

Who Does What?

**The process of enabling
people with learning difficulties
to achieve what they need and want**

by

Steve Dowson

ON LINE EDITION

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First published 1990

Revised edition published February 1999

Published by

Values Into Action

Oxford House
Derbyshire Street
London
E2 6HG

PREFACE TO THE SECOND EDITION

Who Does What? was first published in 1990, as one of VIA's *Challenge to Consensus* papers which offered brief discussions on topical issues. At that time, social services were on the brink of major changes, termed by the government of the day as 'community care reforms'. The new system of privatised provision, care management, formalised assessment of need, and costed packages of care, is now so familiar that it is difficult to remember the very different world of social care which then existed.

In view of the changes which have since taken place, this discussion paper might be expected to be well past its sell-by date. But the general analysis of roles in planning services and allocating funds is still applicable, and it is pleasing to find that the booklet continues to be requested and quoted. Less happily, the flaws in the care manager role which were predicted in the paper have now become all too evident.

For these reasons, this new edition has been published. The design has been improved, and the format changed from A5 to A4 to bring it into line with other VIA publications. Obviously outdated references - notably to the White Paper on community care, which has now been superseded by legislation - have been corrected. And the section which originally focused solely on service brokerage has been extended slightly to acknowledge other models of individualised funding, not least Direct Payments. But the paper was never intended to provide a comprehensive account of every funding and planning model in operation. With all the developments of the last eight years, that goal is now even more unrealistic, and it has not been attempted in this new edition. Instead, some recent publications are suggested for readers who want to know more about particular issues and innovations.

Steve Dowson
February 1999

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INTRODUCTION

Travel agencies recently came in for some criticism on television and from consumer groups. It was 'revealed' that many high street travel agents were owned by travel operators, and consequently had reasons to promote some holidays rather than others. In addition, in some cases travel agents received extra commission for selling certain packages.

The discussion in the media examined the extent of the problem, and the kinds of practice which resulted - for example the display of some holiday brochures more prominently than others. But there was little discussion about the nature of the problem: It was clearly considered self-evident that an organisation which purported to provide information in order to help people find the package which suited them best was unlikely to do its job properly if it had a financial interest in the choices that people made.

This sort of problem can and does occur in many areas of life, and the best solution has been embedded in our culture for so long that we are likely to take it for granted. We know that when an organisation is suspected of malpractice or incompetence, an 'outside', independent body is more likely to get to the truth than an internal enquiry. We recognise the evils of 'the lynch mob', and so our legal system separates those who make the law (parliament and the courts) from those who enforce it (for example the police). Similarly, we accept that a fair trial requires different people to prosecute and to act for the defence. In these and many other instances, it is well understood that when different roles are in conflict they should be clearly separated and taken on by different people.

In the operation of social services, however, the same principle has not always been applied, and roles are often confused or overlapping. The legal model has not penetrated health or social services beyond a few very specific situations such as mental health tribunals and some complaints procedures. Neither have consumer protection models been adopted extensively, probably because the majority of services are funded from the public purse. The fashionable accent on multidisciplinary teamwork and inter-agency cooperation pushes in the opposite direction, actively encouraging a blurring of roles.

Now, however, the structure of social services created by the 1990 National Health Service and Community Care Act and detailed in policy guidance makes the independent sector (i.e. private and voluntary agencies) the main provider of services, which are purchased by the local authority. In so doing, the Act established a separation of roles, although at a very coarse level.

The main function of social services, especially in relation to people with learning difficulties, is to provide services or other supports which meet a person's (or family's) 'needs'. In services which reckon to be based on the individual user, the starting point of the process is - or at least should be - the person's individual aspirations and needs, which may or may not be clearly identified: The end point is an arrangement of effectively operating supports. In the structure which has resulted from the Community Care Act,

the starting point is within the remit of the local authority, the end usually the direct concern of the independent agency. But between the beginning and the end, and somewhere between the statutory and independent sectors, is a complex series of steps, as needs are identified, plans formulated, funds negotiated, and action finally taken. This series of steps forms the link between the local authority and the service provider (figure 1).

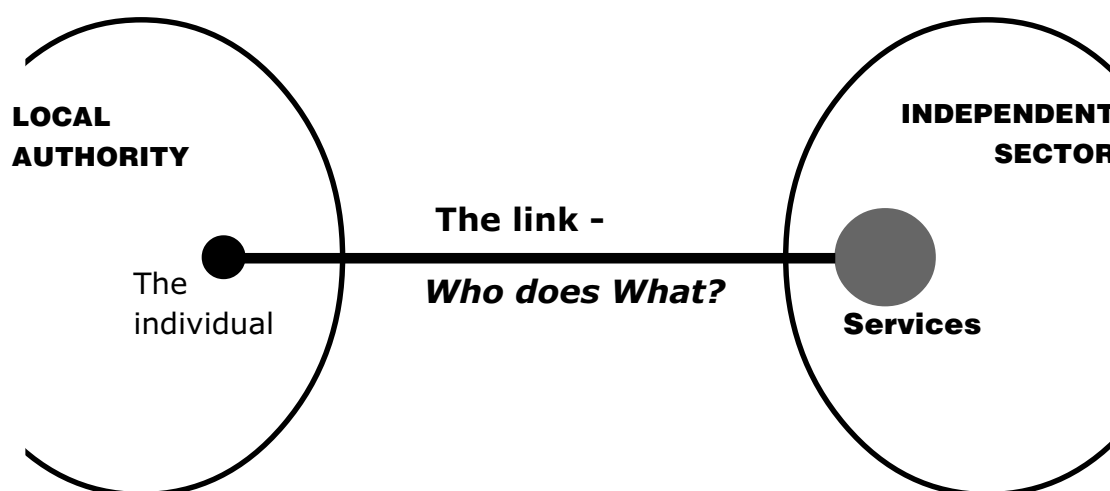


Figure 1

The Act places responsibility for this series of steps with the local authority, who employ care managers to complete the tasks involved. Yet it also seems that there would be some scope for contracting the responsibility to private or voluntary agencies, treating it as a service in itself, rather than as the route to services. Other models - notably case brokerage - are being championed as improvements on care management, and added to the extensive repertoire of assessment and individual planning instruments that are already established in services.

However, as so often happens in services, different models and methods are being promoted and implemented without sufficient analysis of the function they are intended to provide. Assumptions and values are left unstated, and no yardstick developed which would make it possible to judge the merits of each model. The aim of this paper is to return to first principles to consider what the total process should achieve, what steps it involves, and who should take responsibility for each one.

SOME WORDS ASSESSED

Every specialist area of interest develops its own language, often giving special meanings or connotations to everyday words. This may be useful, to the extent that it enables specialists to communicate more easily with each other, but it has disadvantages. Firstly, it may exclude other people - a particularly worrying effect when those other people may be the topic under discussion. Secondly, the special meaning may not be clearly defined, so that apparent communication conceals misunderstanding.

