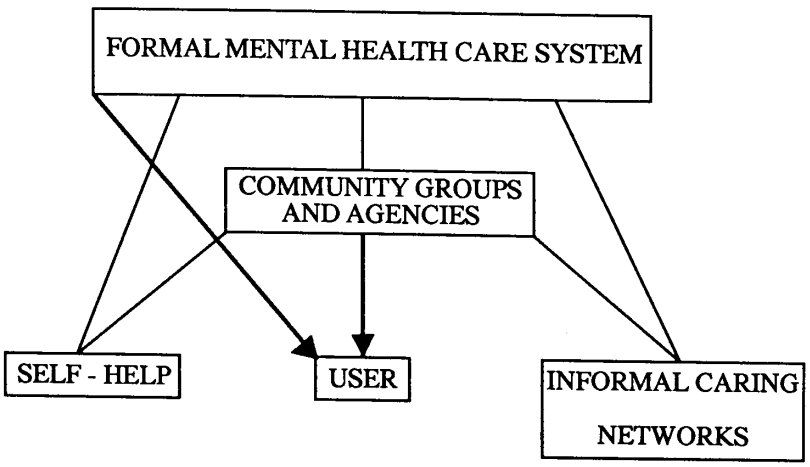
Under current welfare systems users [5] have relatively little choice in the range of services available to them. The focus has been on 'Consumer Participation' in the management of local services (see for example Hawker 1989) rather than consumer choice from a range of services. Users are restricted to extending their autonomy through using their own resources to personalise the packages they receive from the state.

One of the main aims of the contract culture should be to open up consumer choice: there is a continuum of user status which also indicate different levels of autonomy for each user. (and which incidentally reflects available case management models - see Beardshaw and Towell 1990):(Fig. 4).

The shift in location of service delivery from the current 'service' base to community base also demands a complete reappraisal of the relationships between service, community and the user. Pape and Church (1987) have argued that the change needed can be represented as follows:(Fig. 5)

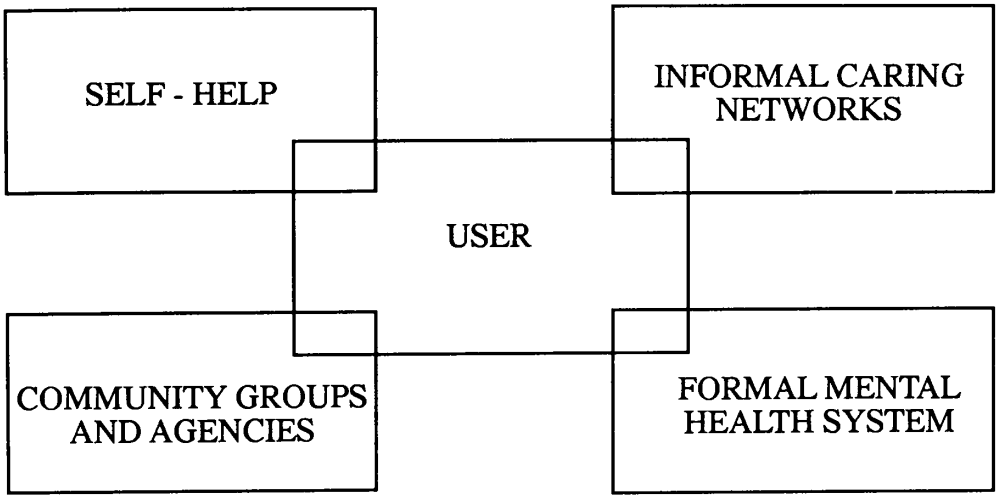
In the traditional model the sets of relationships are dominated by the formal mental health care system.

Fig. 5



5 Carers are included in this definition as direct and indirect users of services.

Fig. 6



In the community based model (Fig. 6) the user is the focus for a range of supportive elements. The rationale for this is that communities are people working together and include diversity and difference. They are not systems with rules and limitations.

The role of the consumer in modern service development is the most important and least developed part of the service system in community based care. Much effort should now be expended in educating consumers as to the possibilities of new services and new service managements to ensure the user has an informed choice. This is the essence of the community based model. Experience also suggests that consumers can be very conservative in their choices unless new services are effectively presented to them and it is clear that they will continue to be reliable. At least the hospital bed was always there.

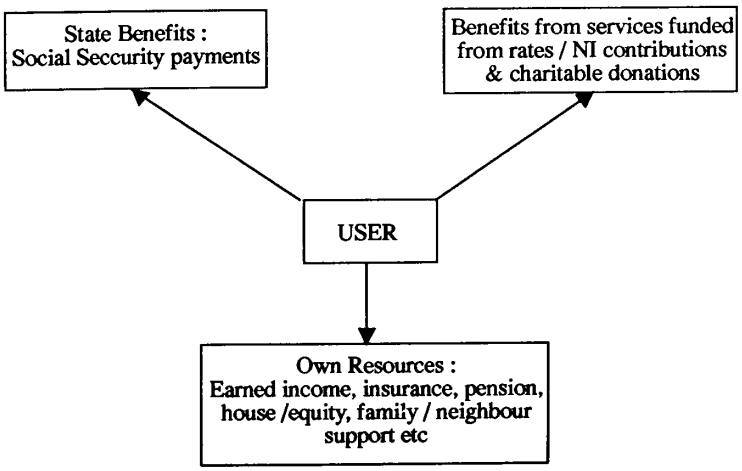
We know relatively little of how users can be given a greater role in the services that are intended for them. Arguably the new systems proposed in the White Paper will be more flexible and consumer groups may be able to have greater impact. Methods for consulting and including consumers in management are primitive at best and the changes created by the contract culture demand important improvements in this area. Even less is understood of the factors involved in consumers and consumer groups managing their own services - a realistic possibility in the contract environment.

These are the areas that must be developed if the contract culture is to improve the quality of life for service users.

Financial Arrangements

It has been argued in some quarters that the State's financial support for community care should be given directly to each 'client', others have argued that basic guarantees can only be provided if there is collectively controlled provision. The current system, largely unchanged by the White Paper from the user's point of view, demonstrates a mixed approach: (Fig. 7)

Fig.7



The White Paper opens the debate about how state support should be provided. The current system is partly based on some sort of minimum' service standard and partly means tested. Within this is a notion of what constitutes a 'fair deal', though in practice it is often uneven and unfair. How are the new services to be spread to meet individual needs and yet deemed to be 'fair'? Should 'notional' costs and benefits be attributed to each user? (see for example Challis and Davies 1986). Should case managers become individual 'budget holders'?[6].

Figure 8 locates the various financial options in a continuum, each offers users and service providers different management options.)

In fact users may 'pay' for services in very different ways - from accepting 'charity' to buying and negotiating the best 'price' in a market economy.

New systems of case management may help to clarify how social care budgets can be apportioned to each individual. However, the success of such a system depends upon the overall level of resources. A level exists above which it is possible to generate service patterns which enhance individuality and dignity, and below which users may have even less autonomy than they have now.

Creating individual budgets cuts both ways. They could:
(i) lead to greater user control over how 'their money' is spent.
(ii) be used to reduce allocations and entitlements for individual users, especially those who need high levels of care.

The social security system assesses benefits on an individual basis and the entitlement is probable. In the new system while needs may be separately assessed the response will be in the form of a service rather than an amount of cash.

Fig.8

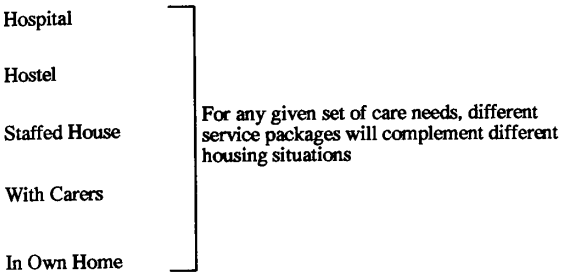
FINANCE BASE	USER OPTIONS	SERVICE SYSTEM
Vouchers (banded entitlements) and own resources	Purchase service packages from a range of suppliers.	Social work staff a service. Managers negotiate with car suppliers
"Mixed economy" - banded entitlements / benefits / income top-ups with other free or subsidised services and own resources	Purchase some services; use services provided communally	Social work staff as care managers and brokers
Service budgets distributed to individuals through their use of the services. Personal resources largely ignored. Social security seen as safety net not major supplier of e.g. funds for private residential care.	Corporate approach. At worst "conveyor belt" care, at best hotel standard service with no personal responsibility by user (pre 1979)	Social work staff as distributors of public care

6 cf The proposals for general practitionersin the recent NHS White Paper & also the Audit Commission (1989) pp 16 / 17

The range of housing options adds an additional aspect to costs and assessment: (Fig. 9)

Fig.9

HOUSING OPTIONS



In general it could be said that hospitalisation (health budget) is a more expensive way of housing someone than specialist housing (health, social services or housing department budgets) or people's own homes (users budget). However, the social care costs to the State will probably increase as housing costs decrease.

Cooperation?

The White Paper calls for non-bureaucratic cooperation between health and social services departments. This will be very difficult to achieve in an era of concern with the 'bottom line' in health and social service budgeting, and is further complicated when housing budgets (whether the house is owned by the user, a housing association, local authority or is privately rented) are included. None of this actually precludes putting the financial decisions back into the hands of the user - it is after all still 'their' money. Arguably even the extra resources that are to be provided through the Revenue Support Grant and the local authorities own funds could be included in such a package.
The White Paper argues that case managers, on behalf of users, should 'shop around' for the most appropriate services. This could lead to a rigid categorisation of services rather than what is actually needed: an ability to 'customise' services to users needs that is buying different types and levels of service from within particular units. Ways of costing services should be found that encourage and enable such developments.

Finally, the way in which contracts are secured and complied with must also include consideration of the need for security in continued use of a service. This will mean, for example, that contracts should ensure that individuals do not lose a specific service as a result of non-compliance in a service contract.