A third, and perhaps the most pernicious effect in social services, is that it encourages the specialists to create a distance between themselves and the people for whom they are working. Actions and attitudes which the specialists would find curious or offensive if applied to themselves seem more acceptable when dressed up in special language. Thus for example, most of us express and assert our own views in our daily lives, but when people with learning difficulties do the same they are described as 'self-advocates'. If they persist in expressing their views in ways that services find difficult to accept or to understand, they are labelled as having 'challenging behaviours'. Most of us would feel deeply patronised if someone was appointed to befriend us, but there are many 'befriending schemes' for people with learning difficulties. And though service workers are happy to talk vaguely about 'user empowerment', there is a conspicuous reluctance to consider the possibility of user control.

For these reasons, as far as possible this paper avoids the special language of social services, and the reader is invited to make comparisons between the procedures used to define and deliver required services for people with learning difficulties, and the equivalent processes used by citizens who have not been socially devalued. However, there are three words - 'need', 'want', and 'assessment' - which are so central to the topic that they cannot be avoided and require clarification.

'Need' and 'Want'

'Need' is a word much favoured by service workers, for example in talking about 'client needs' and 'assessment of need'. It is much more unusual to hear talk of 'client wants'. ('Client wishes' could be another alternative, but is rarely used, and suggests an aspiration which is hypothetical; the concern of genies in lamps.) The preference for 'needs' may be partly because 'wants' as a plural noun in everyday speech is unusual; indeed it is questionable English. But in itself that may hint that the two words are not equivalent in meaning. 'Want' is generally used as a verb, emphasising personal and active ownership of the 'want'. The point was well made by a recent TV advert for financial services which consisted entirely of short scenes, each accompanied by a voice making a statement starting "I want . . .". It both expressed and exploited the use of the phrase to epitomise the individuality of the hopes and dreams which are the driving forces in our lives.

'Needs', in contrast, are things which can be identified or assigned. They are often presented as statements of fact which can be deduced by someone else. Ownership of 'needs' is much less clear than ownership of 'wants', and therefore control can be taken by those - usually 'experts' - whose job it is to define needs. This is sufficient to

explain why social service workers prefer to talk about 'needs' and avoid 'wants'. They are willing to give people what they need; much less comfortable giving people what they want.

Common usage suggests another distinction between the two words. Consider the following statements:

"I want to get better. I need to go into hospital."

"I want a house. I need a mortgage."

"I want to go to college. I need three A levels."

People generally do not want mortgages or hospital operations for their own sake. They need them in order to get something they want. So 'needs' often refer to means to an end, whereas 'want' concerns the end goal.

'Need' and 'want' words will be used in this paper to indicate these distinctions

Assessment

Assessment involves acquiring information about an object, person, or situation. That information could include a statement of a person's wants, and this is clearly the intention in Individual Programme Planning (IPP) - when used correctly - and in other person-centred methods such as Shared Action Planning. But 'assessment' is often used according to its wider sense, as a one-way process which someone applies to some thing. Many assessment procedures used in services for people with learning difficulties, especially those based on charts composed of tick-boxes, follow this approach. If they are part of a larger procedure, and serve to support planning towards goals which have been separately identified, they may be useful. But, used in isolation, they are likely to produce nonsenses. For example:

End goals defined by the service workers rather than the individual user.

For example: *"He needs something to do during the day. Therefore he needs an ATC."* (ATC is an obvious service option, but may not be what he wants.)

End goals defined by incompetencies.

For example: *"She cannot cook for herself. Therefore the best place for her is in the institution."* (If she wants to live in the community, what she needs is someone to help her cook.)

Means to an unspecified end implied by assessment.

For example: *"He can wash and iron clothes, but not sew buttons. Therefore he should learn to sew buttons."* (For a career in tailoring, perhaps, but many people get through life without sewing buttons.)

Of course, a statement of needs, in terms of the current position and the resources or skills we shall require in order to achieve what we want, is important. In the real world we cannot always have what we want: we often have to reconsider our aspirations as we find out what is possible. People with learning difficulties may need help to go through this process. But, in the journey through life, we are very unlikely to arrive unless we know where we want to go.

STAGES IN THE PROCESS

As suggested in the Introduction, the process of making the link between an individual and the services and opportunities that he or she requires involves a series of steps. For services which are based on individual wants and needs, the logical progression must be as follows:

STEP A: *Identifying wants - the end goals.*

Planning which aims to respond to the individual must start with the individual. Moreover, for the reasons described earlier, it must start with the individual's broad goals in life; a picture of how they want to be living. It is very likely to be concerned with very ordinary aspirations, and based on ordinary human desires and experience rather than technical knowledge. Nevertheless, we cannot want things unless we know that they exist, and so some additional information may be needed. Therefore there is an associated task -

TASK A1: *Supply of information about possibilities.*

STEP B: *Identifying means to achieve the end goal.*

Comparison between the current and the desired situation will indicate, in broad terms, what additional components must be put in place as the means to reach the identified goal. These are likely to fall into broad categories, concerning areas such as housing, employment, leisure and social opportunities. This stage is not concerned with specific responsibilities or resources, and specialist knowledge will not be required in order to identify most of the components. However, assistance of two kinds may be required:

TASK B1: *Clarification of current situation.*

If the extra components are required to fill the gap between the current situation and the desired situation, it may occasionally be necessary to have very accurate information about the current situation. This may require specialist expertise. For example, a doctor or occupational therapist might be needed to assess a physical disability in order to recommend aids or access requirements; or a person's domestic skills might need to be identified to decide whether or not they could manage without daily support.

TASK B2: *Supply of information about resources and opportunities.*

Additional information may be required, for example, on the welfare benefits available, or current employment opportunities.

It is important to note that although information of these sorts may impact on the feasibility of turning the picture of the desired future into a reality, and thereby modify the practical goal, it does not in itself redefine the ideal of the original 'want'.

STEP C: *Making a plan*

From the broad identification of the required components, a plan must be produced. This will identify the specific resources, mainstream opportunities, and responsibilities for implementation.

STEP D: *Gaining access to resources*

Some of the resources and opportunities may be easily available. A case may need to be made in order to gain access to others.

STEP E: *Negotiating funds*

Public funds may be one resource that is required. This is likely to involve a process of advocacy and negotiation.

STEP F: *Implementation*

Even when the resources have been identified and agreed, the plan has to be brought into operation and resources mobilised. This could involve administration, arranging dates, and making introductions.

STEP G: *Service provision*

All the previous stages have been concerned with identifying and accessing the components required to achieve the end goal. Now the services and other opportunities have to be provided.

STEP H: *Funding*

Previously agreed funds must now be provided to meet the costs of services.

STEP I: *Evaluation*

The funding agency has an entirely legitimate need to ensure that public funds are used effectively and appropriately.

STEP J: *Review*

While the funding body is concerned with the use of public funds, there is also a need to evaluate whether the plan, as formulated, has fulfilled the wants which were originally identified. In addition, the plan may have taken some time to implement. Does the person still want the same things?

Review becomes a re-assessment of goals, and thus the stages form not a one-off process but a continuing cycle. For this reason it may be presented as a circle (figure 2). This circle provides the basis for a discussion of various current and proposed models. For ease of reference in the discussion which follows (rather than as jargon for its own sake) it will be called the **EMPRISE*** Circle, as shorthand for the main stages; **E**nds, **M**eans, **P**lans, **R**esources, **I**mplementation, **S**ervices, **E**valuation.