Service Systems

A large number of professionals have contact with consumers in current services and result in enormous variations in services within and across the country. This variation will continue, and could even increase, as the White Paper does not specify the local mechanisms by which the 'contract culture' is to be mediated. Users will, though, have to deal with two new forms of professional 'relationship': (Fig. 10).

This gives rise to new approaches in the relationships between users and services, and purchasers and providers. These relationships can either enhance user autonomy or repress it depending upon how they are developed in each local situation.

Whilst the 'mixed economy' of welfare continues to dominate the overall pattern of care, these key developments (the separation of purchasers from providers and the introduction of case management,) could go some way to enhance user autonomy but this depends to a large extent upon how they develop.

Fig.10

CURRENT	WHITE PAPER		IDEAL
Local Authority	Competing Providers	Case Managers	Consumer Choice
Management of "need" by professional staff. Concern with rights of individuals and a "fair deal" for all, balanced against local willingness to pay	Client chooses from a service led range of services, but within funds from own or "mixed economy". Choice limited by provision	Professional support provided for users to negotiate own care packages	User demands (and pays for some ?) resources as of right. Self assesment, access to own and state managed / contracted resources
"Care"	"Service Led"	"Needs Led"	"Citizenship"

Service organisation - issues for purchaser and provider

In addressing the different issues for the two sides [7] to any social welfare management contract, it is important to identify some other different and underlying motivations in the actual practice of the 'contract economy'.

Two contrasting models capture these themes:

- **the 'status quo' model**
- **the 'social progress' model.**

The Status Quo Model

This model can be described as the provision of services to minority (disadvantaged) groups by a body elected by a social majority. These services are secured by legal 'guarantees' and the setting of minimum standards and guidelines. Ultimately the provision of these services exists within a value system dictated by a majority view of how they should be provided, modified by the interests of staff and various lobbying groups.

Under this model contracts remain the responsibility of the purchaser and promote their interests. Two possible types of contract can be promoted:

a) Devolved Management

Specific areas of work are managed by providers to maintain services within the legal and value systems espoused by the purchaser. There is no intention to look for cost savings as such though it is hoped that efficiencies may result from the devolution of the management. This would be a 'corporatist' approach by the local state.

b) Profit Led / Cost Saving Management

Under these contracts the objective is to seek cost savings, primarily through the workings of a market economy. Whilst this may result in changes to the way services are delivered, the intention remains broadly to retain the current levels and types of provision within the competitive ethic through contract provisions, monitoring etc. The competitive advantage of the service provider is assumed to come from a mixture of working harder (due to the profit motive), better management (i.e. more commercial) and/or better technical skills. In practice, where it exists (e.g. in private residential homes), it tends to come from lower wages, poorer service and worse working conditions. Ironically, this model may lead to increased costs given the need to sustain a service and generate a profit. This would be, nevertheless, a monetarist approach to the management of local state services.

7 These are identified as 'purchaser' & 'provider'. The former are the agencies which have the power in law to pay for the contract work, the latterare the bodies who agree to provide services under such a contract. Arguably many 'purchasers' are themselves in a sub contracting position to a larger body. For example local authorities & Health Authorities are sub contractors to central government for the services they provide.

The Social Progress Model

Contracts under the social progress model bring together other strands in the development of social welfare and the state. These include:

- Both the political 'left' and 'right' agree to some extent on a modern framework for 'citizenship'.
- The fashion for decentralising service management has left unanswered the dilemma as to whether services should be managed within the umbrella of the wider 'local' state or whether they should be run by local groups with specialist knowledge and commitment. Differences within and between communities have become more visible as a result.

- Finally there has been some recognition that minimum standards are not an effective way of improving service provision. New practice is evolving which specifies each individual users needs and treats the users own ideas as paramount. [8]

These three strands have informed developments such as 'advocacy', 'consumer participation' and some radical practice models in therapy and counselling. Support has also come from conventional practitioners as they seek greater autonomy and a more natural relationship with their 'clients'. In the social progress model this new freedom is used to improve the quality of services by underpinning the rights of users for choice and dignity and ensuring continued service development. Under this model there are three broad kinds of contract management:

a. Professional Management

A team of professionals undertakes to provide and manage service delivery to users. Their commitment to a quality service arises from their 'professionalism' which brings together a value base (e.g. the 'Hippocratic oath') and advances in scientific discovery, technical skill and equipment. Whilst they recognise the need to work within certain cost levels, it is their skill and expertise that will result in the best possible service (and possibly lead to increases in budgets validated by their 'success'). This would be, for example, the rationale for a 'management buy out' of a service.

b. User Management

Several groups (e.g. Independent Living Centres) are already experimenting with this process which has two main variants:

each person given individual budgets each person given the opportunity to choose and self manage personal facilities from within a range of services such as housing, domestic and nursing help.

Individuals might work collectively to negotiate for these resources from the local state; effectively they are 'sub contractors' for their own care.

c. Collusion of Interests Management

Consumers (either direct users or indirect users such as carers), advocates, practitioners and voluntary or campaigning groups 'collude' around a common value set. Management under this model is guided by a shared philosophy and practice, examples might include 'normalisation' in mental handicap, separate provision for ethnic minority groups, feminist inspired provision for women etc.

The aim is to use existing financial (and possibly other) resources to explore and develop services which express the shared values of the group. The fear is that this cannot be achieved within a competitive tendering strategy as such because the chosen values might not be the cheapest. On the other hand the contract economy offers opportunities which are unlikely to be achieved in any other way at the moment.

Discussion of Models

This analysis also suggest that very different approaches can be taken by 'purchasers'. It will be important to understand this at an early stage in any local development process.

Very broadly speaking, the 'status quo' models represent the interests of the local state and the political factions within both the left and right that support it. The 'social progress' models can be seen as those espoused by parts of the voluntary and nonprofit sectors. However, this description is too simple as local motives vary enormously.

Issues addressed in contracts

Having investigated 'underlying' motivations, the issues which each party to any contract will need to address can be listed. These are shown below as 'lst order' and '2nd order' issues; the former concern issues of principle and the latter issues of practice. The intention is to provide a checklist for purchasers and providers to allow them to explore the exact nature of the underlying contract they are entering into.

8 An objective of the All Wales Strategy for People with a Mental Handicap.

The issues for the 'purchaser'

lst Order
What 'long term' view does the agency hold of society and the place of people with long term care needs within it?

What is the motivation of the agency in considering the use of '"contracts" in social welfare?

Does the agency view its statutory obligations as restrictive and limiting or as permissive and flexible?

What responsibility does the agency have to the consumer? What can be learned from this process?

2nd Order
What exactly is to be contracted? (e.g. current statutory obligations and/or only the provision of service?

Should whole service areas be contracted to a single sub-contractor or can it be parceled up into different 'packages'?

How should 'client cases' be managed?

What new skills are required by the purchaser (and sub contractor)? Will the contracting process be competitive or collaborative?

How is the contract to be monitored?

What limits should be put on the maximum or minimum size of any service agency?

Should preference be given to local agencies?

Should some services provide for more than one (or all) 'client' groups? (e.g. supported employment schemes)

What re-negotiation clauses will be required? How long should the contract be for?

The issues for the 'provider'

lst Order
What 'long term' view does the agency hold of society and the place of people with long term care needs within it?

What is the motivation of the agency in considering the use of contracts in social welfare?

Does the agency view its statutory obligations as restrictive and limiting or as permissive and flexible?

What responsibility does the agency have to the consumer? What can be learned from the process?

2nd Order
What is the contracting to do/achieve?

Can it provide a more effective service than the existing system within likely cost limits?

What management process/structure is most useful? What new skills will be needed?

How will contracts be re-negotiated? What compromises can be considered?

What statutory obligations might be taken on? How can the agency's work be monitored?

The separation of service provision from purchaser generates an opportunity for the conflict between 'needs' and 'the resources required to meet needs' to be crystallized. The distinction between the two models lies in how this potential conflict is addressed. In the 'status quo' model underlying service values are not easily accessed. If the 'system' learns at all it learns within a 'single loop' of existing value systems (Argyris and Schon 1978). For example, if an old person refuses to go into a residential home it would most naturally follow that s/he is stubborn and not because the home isn't satisfactory. Arguably because of this systemic change is (and has been) slow in current service systems.

In the 'social progress' model lies the opportunity for experience to affect practice within the service providing agency. Agencies have to justify the maintenance of their contracts. Thus if a home is having difficulty in holding its elderly population its practices, rather than its residents, may be questioned; the very need for such a service may ultimately be begged perhaps generating other moves towards helping people live in their own homes.

In such an open questioning of these values lies the opportunity for 'double loop' learning in the system. The 'contract system' in this way could lead to a questioning of the values of the provider and the opportunity to expose (and debate) the values of the purchaser. The following table summarises some of the factors which inform the two models: (Fig. 11)

Fig.11

	STATUS QUO	SOCIAL PROGRESS
VALUES	• Implicit	• explicit
TASK	• defined closely • already being done by purchaser	• defined broadly • only partially being done by purchaser at present
PRIMARY IMPETUS	*purchaser* • compliance with law • cost saving • rationalisation *provider* • profit / turnover • power	*purchaser* • extending / improving service • recognition of providers advantages *provider* • consumer benefit • power
MONITORING	• purchaser led • standard specification • compliance to values	• jointly undertaken • standards developed jointly • compliance to standards
SCOPE FOR USER INVOLVEMENT IN MANAGEMENT	• low	• high