*emprise = "a daring enterprise"

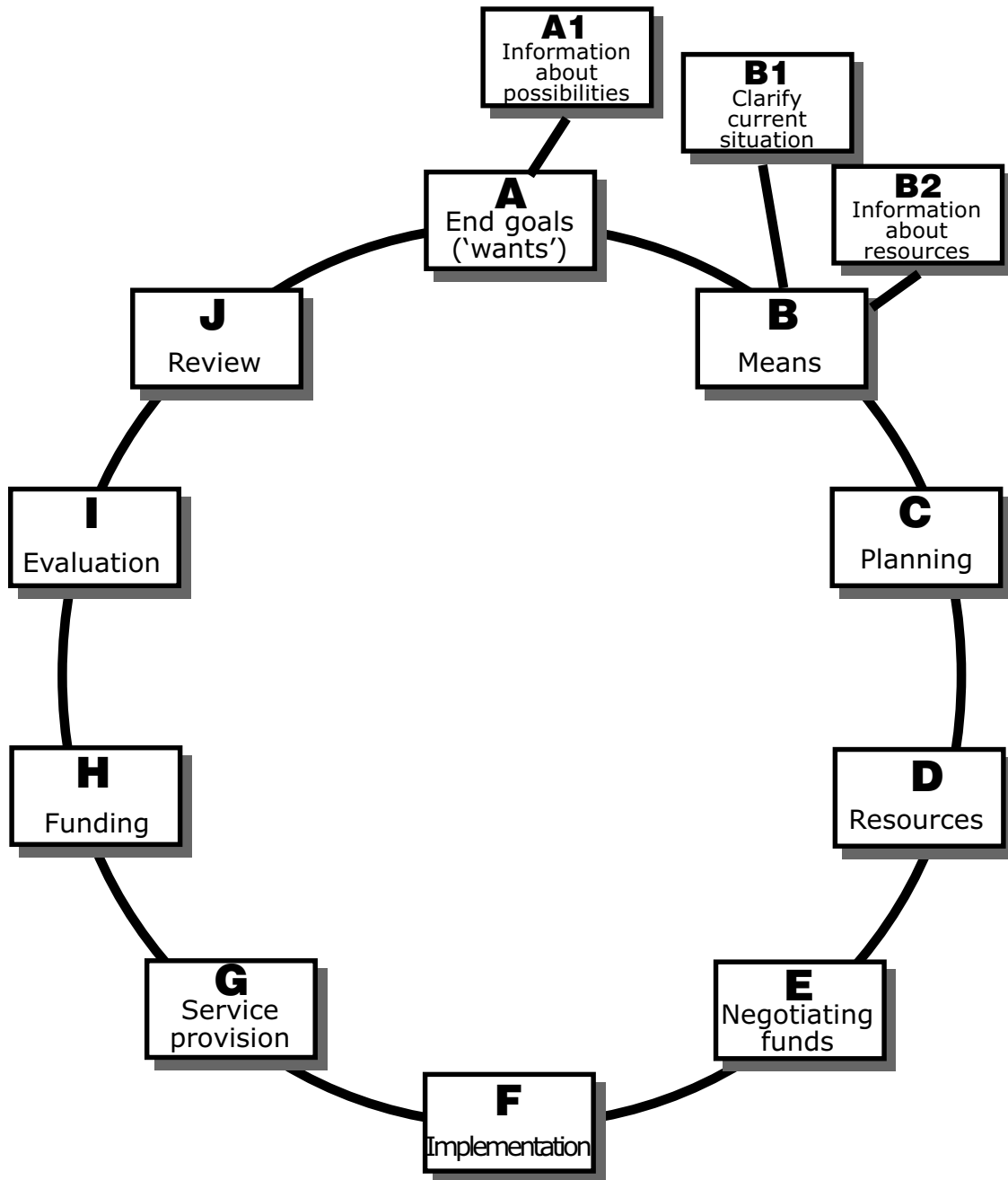
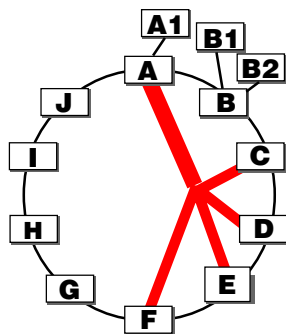
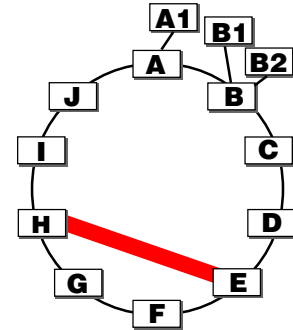


Figure 2:
The EMPRISE circle

ROLES IN CONFLICT AND CLUSTERS

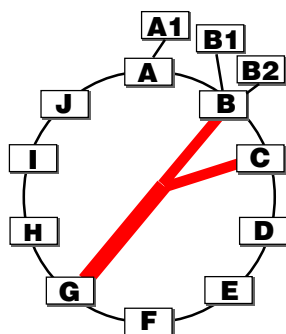
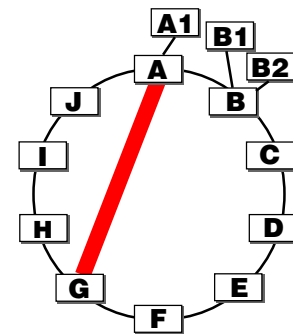
Just as a travel agency cannot be in the pay of a travel operator without a conflict of role which is to the disadvantage of the service user, so different stages in the EMPRISE Circle must be kept separate, and given to different people or agencies. The most obvious conflicts, indicated in figure 3, are as follows:

Conflict 1. H and E. The funding agency cannot properly negotiate with itself. Negotiation which recognises both the need to use funds, rationed between many people, in the most efficient way, and also the needs of one individual, should be conducted by two parties, one representing each side.



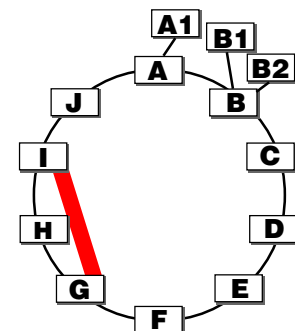
Conflict 2. A and C/D/E/F. Making and implementing the plan, and negotiating funding, will often require considerable work. If the person responsible for these tasks also defines end-goals, there will be a tendency (even if unconscious) to define 'wants' which indicate convenient or low-cost solutions. The one possible exception is where the person in need of services - or the person's supporters - implements the plan; but even in this case the prospect of the effort required may discourage people from admitting their true aspirations, even to themselves.

Conflict 3. G and A. Those providing services should not define end goals. Service providers will have their own investment in the individual which is likely to distort their perception of what the person wants and needs.

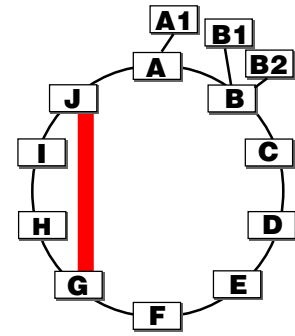


Conflict 4. G and B/C. When plans are being made, service providers may legitimately promote their services as being the best for the purpose, exactly as sales representatives act in the commercial sector. Clearly however, they should not be in a position to dictate that their services will be those selected.

Conflict 5. G and I. Service providers from which services are being purchased cannot be relied upon to give an objective assessment of whether the money is well spent.



Conflict 6. G and J. Service providers have an investment which is likely to distort their ability to assess whether they are meeting the user's needs. They should, of course, attempt to address the question, so that they have a sense of involvement in the process, but with the help of others who do not share their investment. This, essentially, is the basis of quality assurance groups.



If the steps are grouped to avoid these obvious conflicts, we find three clusters:

Cluster 1. J/A/A1/B/C

This cluster (figure 9) centres on the individual for whom the plans are being made, and on the picture that person has of the future they want to achieve. It may involve other people, but their loyalty should be solely to the individual, uncompromised by concerns about the convenience of the plan, or investment in service agencies, or the rationing of funds.

Many people who need services will be able to define and assert their wants, and even convert them into plans, without assistance. But many people with learning difficulties, as a result of their impairment and their devalued status, will need help from other people. In the language of services they have the role of 'advocates', but they may see themselves simply as family and friends.

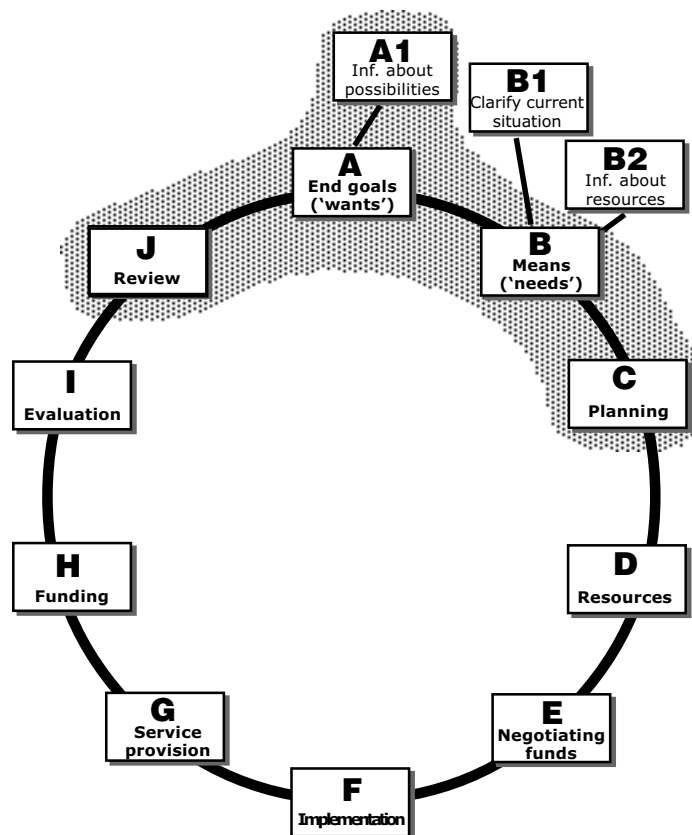


Figure 9: Cluster 1

At the stage of defining end goals, ordinary life experience will provide most of the information that is required. In later stages, as means are defined and a plan made, there may be more need for specialist advice, but the process should still be controlled by the service user and advocates. Equally some people may have the skills and drive to take on those tasks in Cluster 2.

Cluster 2. B2/C/D/E/F

This cluster (figure 10) is concerned with developing and implementing the plan. It includes providing information in the identification of needs (means), though that step should still be controlled by the service user. However, once the plan has been agreed, the work (which may be extensive) can be undertaken in the same way as a solicitor takes instructions from a client. The service user may have to be consulted, but need not be directly involved in the work. Also like a solicitor, the person or people undertaking this work would be expected to represent the service user in negotiation.

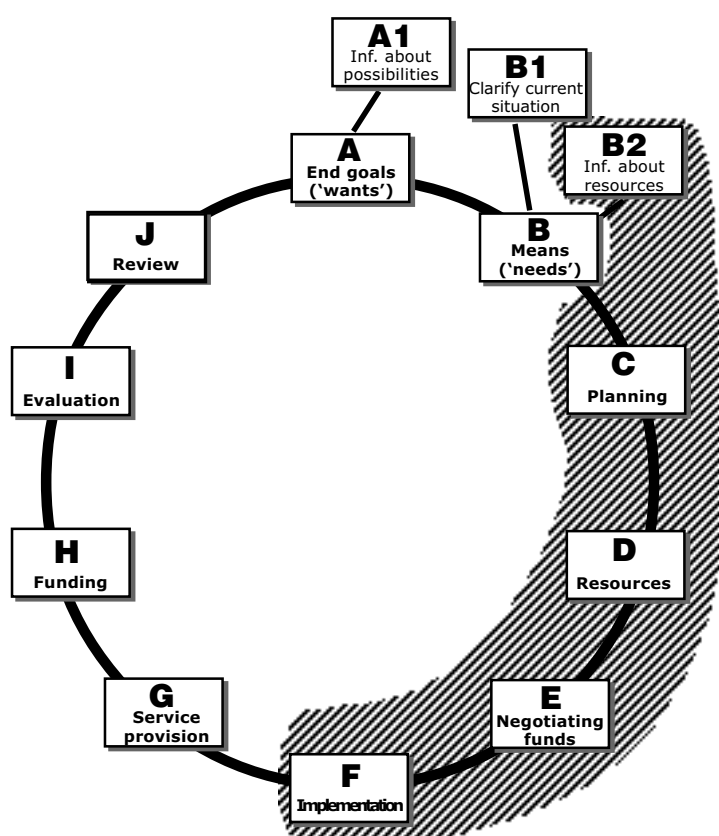


Figure 10: Cluster 2

Cluster 3. I/H

The focus of this cluster is limited to providing funding and ensuring that it is used appropriately.