Service Purchasers

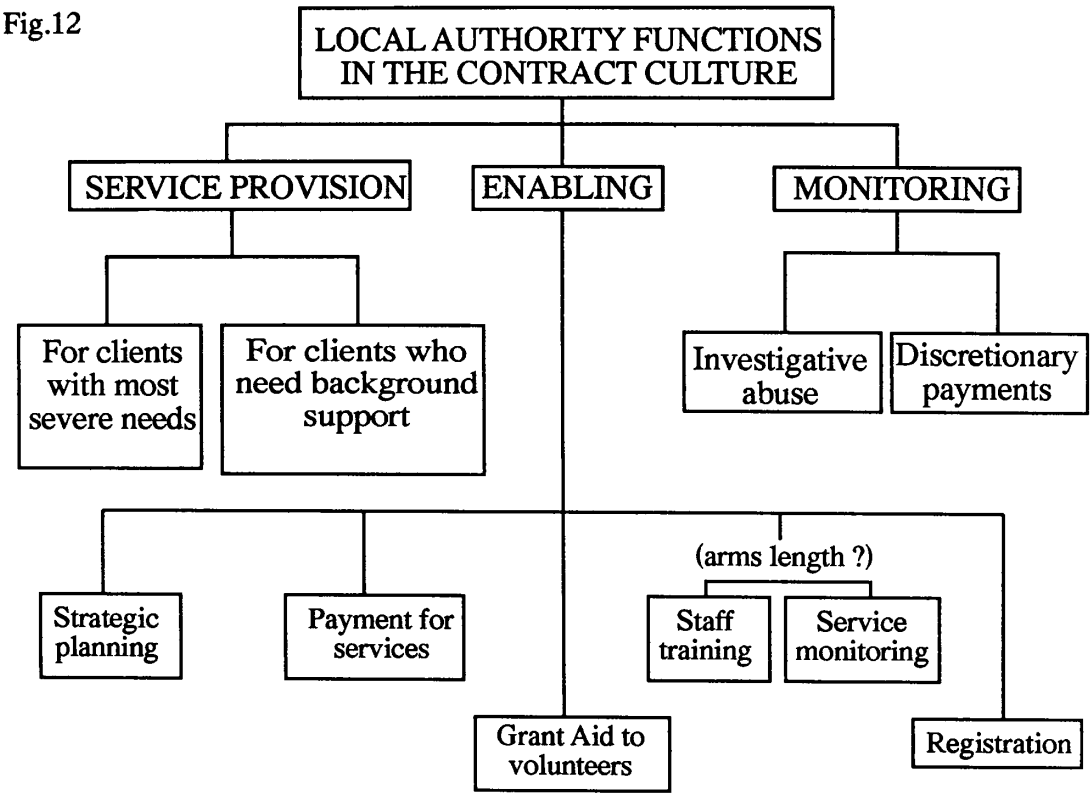
All this suggests a key role for service purchasers. They can generate local enthusiasm for positive developments in services by being creative in the way they agree to contracts. One aspect which needs to be considered carefully is whether single agencies should manage whole service areas or whether there should be clear limits to the number of service units managed by one agency. Thus the new responsibilities being laid on Social Service Departments are onerous and very important. 'Enabling' will mean more than procuring; it will include good practice promotion, service design and strategy. In particular it will mean rising above forms of collusion which might go against the interests of users.

These ideas also suggest the need to design a long term strategy which incorporates community reinvestment, the development of user power and systems which are themselves therapeutic. Thus, for example, contracts could be awarded to provide a crisis intervention service to keep people from having to use hospital beds alongside comprehensive housing and home support service which go far beyond our current concepts of domiciliary care and community nursing. These basic services should then be complemented by a range of specialist services to meet the range of other individual needs.

The responsibilities that local authorities will face under the new system will therefore include providing such non-contractible functions such as development / or advocacy : (Fig. 12).

A dynamic relationship between purchaser and provider should also ensure that contracted services are capable of meeting a range of user needs at different levels. It will be important to reduce the disruption for each user as their needs change and develop. 'Elastic' contracts, a culture of 'give and take', and a shared philosophy and direction to achieve ends agreed between user, purchaser and provider should be the watchwords of contract specifications.

Fig.12



Professional Roles

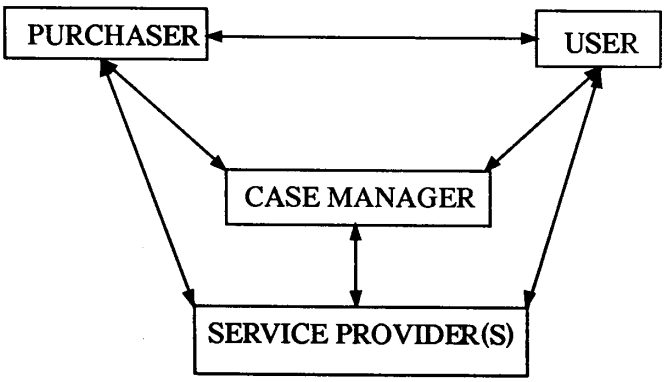
Case conferences typify the current management of professional roles from hospital consultant to home help. Many of these professions carry their own individual sets of values and can generate a useful sense of confusion which sometimes 'works' for the user. On the other hand it sometimes results in their needs being by-passed.

Recent years have witnessed the development of the key worker concept, now enshrined in law in some cases. The 'case manager' (Anderson, Banks and Kerr) represents one development, the 'broker' another (Towell and Brandon 1989). The White Paper makes such a role explicit within long term care services. Each user will have their individual service needs assessed and services organised for them. Major services users will have access to a named individual called a 'case manager'. The role is not fully defined in the White Paper except as the named individual who will arrange for the assessment of the users needs and ensure the implementation of a suitable service strategy. This, however, leaves a great deal still to be decided: a comparison of the concepts of 'estate agent' and 'building society' illustrates how the same objectives, house buying, can be mediated by two very differently motivated agencies.

Case Management

Case Managers will have to work within a web of relationships: (Fig. 13)

Fig. 13



Case managers can come from any part of the system, their role is to seek to achieve 'win - win - win' for all three parties. As such the case manager sits uneasily within a network of demands - alternately resource optimiser, information gatherer, user advocate, system coordinator, quality improver. There is a wide variation in how this role can be organised and how case managers can themselves organise service provision.

These include:

• Key Worker

Fit client to available services, assessment in same organisation as provision, case manager is both provider and mediator. 'Organisation led'.

• Project in Local Service System

Still retains role of mediator but distanced from service provision values. "Organisation led"

• Independent Grant Aided "Case Management" Project

Case manager has power to challenge and coordinate the range of professional assessments. Project can develop influence over service developments as well. "Value led"

The implications of these new 'case management' roles are many and occur at different points in a client case history.

Assessment can be carried out by:

• A separate 'assessment agency'.

• Key worker in a statutory authority.

• Independent case manager chosen by user.

• User.

Negotiated Principles

• Fitting users to services, or

• Working to make services fit users.

Extent Role

• Case manager as 'once- off' negotiator or

• Case manager as continuous 'maintenance engineer'.

Budget Control:

• Held by user, or

• Held by case manager, or

• Held by 'service system'.

Remit:

• As a function in a locality for all client groups or

• Brokers for specific client groups.

Thus professional roles will shape and be shaped by this major new role within the 'system', and the way in which social services departments choose to develop it. Local social services departments need to pay close attention to the development of this role and how they see it fitting into the development of other services.

Management of Professional Staff

Important questions are also raised for other service professionals. Relieved of a service mediation responsibility by case management, other services revert to 'goods' to be matched (or sold) to users. For example, psychiatrists may administer drug routines and other therapeutic practices but will not have sole control on hospital admissions. Such services will be on offer like boutiques in a department store rather than mediated by different 'shop assistants' in their own shops. This means that new systems for managing professionals, including case managers, could be developed. These might include:

• self employment (as are, for example, G.P's)

• state employment

• employment by an independent organisation voluntary, not - for profit or private agencies

• user employed (either by individual users or by a user managed organisation).

Case management will be the key to new service mechanisms. Many professionals are likely to be keen to secure the role for themselves so as to retain some power in the system. It will be of prime importance that the outcomes of this process do not further increase professional hegemony.

Review and Development Systems

From 1972 onwards, social services have been subjected to almost regular 'reorganisations'. There has been little time fully to evaluate the effectiveness of welfare services before they are once again shuffled around. On the other hand the quality of service and flexibility of provision that is sought through the contract culture can only be realised if whatever system is chosen contains the potential for review, improvement and re-design; it is also self evident that this should be a continuing process.

Ideally reviews of services to individuals will need to take account of:

- user desires, their 'wants', expectations.
- user 'needs', their circumstances.
- service provision, its adequacy.

Reviews of service units and systems should consider their accessibility, flexibility, coherence, equity and comprehensiveness. Under current systems, financial decisions have often been subsumed within professional assessments which have, on the whole, been intended to impose some form of quality of service. With the separation of purchaser and provider, there is a danger that 'value for money' will overshadow other essential criteria. In a system dominated by contract and the departmental budget this may constrain reviews to the internal system. Many of these review systems focus on the institutional factors of purpose and process. The challenge of the 'contract culture' will be to create local review systems that continually assess service models in terms of changing user needs, desires and progress.

These reviews should not rely on static standard specifications: such a route offers little to the overall system of which the service is a part. On the contrary, good services will develop from compliance to values, the active participation of users and working methods which improve practice from experience. As these projects make their local impacts, they will contribute to wider changes in society.

A learning dimension

The key is to build this 'learning' dimension into the system. The locus chosen for any service review is important in determining the effect of the outcomes, it can be 'purchaser/provider led' or 'user led'. Arguably neither alone offers a useful model and reviews should be based on an understanding of both sides to the equation. With the development of the contract culture, it will be increasingly important to blend the monitoring of overall service development with how individuals experience local systems. This will demand a culture of 'glasnost', effective communication techniques and structural power for users, both individually and collectively.

SECTION 5

THE WAY AHEAD

We have tried to demonstrate the complexity of the systems proposed by the White Paper, at the same time indicating that every proposal is capable of a local interpretation which could enhance the role of service users. Whilst a major determinant of the scope for improvement will be the level of funding (yet to be announced by the government), attention must also be paid to the dynamics of both the user/service and the purchaser/provider relationships so as to maximise the potential for progress. Clearly no single answer will be the best one for all users; there is no sense in which services will ever be 'right first time'. The long term answer lies in building learning into the system to ensure that it maintains a healthy ability to continually search for better answers.