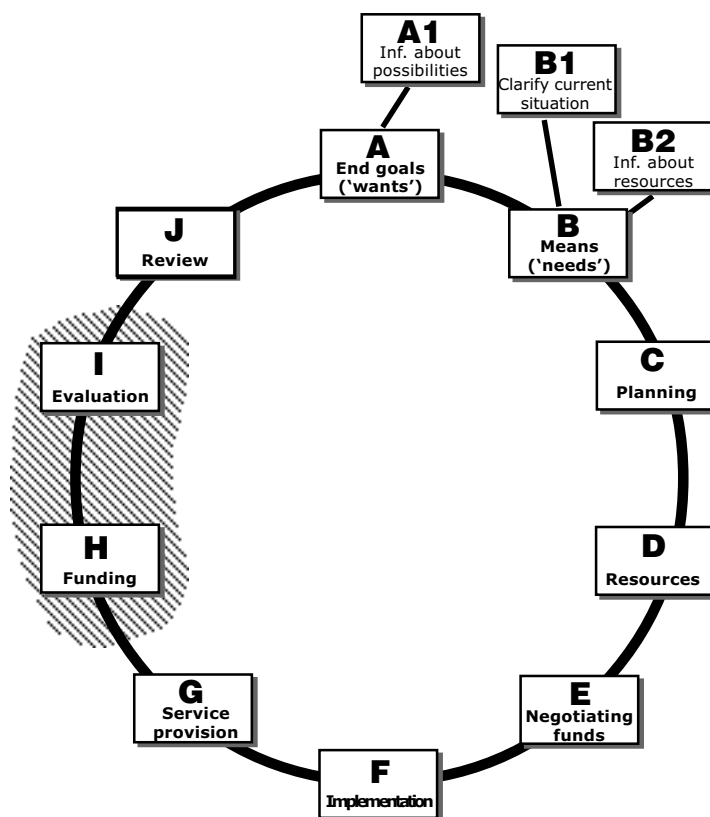


Figure 11: Cluster 3

There are two steps which remain outside these clusters:

B1 - Clarification of current situation. This has been defined as a specialist activity, and so unlikely to fall within the range of skills of the service user or advocates who have no investment in services. Arguably it could be considered an extension of Cluster 2, as part of the work of defining the plan. But this has dangers, because it could have a major impact on the development of the plan, and may involve expert pronouncements which the user and advocates would find difficult to challenge. In any case B1, when it is needed, functions purely to support decision-making, and perhaps should be regarded as a service which should be called upon when those operating in Cluster 1 require it.

G - Service provision. The obvious separation of service provision from the other steps conforms with general expectations of consumers outside health and social services: We expect them to provide a service, not to give us reliable advice about whether we need it or can afford it.

HOW DO CURRENT AND PROPOSED MODELS FIT THE EMPRISE CIRCLE?

1. The in-house social services model.

In services before the implementation of the 1990 Act, the definition of need, the implementation and planning, and the services themselves were all controlled by staff of the social services department. It therefore seems fair to represent this as covering the entire EMPRISE circle, with no separation of roles whatsoever (figure 12).

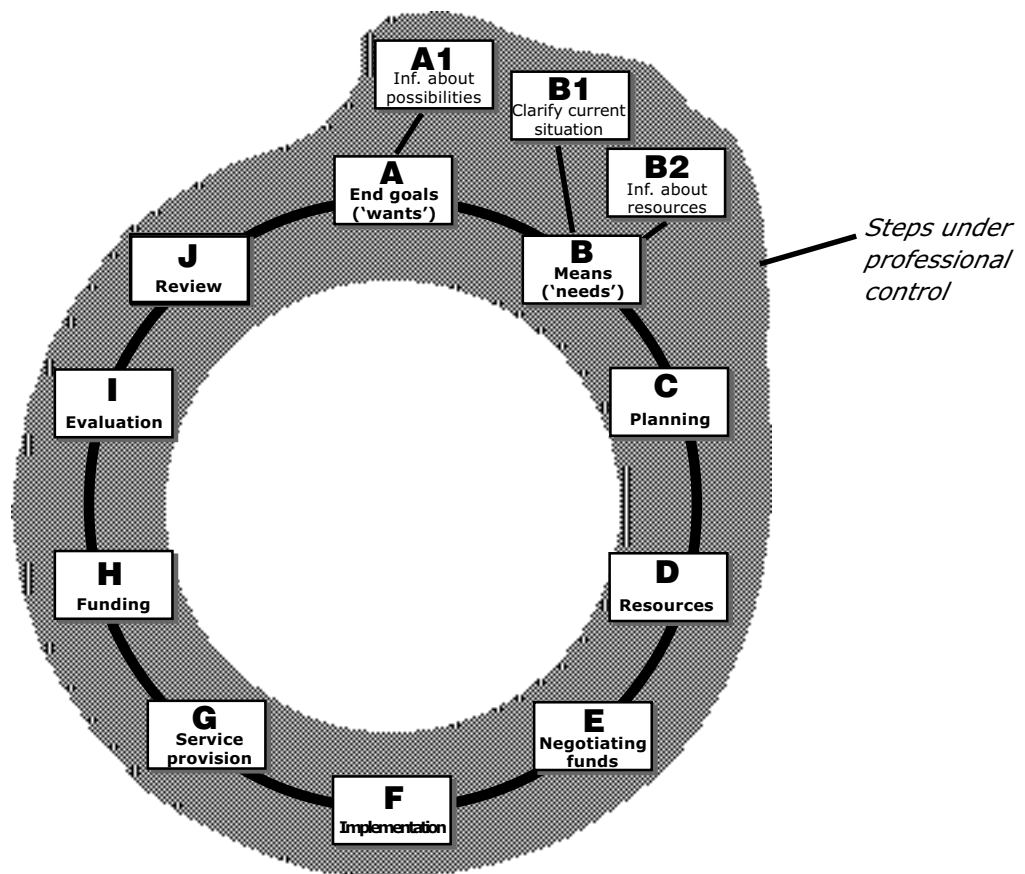


Figure 12:
The in-house social service model

The new community care structure was intended to split social services departments into separate purchaser and provider divisions, but domination of the EMPRISE circle by a single group of professionals, with no real separation of roles, is still commonplace. In some instances this is because the division between the purchasing and providing sections of the social services departments is no more than nominal. More often, it is because the whole individual planning or review process has been passed to the service providers, without any representation of the purchasers. This is frequently the situation in both local authority services and in independent sector agencies which are providing long term care. In the absence of a link with the purchaser, the planning is likely to proceed on the assumption that no extra funding is available, and hence no financial negotiation occurs. Staff from the current service providers, who control the planning

process, are unlikely to be open to the possibility that another agency would provide a more appropriate service: perhaps because they do not want to lose business, but also because they need to believe that they provide good services themselves. As a result, plans are likely to focus on minor adjustments to the current service, or on goals derived from the user's skill deficiencies.

Although the 1990 Act encouraged a separation of roles, there is also a contradictory belief in the importance of co-operative working between different professions and agencies. Individual planning meetings or reviews may bring together staff from different parts of the social services department, or from different agencies. Nevertheless, the potential value of different perspectives and creative disagreement is often sacrificed for the sake of professional and inter-agency relationships. Typically, all involved professionals share information about the service user, and aim to speak to the user 'as with one voice'.

Here again it may be useful to make a comparison beyond services for disadvantaged people. When faced with the frustrations of house moving, a meeting to get everyone together to sort things out could seem attractive. Such a meeting might include the estate agent, the solicitor, the surveyor, the bank manager, a building society representative, the insurance broker, and the family doctor (to assess the insured's state of health). But it might not be such a good idea in practice. They could very easily take over the meeting, talk between themselves using their own jargon, and make decisions to suit themselves, leaving the purchaser powerless. And they might also decide to share information (and gossip) about the purchaser. Faced with that prospect, most of us would persevere with the usual procedures.