The appendices illustrate two different paradigms which are now the foci for development of existing services. Individual case studies reflect aspects of the White Paper proposals on 'contracting out' and 'case management'. Some have been led by an emphasis on service development through contracting; others are led by attempts to alter the relationship between individual consumers and the services they receive through forms of case management. All the projects sought to develop new ways in which services meet the needs of users through re - definitions of organisational relationships. Thus they illustrate the new developments in the relationships between user and services, and purchaser and provider.

In the first group the range extends from the 'whole service' approach of Kent and Paddington, to the contracting out of individual services in the case of Bexley, Brighton,and Hereford and Worcester. The last example in Peterborough illustrates how a particular management process is helping to manage contracted relationships. These changes have been stimulated by external pressures, particularly hospital closures and the disincentive to finance residential accommodation from within local authority budgets. This alone was rarely enough. In each case developments occurred because of local individuals and agencies. The developments are of necessity slow under restrictive financial constraints.

Only the Bromley project has extra development funding. User involvement in the developments varies and some included a role for case management (Bromley, Kent and Padddington); others map onto conventional social work arrangements.

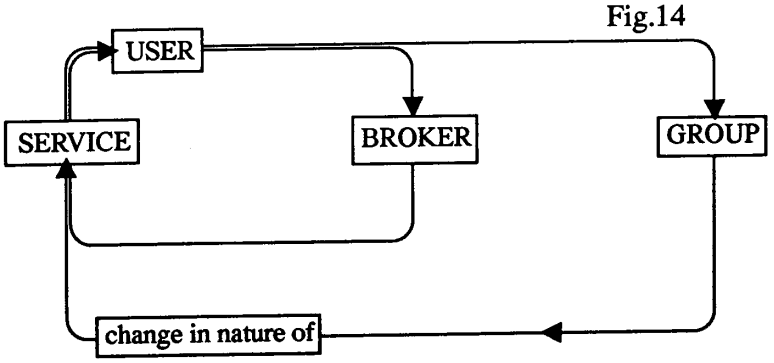
None include a clear role for the for-profit/private sector. The one case (Hereford and Worcester) of competitive tendering resulted in a non-profit agency undercutting any profit led bids. Clearly this was due to the profit margin expected above any costs incurred including loan repayments by private for-profit concerns.

The projects which focussed on user choice or involvement varied from the user led centre in Derbyshire to a health authority case management project (Pontefract and Wakefield) which also had responsibility for project development. The other projects sought to provide a professional base for individualised planning of services around user's needs. The influencing of local service provision was included as an objective of this approach.

Only the Derbyshire development incorporates user management into its practice, though the other case management projects insisted their approach started with the user. All attempt to ensure that users take decisions on their own behalf, the project's role being to enable, provide information, liaison and advocacy. In general the projects see their role as vital in determining the local patterns of future services. They are able to identify the true extent of real needs and avoid users being allocated services which are not themselves needed but which 'need' to be used. All seek to encourage and enable independent living in non hospital settings. Whilst none of the projects actually work across user groups, this is recognised as a possible development of this approach .

One way of looking at the relationships between the two development systems is to consider the role of user groups: (Fig. 14)

Fig.14



The key is the role of the user and user groups in influencing the overall direction of service development. It is not yet clear how such groups will develop in this country, or that a 'contracted' voluntary sector will be an appropriate vehicle for such groups. Neither is it clear how services will react and respond to this input. One possibility is that service providing agencies with users involved in their management could make a direct impact on service development; this demands a sophisticated approach to management which it is not clear that voluntary sector organisations can currently sustain.

Opportunities

Other developments can encourage appropriate changes in service development :

- A sense that change is inevitable and demands a response
- Greater flexibility in occupational roles
- The trend towards citizenship models of society
- Flexibility over area boundaries
- New senses of acceptable values
- New senses of rights seen by the users themselves
- The (slow) changes in placing children with different needs in ordinary schools
- Continuing closure of long stay hospitals
- Emphasis on quality development, targets and performance indicators
- Separation of service provision from service purchasing
- Clearer costing and monitoring of budgeted services
- Questioning of conventional procedures
- Opportunities for strategic planning in the current flux created by the changes
- The use of new technology in developing and maintaining individualised finance plans
- Professionals being made more accountable

Constraints

Against these forces have to be set well known pressures which resist change in service provision:

- Reliance on annual funding cycles slow decision making
- The costs of change use up scarce funding
- Lack of up to date information, especially as to the scale of the local needs
- A shortage of people with skills in the management of change
- A continued shortage of good practice in integrating people with special needs into ordinary services
- Lack of clarity about what a reasonable living standard should be
- An overstrong influence of 'value for money' objectives
- Divisions being exploited destructively
- Making change a matter for profit
- Resistance to changing attitudes
- Continuing low expectations of people with disabilities
- Rigid funding arrangements for external / sub-contracted organisations
- Seeing the voluntary sector only in terms of its potential for service development
- Inflexible contracts
- Contracts welded onto unchanged institutional frameworks

New Developments

New developments can be enhanced by encouragement of the first group and restraints being placed on the second group. The projects detailed in the appendices illustrate these wider factors at work and offer a myriad range of possibilities.

The work in North America is included to illustrate likely scenarios for the future. Both Canada and the USA have developed pluralist models of service delivery in contrast to our own state management of services.

The description of Vancouver's Mental Health Services illustrates very much how British services might look in a few years. Shortage of resources is still a key problem but the emphasis on development of community based resources is evident in professional practice, The Edmonton example of brokerage (or service planning) allied to funding for individual users demonstrates just how, in practice, the system offers many benefits. It cannot, however, answer the basic problem of resource levels; or how innovation can be encouraged in community based services .

The Dane County model from the USA is a very powerful example of how 'community reinvestment' can be quickly achieved if the right incentives are offered and the cost of the changeover is funded. The system itself aims to promote therapy by keeping people in ordinary environments, the whole process based around extensive community based support which provides 'Training for Community Living'. The terms of the implicit contracts are the key to these changes and illustrate how the contract culture can be used to promote effective and appropriate change. On the other hand the welfare system is disintegrated and localised and so it has not been replicated even in nearby counties. In the Canadian system provincial ministries are backed up by Federal ministries and, whilst there are distinct local differences, effective practices are being developed across the country backed up by radical national policy objectives.

These projects illustrate aspects of 'therapeutic systems' and 'community reinvestment' in practice resulting from the use of the contract economy in the development of true community based care provision. These two tenets, alongside the greater involvement of users, provide the basis of a practice for progress in Britain today. We now share the responsibility for the direction of this progress.

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APPENDICES:

ASPECTS OF THE CONTRACT CULTURE IN PRACTICE

This package brings together brief reports of work that is currently in progress in this country. These are complemented by studies from North America. They are of necessity incomplete and are intended only to illustrate different aspects of the 'Contract Culture' in practice at the current time.

The studies have been focussed to illustrate different approaches within each project, they are not intended as complete descriptions of all the work of the individual projects.

The UK Case Studies are indexed here under two broad headings according to the focuses chosen for each report:

UNITED KINGDOM

Service Development Aspects

Bexley - Residential Services for People with a Mental Handicap by "Social Policy Management Services Ltd".

Brighton and Hove Area Group Housing Association Limited - **Contract for Residential Care**

Hereford and Worcester County Council - **Using Competitive Tendering in a Contract for Residential Care**

Kent County Council - **Care in the Community Project - A County Plan for People with a Mental Handicap in Kent**

Mental Health Services in Paddington - **Proposals for a New Organisational Framework**

Peterborough Health Authority - **Quality Assurance Department**

User Centred Aspects

Camden / Islington - **Choice - The Case Management Service**

Derbyshire - **Derbyshire Centre for Integrated Living**

Hillingdon - **Vox Employment Services**

Lifestyle Projects - **The Spastics Society (West Region) and Herefordshire Lifestyles Project**

Pontefract Health Authority with Wakefield Health Authority and Wakefield MDC - **The Case Management Project**

CANADA

Vancouver's Mental Health Services

Service Brokerage in Edmonton's Mental Handicap Services

USA

Community Support Programme - **Mental Health Services in Dane County, Wisconsin**

BEXLEY - RESIDENTIAL SERVICES FOR PEOPLE WITH A MENTAL HANDICAP by 'SOCIAL POLICY MANAGEMENT SERVICES LTD'

Sources: NCVO Community Care Project Newsletter/July 1989 Code of Good Practice/ Service Specification: Bexley Health Authority, Bexley London Borough and Social Policy Management Services Ltd. (11/11/88)

Social Policy Management Services Ltd. (SPMS) is a 'not for profit' company set up by Bexley Council to manage some of its services for people with learning difficulties. The company has taken over the management of former staff of the Social Services Department and Health Authority, however, the company is still clearly linked to the two authorities. A document outlines both a clear 'Code of Good Practice' and a 'Service Specification' relating to the agreement between the three bodies.

Former patients living in the community are eligible for board and lodgings allowance and an annual 'dowry' of £14,000. Care plans are produced for the individual residents and this will be extended to all people with learning difficulties in the community.

The principles of normalisation inform the Code of Good Practice which expands these principles into details of practices in service provision. These are then ensured by a series of checklists for different aspects of clients' lives.

The Service Specification then defines the services which SPMS will make available and the manner in which they will be provided. This specification reflects the Code of Good Practice and SPMS has to make an Annual Report each year. This report should be based upon meetings held in each of the residences for users, relatives, advocates and staff.

The Authorities convene a monthly 'Placements Panel' which allocates individuals to different homes. This panel consists of the the General Manager and other staff of SPMS, a member of the Community mental Handicap Team (CMHT) and representatives of the authorities. Decisions are based on a comprehensive report made by the CMHT which includes a statement as to any wishes of the service user.

The authorities have to approve the short list from which SPMS appoints its General Manager and individuals in charge of each home have to be approved by the Registration Officer in respect of the suitability of their qualifications and experience. All senior staff of SPMS and all persons in charge of homes attend a 'Service Development' meeting convened once a month by the Authorities. This meeting reviews current and planned service developments, coordinates different aspects of service provision and provides a forum for an exchange of views on operational problems.