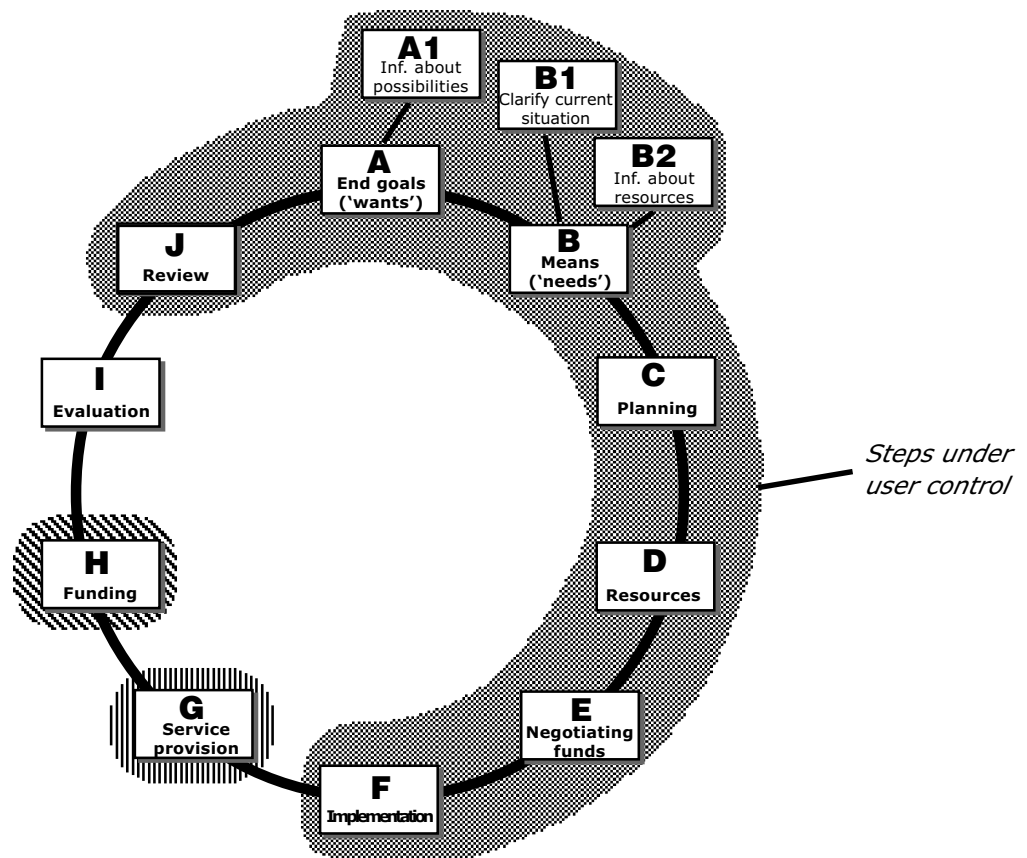
2. The social security model.

The changes introduced by the community care reforms largely removed another system of funding which people could use to access money to pay for services. Before these changes, funds for residential services were available through the system of social security benefits. In reality, many people with learning difficulties in private or voluntary sector residential care very often relied on the local authority for 'topping up' funds, and therefore control of the placement rested with the social services department. Nevertheless, in principle the system allowed a person who required residential care to select a residential home, apply for an allowance, and move in.

When the person requiring services was someone with learning difficulties, it was probably the family who applied for the funds and selected the residential home. However, if it can be assumed that the family was acting in support of the person's own wants - not always a safe assumption - then this model more closely matched the clusters on the EMPRISE circle (figure 13). There were, however, three major shortcomings:

Firstly, sources of advice were not readily available, increasing the likelihood of plans which were unwise. In the process of removing professional control, information about possibilities and means also disappeared.

Figure 13:
The Social Security
model



Secondly, the service user or the family also had to carry out the steps in Cluster 2 - planning, implementing, and possibly negotiating - for themselves. The net effect of these two shortcomings, added to the inbuilt bias of the system towards familiar residential services, is that the plan is likely to be unadventurous, unless the person or family is both very determined and exceptionally resourceful.

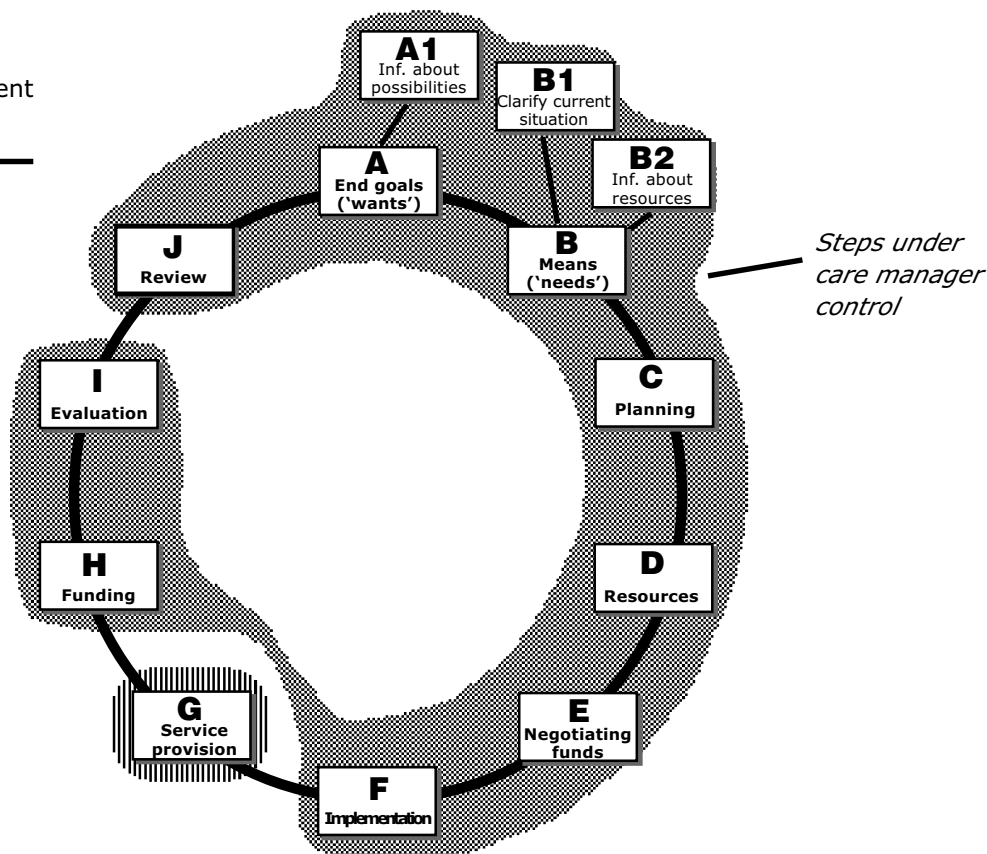
Thirdly, this model offers no mechanism for ensuring that public funds are well spent. The hand-over of funding from social security to social services was justified on the basis that the old system biased service provision in favour of residential care and against support delivered at home (which indeed it did); but, more significantly, the new system allowed much more effective rationing of welfare expenditure.

3. The care management model

The care manager is the person who arranges assessment, makes the plan, and implements it. Each plan forms a costed care package, and some care managers have delegated control of a budget to pay for the package. At first sight, all this seems closely to match the tasks of Cluster 2.

Unfortunately, the responsibilities of the care manager spill over into other steps. Matched against the EMPRISE circle (figure 14) it is apparent that there are serious role conflicts. Firstly, assessment of need - commonly involving a standardised procedure devised by the local authority - is regarded and organised as an essentially professional task. There is no recognition that the person's wants (not needs) are the starting point of the whole process, and so no space is reserved where it can happen. The person may of course have their own ideas about what they want and need, but the assessment process is firmly under the control of the professionals.

Figure 14:
The care management
model



Secondly the care manager is not independent of the funding agency. They are strongly linked by formal lines of accountability and professional loyalty to the system which rations funds. Where budgetary control is delegated, they are personally responsible for ensuring that they do not over-spend.

The net result is that the case manager occupies almost as much of the EMPRISE circle as the social service model, with only service provision separate.

4. Individualised funding, Direct Payments, and the service brokerage model.

In recent years (ie since this paper was first published) there have been a number of innovations which allow people to have control over the money to pay for the support they need. In terms of broad principle, this involves *individualised funding*: Identifying the amount of money which is already being used to pay for services, or which is newly available to pay for services, and allowing the person (with help if needed from family or friends) to choose the agency or individual workers who will provide the support. Individual funding does not necessarily involve physically handing the money over to the individual - what is ultimately important is the control of funding, not the location of the money. However, actual payment of the money to the person is the most clear-cut way to hand over control, and this has been achieved for relatively small numbers of disabled people in the UK. Three main methods have been used. Firstly, the Independent Living Fund was introduced as a national source of state funding to which disabled people could apply (if they were already receiving a high level of disability benefits) for grants to enable them to live independently with personal supports. Secondly, Independent Living Projects have been set up (mainly by disabled people) in many parts of the country to act as third parties which hold money from the local authority, and

distribute it (usually with advice and advocacy services) to disabled people to purchase personal assistance. Thirdly, and most recently, the Community Care (Direct Payments) Act 1996 opened a way for local authorities to make payments to people requiring support at home instead of providing them with services. All these systems continue to operate, but most schemes involving third party arrangements are moving over to Direct Payments.

Transfer of control over funding has the effect of transferring almost the entire EMPRISE circle to the control of the disabled person (figure 15), in much the same way as the social security model. If the person employs their own personal assistants, their control even extends to service provision itself. For disabled people who want to maximise their control, and are able and willing to be responsible for all these tasks, this is a very satisfactory outcome. The only shortcoming, which applies to all three models, is that the local authority will still carry out its own assessment of need. This is true even in the case of the Independent Living Fund. Changes made in 1993 to the regulations governing the ILF now mean that ILF payments can only be made if the local authority also provides either funding or services. As a result, receipt of ILF payments requires the involvement of the social services, who will carry out an assessment of need.

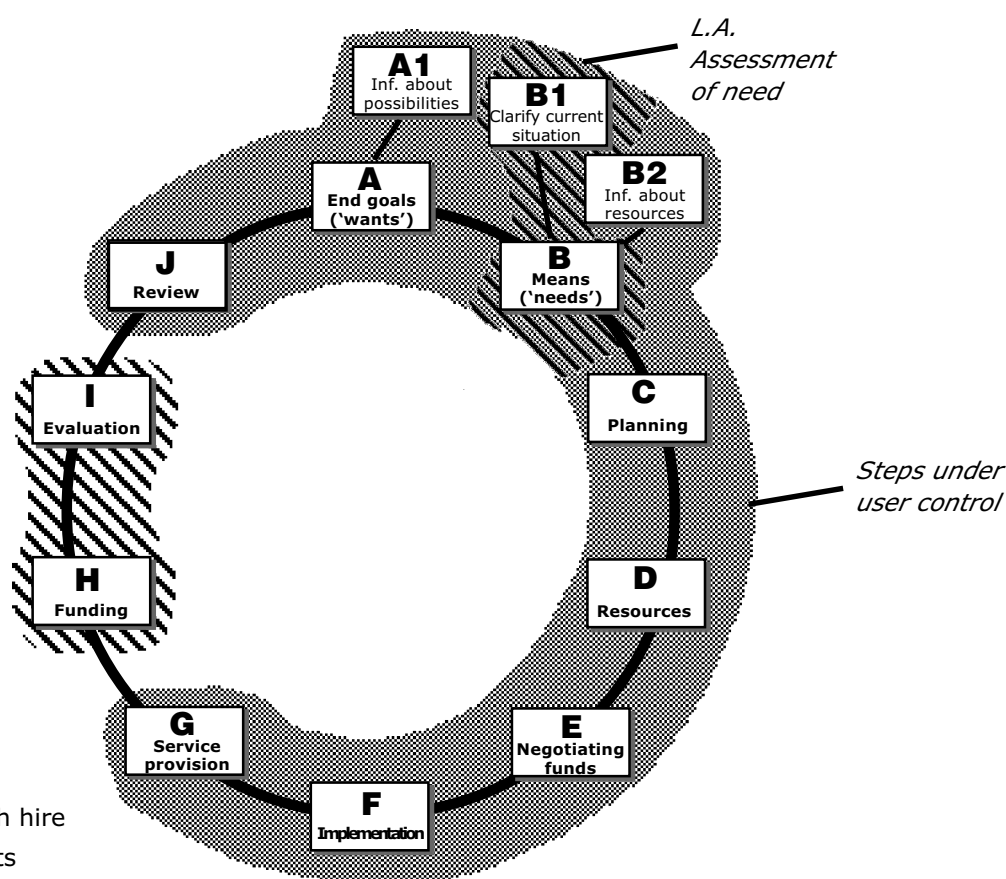


Figure 15:
Direct Payments with hire
of personal assistants

It is plainly necessary for the local authority to satisfy itself that a person has a genuine need for services, and to identify the level of funding which is justifiable. However, the imposition of a narrow, standardised assessment of need is less justifiable, and seems all the more offensive within a system designed to respect and promote the autonomy of the disabled person. Moreover, there is no clear mechanism for negotiation about the level of funds which will be allocated.

For many people, especially people who have severe learning difficulties, the transfer of so much of the EMPRISE circle into their hands will not be so welcome or practical. The activities in Cluster 2 - identifying, locating, and organising specific sources of support, and negotiating funding - are complex, technical tasks which many people may not be able or willing to carry out. In fact, the present regulations for Direct Payments require that the person must be "willing and able to manage them (alone or with assistance)". Although there is scope for varying interpretations of this requirement, this has undoubtedly served to obstruct access to direct payments by many people with learning difficulties.