The agreement also lays down standards for staff training key workers advocates rights to complain short term (respite) care records placement difficulties and breakdowns fire precautions service users money lifting and moving service users medicines

In general these provisions attempt to offer service users maximum autonomy and respect whilst balancing up other legal constraints and staff needs; indeed stress is placed on the proper training and supervision of staff.

BRIGHTON AND HOVE AREA GROUP HOUSING ASSOCIATION LIMITED - CONTRACT FOR RESIDENTIAL CARE

Source: Notes prepared by Ken Whitehouse, Director of Brighton and Hove Area Group Housing Association. Additional conversation with Chris Sevinck, East Sussex Social Services Department.

Brighton Health Authority/East Sussex Social Services Department have worked together on two major Care in the Community Projects; one of these has been for people with learning difficulties which has seen the closure of two hospitals affecting some 150 people. East Sussex Social Services Department took the lead agency responsibility for the planning and management of all residential and community services for people with learning difficulties.

The Department, with the agreement of Brighton Health Authority, asked the Housing Association to take over the support services and, via leases, the property management for 35 people involved in the programme. Another 15 people may be included. These

services are high ratio staff supported community housing with 4/5 people in each property and one daytime service programme for 15 people. The projected amount of revenue top up could eventually be about 750,000 per annum, the scheme has now been running for five months.

Brighton and Hove Area Group Housing Association Ltd. has been in existence for 15 years operating a number of accommodation services for people with mental health problems. It has close links with the local MIND organisation which has provided voluntary support to people with mental health problems living in the accommodation. It undertook a major restructuring in order to take on these new ventures this included:

- the introduction of new members to the main committee from both business and professional sectors

- the development of a new committee structure to accommodate the new responsibilities for property management and care services

- the employment of a new Director and two care service managers along with new central office administrative services and staff

The properties are leased from East Sussex Social Services Department and from Brighton Health Authority on 28 year leases. The services are subject to an agreement which covers:

- the philosophy and values which East Sussex Social Services Department wish to see reflected in the style, quality and organisation of services

- the financing of the service; the base line for initial funding and the links between levels of funding and levels of service

- 'Escape routes' at points of disagreement -issues related to staffing 'terms and conditions' and training

- monitoring and evaluation of service quality -annual review procedures

The monitoring system is 'aggregated' from individual user reviews to whole service system reviews.

HEREFORD AND WORCESTER COUNTY COUNCIL - USING COMPETITIVE TENDERING IN A CONTRACT FOR RESIDENTIAL CARE.

Source: Discussion with Tim Holbert, Assistant Director at Hereford and Worcester County Council SSD

Background

The balance between private and County Council provision of residential care for elderly people in the County has dramatically changed over the last six years. In 1983 the County Council provided 1300 beds and the private sector provided under 500 beds. In 1989 the figures were 1200 and 3,500 respectively. In effect the private sector has completely filled the need for an extra 500 - 600 beds that was identified in 1983.

To the surprise of the Social Services Department, the controlling group on the Council used these figures to propose and support an objective of privatising six local authority homes. It was suggested that this would save £1m revenue expenditure. This proposal caused some consternation for all concerned, not least for the staff who were instructed to implement this proposal. The major issues seemed at first to safeguard the rights of the residents and staff of the homes.

Various proposals were put to the members concerning the properties that the Council owned or were about to build. Most of these were agreed as being unsuitable for the proposal and in the end just one building, which was then actually under construction, was accepted for the plan. This avoided all the issues concerning continuity for any staff and residents. The building was a 28 bed house. A private management contract would result in savings to the Council of between a £100,000 and £150,000 purely because clients would have access to full DSS benefits in what would be an independently managed home.

The different ways in which the 'privatisation' of this building could be achieved were then considered:

1. Management buy out. This was canvassed amongst staff. However, it was considered that the management of a single unit such as this would not make a viable enough commercial proposition to warrant the setting up of a completely new company. Existing staff, whilst interested in the idea, could not take it forward. They

would have to borrow money on the commercial market which would result in incurring debt servicing costs which would make the financing of the scheme unworkable.

2. The setting up of an 'independent' trust. In order for the Council to set up a trust which would remain under its control at 'arm's length', the trust would not be deemed to be independent enough from the Council for it's residents to attract DSS payments. Such payments are only available to the clients of homes that are clearly voluntarily or privately managed. Furthermore such an organisation would face the same financial blocks as the management buy out proposal.

If the trust was set up in such a way as to be genuinely independent of the Council, it was thought the Council would have even less control over the contract than if there was a clear financially based contract for service.

3. Competitive tender for a management contract. It had been calculated that the Council's cost for managing residential services were as cost efficient as private sector costs. The major benefit of independent management was access to DSS payments. The concern then was that agencies which sought to run the home with a profit margin would have to have unacceptably low standards of staffing and/or salaries, however this could be established and avoided through the terms of the contract.

On balance, the officers agreed that the only reasonable option available to them was the competitive tendering process. The process of setting up the terms of such a contract was begun with the objective that the conditions should be made as tight as possible and should reflect the authority's values and standards. On taking legal advice, it was discovered that if the contract was drawn up in this way then the home may not have been deemed truly independent of the Council and thus ineligible for DSS payments. In spite of this a tight contract was drawn up which the Council members rejected. Thus the eventual contract had to have a very limited set of conditions. The focus was then placed on the tendering process. (The authority has, however, applied its 'tight' contract conditions to its own homes. It was thought that the whole process had raised many interesting and valuable insights into the management of residential homes.)

A two stage process involved seeking an approved tender list before making contract details available. Nine approved tenderers were accepted from an original list of 13 applicants. This was based on financial and legal checks, an acceptable level of professional experience and clear evidence of management ability.

Five tenders were eventually received which included a range of conditions as to nomination rights etc. Only three tenders were within the terms of the contract, two were commercial organisations and one was a voluntary organisation. The council had a clear financial benchmark for the actual financial costs of running the home, this was to ensure that contracts would only be accepted that were actually capable of delivering reasonable standards of care. In fact only two of the tenders marginally undercut the Council's own figure for the management of the building, all the other proposals were higher - private management does not necessarily mean a reduction in overall costs - in fact the opposite may be true.

The successful tenderer was a non-profit making organisation (The Birmingham Council for Old People). Their interest sprang from their need to continue the employment of various staff that would otherwise be made redundant. Arguably they were able to beat the commercial concerns because of their intention not to take a profit from the contract. The contract is a few months old and already substantial parts have had to be renegotiated and clarified. Fortunately the overall interests of the contractor are not in conflict with the Council and so these negotiations have been reasonable and effective.

A further complication is that the Council is both the contractor and the inspector. Whilst this gives strength to the Council's hand in one way, it could also be seen to raise a legal concern over a conflict of interest, especially if the Council's direct concern was to reduce care costs to the very minimum.

The Care Process

Under this model the Council's Social Work staff have a normal relationship with the clients; care plans are agreed and effected through the Council's nominated places within the home. The sub-contractors are partners in this process by negotiation rather than as part of the original contract (again this aspect had to be left out of the contract for legal reasons).

The sub-contractors have appointed a SRN to manage the home. This has caused some concern that the home may be managed on a medical rather than social work model. One result has been that the authority's social work staff have had to make a greater input, for example, in helping clients with their financial arrangements.

The whole process of transferring the home into alternative management has been professionally difficult for many staff in the department. The major concern was that the 'social work' values will be eroded. However over the months of internal discussions it became clear that these values had only been defined within the framework of the 'organisation' of the department. The process of drawing up and agreeing the tender had brought the nature of these values to the surface, it became clear that they were actually made within the overall resource base of the department but that actual costs were hidden by the 'global' nature of the budget. Thus judgements are currently made as to the 'right' forms of care by reference to an organisational culture. This does not necessarily offer clients a clearly expressed range of alternatives. The tendering process demonstrated that 'quantification' of care costs is now important and that in effect social work departments and staff are 'resource managers' whether they like it or not. These issues have to be clearly addressed by social workers if their original objectives are to be met in a society which is now placing limits to expenditure. The key to this process is, however, that budgets provide enough resources for reasonable standards to be maintained. This may only be possible if public and professional judgements are informed of the actual costs of social work care in understandable terms.

Initial conclusions from this experience suggested several possible trends and developments:

There could be some value in sharing the skills and attributes of the best practice in both local authority and privately managed care. Some knowledge of assessing costs of different care options will become increasingly important. This should influence both decision making for individual cases and in establishing the true costs of care in the public domain. In this context a further development of the tendering process could be to establish different payments for different levels of dependency. This would further enable the targeting of available financial resources (always providing the overall resources are actually sufficient for the task.)

Clearly private care is as expensive as local authority care and potentially more so. In the final analysis, sub contractors working to local authority standards are not able to show any real savings and debt servicing in the private sector is more costly than for local authorities. These factors will effectively exclude agencies which are looking for large short term financial returns.

A major problem for private organisations will be the maintenance of training and support packages, ironically it may be that local authorities sell their expertise in these fields back to the 'independent' operators.

A clear effect of the process of costing services has been to uncover the amount of 'hidden' resource allocation that goes on within any service. Arguably this allocation is conducted by officers and politicians on behalf of clients on a paternalistic basis. Thus any proper analysis aimed at increasing client autonomy and public awareness has to take the costing of services seriously and without recourse only to existing service standards.

A 'Not for Profit' trust will be set up in a similar form to a Housing Association. It will have to be independent of the County Council and will lease property from the County Council and others and rent it on the basis of standard licensed tenancies. This would generate the resources to maintain the properties in good order and adapt them where necessary. This will be in addition to residential care units for a small number of highly dependent people in conjunction with the NHS.

Home care services will be developed from a mixture of service providers who are able to meet the needs of individuals and whose services can be acquired by care managers. Carers will also be the subject of a three year plan to promote self help, information and other support networks.

MENTAL HEALTH SERVICES IN PADDINGTON - PROPOSALS FOR A NEW ORGANISATIONAL FRAMEWORK

Sources - Notes provided by Ian Gregory, Coalition for Community Care (CCC) (Mental Health).