There are, however, ways to provide a high level of control without placing so many onerous responsibilities on the disabled person:

- 1 Individualised funding does not necessarily involve direct payment of the money to the disabled person. A high level of control over the funding can be achieved if a guaranteed amount of money is set aside, and made subject to a formal contract which requires the funding agency to make payments according to the instructions of the individual who receives support services.
- 2 Support can be obtained by means of a contract between a support agency and the service user (who can, at last, truly be described as a customer). Most of the disabled people who pioneered Independent Living Projects used their funds to employ their own personal assistants. As a result it is sometimes assumed that Direct Payments necessarily lead to direct employment of support workers. While it is undoubtedly true that direct employment maximises the person's control over the support they receive, it also brings the many responsibilities of being an employer. Support provided by an agency, under contract with the disabled person, can still provide a high level of control with none of the complications.
- 3 Technical tasks can be completed by someone else, with no reduction in the control of the service recipient, provided that this person is answerable to the service user and has no conflicts of interest.

These forms of operation are all key features of the service brokerage model, as first devised during the 1970s in British Columbia, Canada. Small service brokerage projects have since been developed in the United States and the UK, though in some cases the model has been compromised (notably in relation to the independence of the broker).

The model requires that the service broker is independent from both the service purchaser and all service providers. The broker may work as an individual, or as an employee of an independent agency, which will ideally be controlled by service users and advocates. The broker's role is to provide technical support to the disabled person, offering expert advice on the options available, and translating the plan into operational supports. As the broker is offering a service to the support user, and has no conflicting loyalties, the user should retain overall control, even when the tasks are carried out by the broker. The broker also has a role in assisting the person in negotiating funds, and this is recognised by the state fund-holder as a role which is required to facilitate the operation of the whole system. In this respect it is significantly different from that of an advocate.

Set against the EMPRISE circle (figure 16), the service brokerage model corresponds almost exactly to the three clusters. Of the models developed so far, it clearly provides the greatest level of assistance with the development of plans and organisation of supports without jeopardising the control of the disabled person. It is in marked contrast to the care management model, which is inherently compromised.

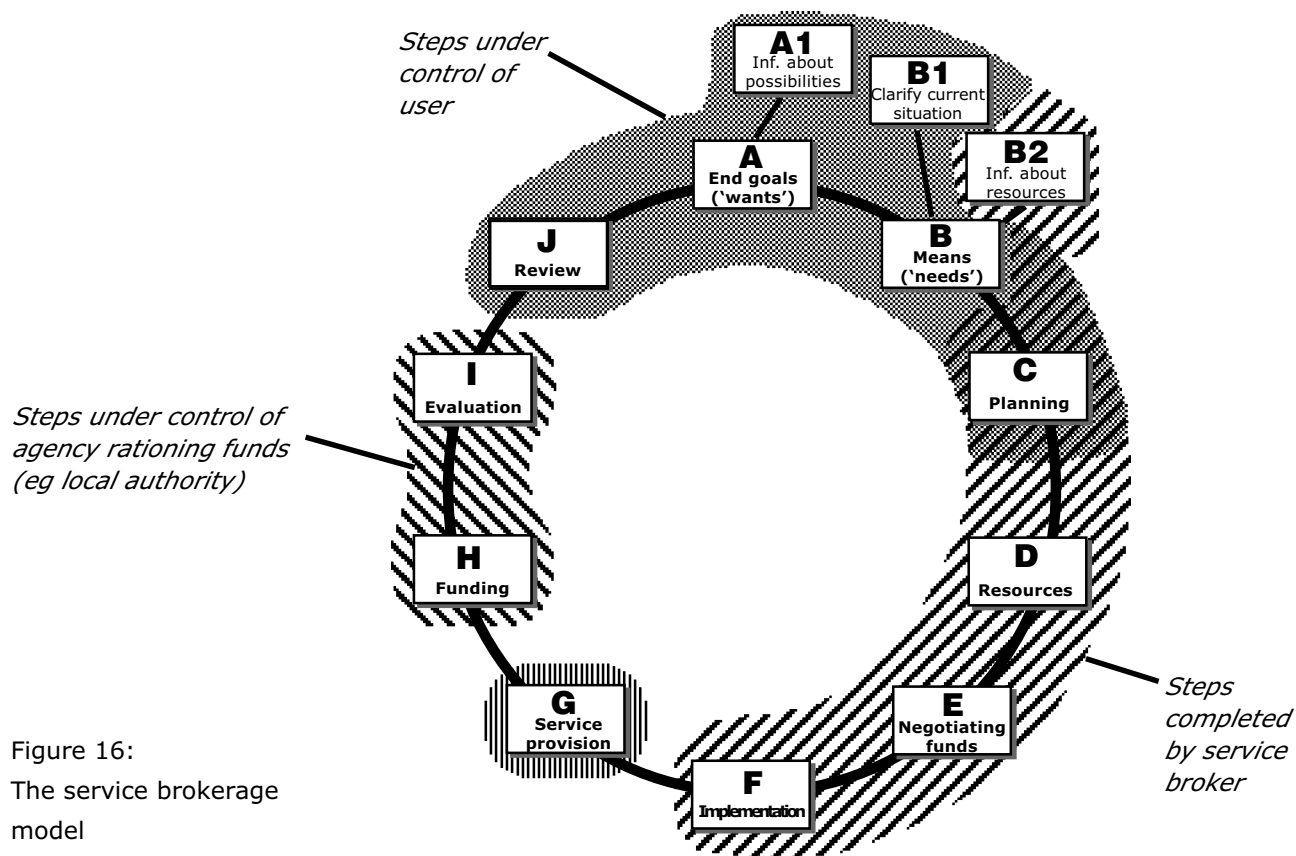


Figure 16:
The service brokerage model

No service model, however promising, has yet proved invulnerable to misunderstanding and misuse, and service brokerage is unlikely to be the exception. A number of problems seem likely to emerge if it is implemented on a large scale:

1. Not everybody will need it. Some people have needs which do not justify the introduction of an elaborate system. Others will prefer to make their own plans, and will want funding without brokerage. They should not have it forced upon them.
2. The EMPRISE circle shows an overlap between two of the clusters which hints at possible problems. The service broker should be able to look to the family of a disabled person to advocate reliably on the person's behalf, with a real understanding of their needs. This is not always what happens. It is not the role of the broker to impose plans, but neither should the broker act in ways which are against the interests of the disabled person. It will sometimes take great skill to work with the family, encouraging them to reconsider their perceptions of the person for whom plans are to be made, and to think beyond apparently safe and familiar service solutions.

3. In this paper, service brokerage and other models have been discussed as mechanisms. Mechanisms - at best - only allow good things to happen. They do not guarantee them. Good things happen only when people, as service workers, users, and advocates have the creativity and vision to make them happen. Where service brokerage has been developed so far there has been a very clear commitment to the importance of enabling disabled people to become valued citizens. This same commitment must be maintained as a fundamental feature of the service brokerage model.

CONCLUSIONS

The purpose of this paper is not to propose another model, except as a framework to assess those models which are in use or being developed. The EMPRISE circle very clearly indicates the advantages of service brokerage, if correctly implemented. But whatever model is introduced it should:

- avoid role conflicts which are against the interests of the people for whom services exist;
- start from what people want - their end goals - rather than from assessment of needs;
- prohibit the domination by service workers of the process of defining wants and needs;
- encourage the development of plans which make the greatest possible use of mainstream services and ordinary community resources, rather than relying needlessly on specialist services.

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