N.B. These notes refer only to outline proposals being discussed between Parkside Health Authority, Westminster City Council and CCC. It is recognised that the proposals discuss an overall objective which will have to be achieved through a series of interim arrangements over several years.

Following concern about the organisation of services for people with mental health problems in the Paddington area, the Health Authority, Social Services Department and the voluntary sector represented by CCC have engaged in discussions and study days to move towards a cooperatively planned solution. At the time of writing the proposals include the following key elements:

- a joint budget for Paddington's mental health services
- a joint budget to manage those resources
- contractual arrangements between the joint board and mental health service providers to ensure an appropriate range of mental health services for paddington
- the establishment of multi disciplinary teams of case managers who will be responsible for assessing the needs of individual clients and negotiating appropriate packages of care for each client with service providers on behalf of the joint board.

The Joint Budget

This budget will be used to purchase mental health services for Paddington. It will be made up of allocations from the health authority and social services and could, subject to the agreement of the relevant parties, incorporate local authority grant aid to relevant voluntary organisations.

It is intended that the joint budget will provide a strong bridging mechanism for resource management and planning purposes.

The Joint Board

The board will be accountable to the relevant authorities for the management of a joint budget. It will be responsible for determining a mental health service strategy for Paddington and for determining broad contractual arrangements with mental health service providers to ensure an adequate range of services for Paddington.

The board will have a small membership made up of health and social service managers and some independent members. The question of whether it should have an executive member is left open at this stage.

Service Providers

These will be health, local authority and voluntary sector agencies which will enter into contractual arrangements with the joint board. Payment will be on the basis of their contribution to the overall strategy and in general contracts should be kept simple and straightforward without recourse to cumbersome legal formulations. Qualitative and quantitative monitoring of the contracts will usually be based on outcome criteria.

Case Managers

A number of multi disciplinary teams will be established to work in Paddington on a case management basis. These managers will be drawn from a variety of professional backgrounds and will be required to provide continuity of care and to mediate between their clients and service providers. They will be responsible for assessing the needs of individual clients and for negotiating an appropriate package of care to meet those needs. Their relationship with both clients and service providers will be crucial in ensuring that the client receives a care package which optimises quality, continuity and cost effectiveness of care.

The possibility of creating on overall 'shadow' budget for each team, which would in turn raise the possibility of budgets for individuals requires further exploration. It might be possible to pilot such an idea with one team in the first instance. Given current central government regulations, it is not possible to incorporate certain resources into the project e.g. social security contributions. It is nevertheless crucially important that individuals have access to an optimal range of resources which can benefit them. The role of case managers in ensuring this will be vital.

Case managers will also ensure that the joint board is kept informed of the overall quality of care which individuals are receiving. Each team will be managed by an identified coordinator/team leader.

It is recognised that this aspect of the scheme needs careful consideration, in particular there needs to be discussion about who will be case managers and their relationship to service providers.

PETERBOROUGH HEALTH AUTHORITY - QUALITY ASSURANCE DEPARTMENT

Sources - Interview with Anne Lockwood, Quality Assurance Manager and documents on the work of the department.

'Quality Assurance' (QA) was launched within the Peterborough Health Authority (PHA) in 1987. It was introduced to complement the Griffiths proposals on General Management. The aim is to provide a clear basis for service evaluation and development and provide a foundation for management decisions.

This approach has been used within Authority managed units successfully but has also been found to be very useful in negotiating contracts with external providers. Up to now this has been very much appreciated by the 'sub contracting' providers, they have been professionals setting up small independent units such as individual residential homes and day centres.

The Quality Assurance process:

An assessment is made of the required outcomes from the unit. These are then linked to the inputs that are will generate these outcomes. It is recognised that outcome measures alone cannot determine a satisfactory level of patient care, the 'cure' of a patient does not necessarily mean that they received the best or most appropriate service for their condition. Ultimately measures are derived from three sources:

- Client perceptions of need
- Clinical perceptions of need
- Public perceptions of acceptable levels of health care.

The inputs and outcomes are then monitored: Inputs may be in terms of numbers of qualified staff, training for staff as well as staff/ patient ratios, equipment levels etc. The needs of individual users with learning difficulties are assessed using IPP's which are fed into the assessment process in long stay or day care units.

Regular staff meetings and 'quality circles' are then used to ensure that the improvements in service are incorporated into daily practice. IPP's are reviewed every three months and monitoring may include consumer surveys; it is however recognised that these can only provide comments on 'niceness' factors (e.g. politeness, promptness of service etc.) and can rarely provide information on whether or not the medical or clinical service was appropriate or the best available.

Working within contracts:

From the start of the QA initiative, the system has been built into any contracts which PHA has agreed. The same standard setting and monitoring process is built into each situation; penalties for non-compliance range from fee reduction to replacement of the (aspect of the) service by the HA using the contracted funds. This has worked well because the individuals involved in setting up private/ voluntary establishments have been professionals who have appreciated the approach; there is a concern that firms which have been involved in large scale residential homes for the elderly and now wish to bid for work with elderly mentally ill and other health service patients will not be so willing to work with this approach.

There is also concern the contracts will not allow for services to change as needs change. However, it was thought that this feature could be built into contracts. This would require that they were time limited (e.g. 3 - 5 years) and a major review and renegotiation option is built into each contract. Further ideas / issues for the future include :

1. Increasingly the department at Peterborough trains Authority staff to undertake the QA process rather than do all the work itself;

2. There is some difficulty over how standards that should be used can be agreed upon; obviously this is ultimately a political decision about the levels of health care and the resources available. In the field of mental health care, Peterborough uses the "Guide to Good Practice" produced by the King's Fund. For services for people with learning difficulties, the STEP package provides the basis for the assessments.

3. It would seem there is shortly going to be a "British Standard" for Quality Assurance processes. This will, however, reflect industrial rather than"human service" situations. (A diploma course in QAis to be at Birmingham from 1990).

4. The work depends on support from senior managers and members of the Health Authority itself. However, it also depends upon a number of other pre - conditions such as staff teams that work together etc. In this respect it has been necessary to develop team building resources to work alongside the QA process

5. The QA process alone does not currently include consumer choice within its brief. It is thought that this should occur in negotiations with GPs but recognised that this is unlikely to happen to any substantial degree at the moment.

CAMDEN / ISLINGTON - CHOICE - THE CASE MANAGEMENT SERVICE

Sources - Documents provided by CHOICE

The Case Management Project has developed and put into practice an independent or user led model of case management. In this project the case manager does not hold a budget but works solely to the disabled person managing the system that is requested by the user. The Project was funded by the Kings Fund between 1986 and 1988 to work with people with severe physical disabilities. The original team members have now registered 'CHOICE The Case Management Service' as a voluntary organisation with the aim of disseminating their findings and developing the model further.

The project was set up to be clearly independent of any service providers; its funding did not come solely from the health or social services. The project had three objectives:

• To provide a client centred service which would help clients obtain the services to suit them best

• To provide other service providers with specialist information on services for people with disabilities

• To provide an overview of services for people with disabilities, pointing up where needs were not being being met by available provision.

The work involves a series of tasks:

• Recruitment of clients who could use the service

• Assessment of client's needs, through discussions with the client and, if necessary, other professionals

• Drawing up a plan of action, detailing the tasks that have been agreed with the client

• Connecting the client with the required services; this includes any coordination necessary to make the services fit the client's needs

• Advocacy and representation which may be necessary in order to obtain services

• Monitoring to ensure that services are provided as planned.

The project evaluation report indicates that whilst the project often dealt with people with severe disabilities, it had been successful in sorting out a reasonable solution in half of the cases and that in a further third some progress had been made. The other clients clearly put the blame on the scarcity of resources to meet their needs. The Case Management approach had been far more successful in this than the social workers or occupational therapists who had previously been working with the clients. These other workers saw the success of the project primarily in its ability to work in an advocacy role.

The CHOICE project has now developed a set of 'STANDARDS FOR QUALITY' to inform their approach and clarify the term 'case management'. The three parts of this include:

A **'People's Charter'.** This sets out the rights of Case Management Service clients and includes:

•A single contact point for the service

•Written descriptions of the service

•A complete look at all the needs of the client

•Devising a ' package of care'

•An independent representative and troubleshooter

•Feedback of the client's needs to service planners

•A written action plan including goals subject to regular review.

A 'Planners Checklist' This mirrors the People's Charter but clearly states that the Case management Service does NOT:

•Provide services or act as key worker

•Act as a gatekeeper service

•Work only with one aspect of a person's life

•Set tasks for the client

•Look at needs in the light of available services

•Ask services employees to go beyond their normal duties

•Ensure that some people get services at the expense of others.

The Role of the Case Manager.

Case managers will need knowledge of the social and political implications of disability and have undertaken disability awareness training; wherever possible they should have direct experience of disability. They will work to fulfill the charter and the checklist, working through the Case Management process detailed above.

DERBYSHIRE - DERBYSHIRE CENTRE FOR INTEGRATED LIVING

Source: Factsheet produced by Derbyshire Centre for Integrated Living.

The Derbyshire Centre for Integrated Living (DCIL) is the product of a long struggle by disabled groups in Derbyshire (through the 'Derbyshire Coalition of Disabled People') for the right to manage (at least some of) their own services. It is reliant on grant aid from the County Council, the Health Authorities and the EEC. The Centre is not the subject of a contract agreement as such although DCIL is an integral part of Derbyshire SSD's Strategic Plan for the development of services for people with physical and sensory impairments. Disabled people form at least 50% of the membership of its governing body together with representatives from the County Council, Health Authorities and local voluntary organisations.

The principle philosophy of the Centre is that of 'Integrated Living'. This focuses on the relationship between disabled and non-disabled people, it sees this relationship has being the 'cause' of disability as such. The aim of the Centre is to enable disabled and non disabled people to work and learn together towards full social integration. This is related to but not necessarily the same as the Independent Living movement which has been developing in the USA.

Thirty four paid staff (half of whom are disabled people) and thirty two disabled volunteers throughout the County provide services in 7 key areas:

- Information
- Counselling
- Housing
- Technical Aids
- Personal Assistance
- Transport
- Access

The Centre also has an Employment Agency.

The services are directed at people with disabilities and, crucially, at potential suppliers of services. These include:

- Housing suppliers; District Councils, private developers and Housing Associations

- Transport operators; community transport operators, taxi and ambulance services

- Providing advice onaccess issues to planners, architects etc.

- Going out to employers to inform them of funding, help available for aids and adaptations, and providing training to new and existing employees.

The services to disabled people provide an interlinked set of resources. Examples include:

- 33 trained counsellors scattered through the County; Advice on disability benefits; Comprehensive local information services by telephone

- A (proposed) agency for advising on all aspects of buying in 'personal assistance' and funding independent living; helping disabled people become employers for the first time.

• An advice and trial service for technical aids and advice on vehicle adaptations

DCIL clearly sets out to both provide services to disabled people and also work to change the environment for people with disabilities. The idea that all that is required are better institutionalised services is strongly resisted through its management and development philosophy. This could not be encompassed within local authority management and suggests an important avenue for contracted services.

HILLINGDON - VOX EMPLOYMENT SERVICES

Sources - Reports and publicity material produced by VOX Employment Services.

VOX Employment Services is actually part of the Hillingdon Social Services Department. Its purpose is to be an employment agency for people 'with a disability of some kind'. It has modelled itself on a commercial employment agency, with specialist back up work required to help employers (and service users) overcome the practical and attitudinal barriers to employing people with a physical or mental disability or mental health problem. The relationship to contracting is three fold:

1. The project has deliberately chosen an image which distinguishes itself from its origins in order to create a positive image for and about its users.

2. The project team will train and support individual SSD staff to enable them to become 'VOX franchisees'; that is to act as employment agents using the VOX model and database with back up support from a member of the VOX team acting as consultant. The project is very clear that employment support work in the Borough should share the VOX image, philosophy and process.

3. Its works with employers and job - seekers on an individualised contracted basis.

An important aspect of the work will be with 'ordinary' high street employment agencies, addressing attitudinal difficulties and providing the 'employer support service' to other employment agencies as well as to employers.

A 'High Street' shop front premises acts as the focus for the operation. There is a promotional 'consultancy' arm to work with employers and a 'recruitment' arm to work with users and SSD staff in day centres, ATC's and residential establishments. In addition an 'enterprise' arm will promote self employment opportunities for teams of individuals in several different projects.

VOX sets annual targets and attempts to operate as far as possible as an independent project. The project is to be monitored by an external agency.

Thus while VOX is undoubtedly a concerned and specialised agency, it is distancing itself from the 'welfare' images normally ascribed to services for people with disabilities.

LIFESTYLE PROJECTS - THE SPASTICS SOCIETY (WEST REGION) and HEREFORDSHIRE LIFESTYLES PROJECT

Source - Notes provided by Paul Robinson, Spastics Society, West Region. Notes provided by Herefordshire Lifestyles Project.

The Wiltshire projects have been set up under the DHSS Opportunities for Volunteering Scheme in Swindon and Salisbury. The Herefordshire Project sprang from an initiative made by a Specialist Careers Officer through the Herefordshire Joint Health Care Planning Team. It has received support from the Spastics Society and is currently funded by the Nuffield Provincial Hospitals Trust and 'Charity Projects'. They bring together ideas from advocacy, brokerage and voluntary support.

The Wiltshire Projects:

The project is aimed at younger disabled people and is designed to enable them to develop a full 'lifestyle', where possible independent of stigmatised services. A 'Project Coordinator "works with an individual disabled person to identify their interests, aptitudes and needs. Information is provided and an individual is enabled to construct their own personal 'Lifestyle package'. This may include needs in three different areas:

1. 'Maintenance/Care' e.g. cooking, shopping, physiotherapy.

2. 'Work or investment towards work' e.g. educational courses, rehabilitation.

3. 'Discretionary/ Leisure' e.g. art and recreation, sport.

The projects are based upon the 'Key Principles' contained in 'Living Options', the guidelines produced by the Prince of Wales Advisory Group on Disability, and the principles of 'Social Role Valorisation'. The agency can then arrange for voluntary support to be provided where needed within the package and also support the person in lobbying for the provision of a service that they may need. The packages are monitored and reviewed on a regular basis.

This project offers an interesting model for assisting with 'total management' packages for people with disabilities. It is clearly aimed at providing a service on an individual basis; one of the main aims is to enable disabled people to use ordinary services. It does however depend upon other specialist services being available for people with disabilities and does not manage the spending of any financial resources available to or for the individual. Where additional help is required, family, friends and volunteers are engaged with the 'package'.

The Herefordshire Project

The Herefordshire project works from similar principles. There are two parts to the project:

• The Adult Lifestyles project works with people above 16 with no upper age limit

• The Student Lifestyles project works to help young people (aged 14 - 25) prepare to leave their school/college community to return to the community which hosts their home, leisure and occupation.

PONTEFRACT HEALTH AUTHORITY with WAKEFIELD HEALTH AUTHORITY AND WAKEFIELD MDC -THE CASE MANAGEMENT PROJECT

Source - Notes supplied by the Case Management Project.

Background

The Case Management Project is a joint venture between Pontefract and Wakefield Health Authorities and Wakefield Metropolitan District Council and local Mencap groups. It has been funded by the Yorkshire Regional Health Authority for an initial three years at a cost of £62,000 per annum for the project costs with an allowance of £100,000 pa available for purchasing services. Individuals will be entitled to money on an annual basis on moving from Fieldhead and this will be mixed with finance available from DSS and other sources.

The immediate task is to work with people currently living in Fieldhead Hospital, a long stay hospital for people with mental handicap in Wakefield. There are no specific numerical or time deadline targets, the project will simply work with those residents whose original homes are in Wakefield or Pontefract (and also those who are 'stateless'.)

Case Management

The aim is to discover the needs and wishes of 'clients' in their own terms. It is important for the Case Manager to work with the client on a 'getting to know you' basis and avoid formal or traditional assessment tools. The task is then to assist the client obtain services which fulfill the needs they have expressed.

It is an attempt to avoid resource led planning; its aims are enable and empower people to make their own choices and have control over their own lives and futures. It is important to start working with a client without preconceptions about their needs or their abilities, especially as they may be defined by their current hospitalised situation. It is also important to involve any family and professional support networks the person may have.

Once the network of services has been arranged, the Case Manager is then responsible for the coordination

of the services and the monitoring of their effectiveness and appropriateness alongside any changes in the needs of the client. The process depends upon the clients views being expressed and respected.

The Project

The project team consists of a Project Coordinator, two Case Managers and a secretary. The Coordinator's role is pull together the information provided by the Case Managers and arrange for the necessary services to be provided; this could be through existing resources or promoting and pump priming new projects which will obtain longer term funding from permanent sources. She is then responsible for monitoring the services and ensure that changing needs are met by service providers.

The project is being evaluated by staff from the Nuffield Institute and the evaluation is being funded by the Joseph Rowntree Memorial Trust with contributions from the project itself and from Yorkshire RHA.

VANCOUVER'S MENTAL HEALTH SERVICES

Sources - Chloe Lapp, Stephen Garnett and Dawn Norris, Canadian Mental Health Association, British Columbia.
Darrell Burnham, Coast Foundation Society(1974), Vancouver, B.C.

Background

Vancouver is a city of approximately 1 million people. Canada has a national health insurance system and services are funded by provincial ministries, in this case British Columbia. Mental health services are operated under the Family and Community Health Service of the Ministry of Health. Limited public housing and (low) welfare payments are provided by a Ministry of Social Services and Housing.

Psychiatric and Social Work Services

The formal state service ('Greater Vancouver Mental Health Service') operates through Mental Health Teams and Mental Health Centres. In addition there are psychiatric wards in the main hospitals. Access is either directly to the Centres or via referral by a GP. After hours the City provides a combined police/social work mobile unit with the specific remit of avoiding either hospitalisation or prison stays for individuals with mental health problems.

The Mental Health Centres offer psychiatric services and social work support. They can handle emergencies and offer respite care. 55 are scattered throughout the province (of 3 million people). The Mental Health Teams provide community based occupational therapy and other social work services. Psychiatric care is available but only by referral through the social work staff.

In addition users can request to see and use a private psychiatrist under the insurance scheme. The keys to the system are that the user has access to the kind of psychiatric care that they want and that the service is designed to avoid hospitalisation of users.

Accomodation, Employment and Day Services

It is in this area that there is a truly pluralist basis for the provision. This is also the area where there the need for services far outstrips supply.

Some people are able to obtain public housing, usually in ordinary housing. The majority still have to use either 'boarding houses' or private homes, although it should be noted that in British Columbia all developers are required to provide units in their apartment blocks ('condominiums') which can only be used by people referred by social services.

Rents are paid directly to landlords. Whilst up to $100 (£54) can be earned in a month on top of a personal spending allowance without deductions being made, the allowance is very low at $60 (£32) per month.

'on profit organisations also provide substantial (but never enough) housing of a high quality. Two major organisations, the 'Coast Foundation' and the 'Mental Patients Association' provide a range of different accommodation settings. For example the Coast Foundation houses 250 people in:

- Purpose built or adapted community homes with 24 hour staff support

- Apartment blocks with minimal (caretaker) staffing and run on democratic lines by the residents. Each

resident has their own self contained flat (for either singles or couples) with use of communal social areas. These are built to a high standard in ordinary streets with no special identification.

• Apartments owned by the Foundation scattered in ordinary apartment blocks throughout Vancouver. Outreach support provided from the Foundation's office.

Employment services are provided through several units. The Coast Foundation provides Pact Employment Service which provides job training and employment counselling for 'job ready' persons (in 1988 it placed 172 people in jobs). The Foundation also provides a home for a 'Clubhouse'; this is managed by its 500 member users and provides supported opportunities in voluntary and paid roles. It has a full social programme and a large transportation programme. 36 people, for example, were placed in 'transitional employment'. The Mental patients Association runs a woodwork training workshop.

In addition, there are two drop in/ day care centres run by non profit organisations and a working farm providing a therapeutic volunteer work programme which is actually run by the provincial government.

The Canadian Mental Health Association offices, funded by the provincial government, provide information services, generate action on policy and service development and are now nurturing new consumer led organisations.

Both the state and non profit provision was of a relatively high quality and designed according to modern principles. The major areas of difficulty were in the numbers of people forced to live in inadequate rented housing or in private residential accommodation. It should be noted that Vancouver's services were very much the norm for the Canadian mental health services, neither 'top of the league' nor 'bottom of the pile'. The most obvious contrast with British services is the 'place' in the system of psychiatry: it is simply a service provided to users alongside a range of other equally important services.

SERVICE BROKERAGE IN EDMONTON'S MENTAL HANDICAP SERVICES

Source: Barry Hudson, Robin Hood Association for the Handicapped, Edmonton Alberta, Canada.

Background

The system of funding services for people with mental handicaps in Edmonton is known as 'Individualised Funding' (I.F.). It replaced the previous system two years ago which depended upon several large agencies providing a range of services. Under this older system it was felt that users had little power and the system was not flexible enough to properly accommodate their diverse needs, nor was there any innovation in service development.

Individualised Funding and Service Planning

This system is seen as a means of funding service provision through the user. Dollars are 'attached' to the individuals (and their families) for them to spend as they want to. However, the system also relies upon a network of 'Service Planners'. These are individuals who are able to negotiate a suitable package with and on behalf of the users. These service planners are usually based in existing (non-profit) service providing organisations, though they are given autonomy and a mandate to work on behalf of consumers to reduce the potential conflict of interest. The first private service planning agency has also recently been set up in the City.

Referral to service planners comes from social work services or crisis agencies. Upon referral, users and planners work out a 24 hour lifestyle plan which accommodates the users needs and desires as much as possible and identifies the support network to enable the user to carry out the programme. This includes the nature of the residential setting, the qualities of staff support required and how many and what kind of other people the user might be prepared to live with. Personal support networks (provided voluntarily) are also identified and confirmed to provide ongoing help, particularly with making choices.

These plans form comprehensive documents (often exceeding 20 pages in length). They are then approved by the social services department (which has to provide the funds) before being set in motion by the user, their

support group and the service planner. These approvals can take some time, which also applies to changes to plans over time.

Financial Factors

At its inception the scheme had no individual costings limits. Users could have whatever services were felt necessary for a reasonable standard of living. The basis for this was that the government should meet whatever the real needs were. However, partly due to the fact that this system had to meet the needs of a lot of individuals whose needs were not being met at all before, it was not long before an annual individual 'cap' of $36,000 (approximately 20,000) had to be imposed. This cap can be exceeded in special cases.

This has led to limitations on the system. Service planners have to look for ways in which these amounts can be used most effectively. This has led to a system of 'room mates'; service planners work together to meet the needs of several users (identified as having compatible needs) in one residential or vocational setting as a way of making more efficient use of the available finance. It is felt that this has reduced the scope for innovation and led to the need to fall back on 'group homes', albeit smaller and more independent and individual than in the past.

Service planners have found themselves oriented towards keeping the costs reasonably low in order not to frighten the government into reverting to the previous system.

10% of any individual budget can be used for service planning. However, this is widely considered to be inadequate and 'host' agencies are subsidising the costs of service planning. It is thought that the real costs are as high as 20%. Furthermore no funding has been made available for service planners to monitor the individual programmes.

The user (or family) receives the money on a monthly basis which they then use to pay for services. One outcome has naturally been the need to set up a more sophisticated financial system.

Overview

Switching over to this system caused some difficulty as might well be expected. A major concern for families was that the new system would continue to provide some security over the arrangements made for their dependents. There is a concern that no 'authority' can make decisions 'for' their dependents after they themselves are no longer living. Many families have continued to work through the service agencies that they were familiar with prior to the new system being introduced. This has led to moves to provide 'guardianships' for users as service planners cannot take on such responsibilities.

One interesting outcome has been that families have sometimes banded together to buy or rent accommodation for their dependents, effectively setting up their own non-profit agencies. Thus although the accommodation provision does not basically differ from the group home model in practice, the distinction is in the power that users and their families have over the nature of these homes. Any staff in the home know that they are working for the users of the home.

The system depends upon the integrity of service planners and providers and a 'Consumer Board' to monitor service planners has been set up. On the other hand some families can use the system to protect their dependents from living a full 'real' life. It would seem that service planners have intervened in these situations to persuade the the family to change their approach. A key to the system is that families and users are able to take decisions based on full knowledge of up to date practice and ideas, if such a system is to lead to real 'normal life' type improvements for users. Arguably families might need some form ofeducation before they embark on taking decisions on services for their dependents.

Thus whilst as yet forms of care do not differ dramatically from those that went before, the system has brought about a tremendous improvement in the 'fit' of service to user, alongside a dramatic shift in the location of power in the direction of the user. Though cautionary notes have to be sounded about the power of the service planner as a replacement professional instead of the social worker or psychologist.

COMMUNITY SUPPORT PROGRAMME - MENTAL HEALTH SERVICES IN DANE COUNTY, WISCONSIN.

Source: 'An Overview of the Dane County Mental Health System' and discussion with Ron LaJeunesse and Tony Hudson, Canadian Mental Health Association, Alberta Division.

Background

Dane County, in southern Wisconsin, has a population of 330,000. Its main city has a population of 172,000 of which 45,000 are students. The Dane County Mental Health Centre serves the whole county, however, the system itself is 'urban' in design, rural patients travel to Madison for service. There are more than 2,300 mentally ill people within the county's mental health system, of which about 1,275 are considered chronically mentally ill.

Experiments in treating chronically ill patients in the '70's showed that much greater success rates were achieved if patients were treated in the community. This led to a new 'treatment' model being devised called 'Training in Community Living' (T.C.L.). The key philosophies behind this programme are that:

- The treatment of long term mental illness requires that patients not be prepared in hospital for community living, but maintained in the community; and

- Although the hospital has a very important role to play in the continuum of service, that role is limited and the major therapeutic role needs to be directed towards the community.

Adult inpatient hospital days have been reduced to 3,800 from 10,107 over ten years. The services to chronic patients have shifted to 26 community agencies which are contracted to provide crisis intervention, community support, accommodation, day service, work related services and therapeutic resources.

Budgeting, contracting and evaluating these community agencies is the responsibility of Community Support and Health Services Department. A board of nine individuals (five elected commissioners and four politically appointed citizens) oversees the provision for the mentally ill (and other groups). In 1986 this budget was S6.6 million (13.5 million) with 85% serving the chronically mentally ill. Dane County receives less per capita than the average Wisconsin county for its mental health programme.

The board contracts with a range of providers who place an emphasis on the chronically mentally ill. In addition the county budgets for inpatient costs on the basis of the previous years usage. If these costs are lower than anticipated, unused monies are used to increase community services. If inpatient costs exceed the budget, community programmes are cut. This system allows dollars to follow the patient in a crude sense. Some programmes are block funded, others are funded on the basis of patient days.

A community agency, the Crisis Intervention Service (C.I.S.) acts as 'gatekeeper' of all those patients who are admitted to hospital on county monies. The C.I.S. apparently diverts 75% of potential admissions.

It is important to note that in the first few years of the programme it was necessary to double fund both hospital and community services in order to allow for the latter to be put into place. Furthermore a hospitalised population of mentally ill patients are still looked after in hospital settings, though it is hoped that even these will eventually live in community settings.

The Contract Agencies

The major contracted agency is the Crisis Intervention Service. This is a non profit private agency operating 24 hours a day. The service operates like a combination psychiatric emergency and urgent clinic, all types of emergency are dealt with as well as return appointments.

Whilst the service runs some therapeutic programmes, the major role is assessment and referral to other agencies including where necessary hospital programmes and residential services.

The Mobile Community Treatment Programme is the mainstay of the community base of the system. This is a 24 hour intensive psychiatric support service which offers the clear alternative to hospitalisation. The workers in the programme undertake a range of activities to enable clients to remain in their homes (or in other domestic situations during acute phases of illness or unstable periods. These services include:

- daily visits/assessments

- therapy with family, friends and 'concerned others'

• supervision of financial support, including handing out cash to the client on a daily basis

• total assistance with activities like cooking, shopping and travel if required

• intensive monitoring of medication

• provision of additional support services e.g. assistance with finding residential accommodation, employment or pre vocational assistance, day activities

• advocating on the clients behalf

• obtaining and maintaining appropriate medical and other necessary professional services.

Staff are encouraged to be creative and use as many short term measures as possible. There are a number of students and volunteers attached to the programme. Staffing is based on caseloads and there is not a defined 'primary therapist', the programme works on a form of 'group' case manager model.

Other facilities funded under the system include a user managed 'Clubhouse' for members to use for self help support, educational, social and vocational programmes (including 'on the job placements'). Another clubhouse provides a less structured environment for users who simply want some sort of social setting and access to cheap meals.

A 'Centralised Housing Assessment' provides a range of high or minimally supported residential opportunities, including a respite service. This service ensures that hospital beds are not used simply to meet accommodation needs.

The latest addition to the services are 'Community Crisis Beds'. These are located in private homes and are used as last resort alternatives to hospitalisation. Private individuals are selected and paid to manage one severely disturbed client for up to 24 hours to a maximum of 14 days during the period of an acute illness. Operators are paid a flat rate of $900 (approx 450) to make their homes available on a 24 hour a day basis. Occupancy is between (an optimal) 75 - 80%.

Other specialised services are available, for example for children, alcohol and drug abusers and a special programme has been set up inside the local prison. The use of the latter as 'treatment' for individuals with mental health problems is of great concern to the Mental Health Service.

Outcomes

75% of people with severe mental difficulties live in independent settings in the community, readmission rates to hospital are 25% and 83% of the mental health budget goes to community based services. It is argued that the system works well because:

The funding comes from a single source The strength of the value given to community care The capacity for creativity and innovation Stability of administrative and clinical staff

in addition to the size and concentration of the catchment area.

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