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Users and providers : different perspectives on community care services

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Abstract

Elderly clients usually express satisfaction with their services when they are asked. Surveys of clients and carers therefore have to take this tendency into account. It is important not to ask direct questions and to allow for positive, neutral and negative responses, otherwise positive responses will be overestimated. A survey of clients and carers served by a community psychogeriatric service indicated that the way a service is delivered can be more important than what is provided. The differences between staff and user perceptions of services are analysed. There are theoretical reasons for the differences connected with the combination of care and control exercised by service providers. There are also practical reasons in terms of staff perceptions, which are dominated by process, and client perceptions, which are more directly influenced by the services as they are actually delivered. Attempts to incorporate users' views into the processes of service delivery need to understand these differences and to acknowledge the limitations of user satisfaction surveys.

Users and Providers: different perspectives on community care services (1)

The aim of this paper is to look at various aspects, theoretical and practical, of the differences in the way that clients, carers and staff perceive community care services. Recent policy developments give greater prominence to client views of services and this is to be welcomed. It is, however, easy to forget in the enthusiasm for new developments that it is very hard to get an accurate picture of client views, and having got one, to incorporate it into service delivery.

The simplistic approach is exemplified by the Griffiths report: 'the people receiving help will have a greater say in what is done to help them and a wider choice' (1988: 28) and the white paper Care in the Community which sets out a new view of the client as consumer. The stated aim is to develop client oriented services even if, in most areas, clients still have no real consumer power to choose the services they want. Instead of choice a care manager will assemble a package of care services designed to meet the special needs of each client. In default of market power based on consumer choice there is a growing belief in surveys of client satisfaction. (Labour Party 1991).

The results of surveys of clients or patients are usually highly reassuring. White (1990) describes a survey which found that 93% of old people in St Helens were happy with their meals on wheels service. Salvage too found highly satisfied clients and patients. In her 1986 study, all health services except the day hospital (73%), were rated satisfactory by over 90% of users. Social

services were recorded as satisfactory by over 80% except for luncheon clubs (67%) (Salvage, 1986: 17). The Wagner Committee collected evidence on life in residential homes but found that unfavourable opinions were more likely to come from relatives or staff than from residents (National Institute for Social Work, 1988:138-146). Others have noted the same phenomenon (Age Concern, 1974; Goldberg and Warburton, 1979; Goldberg and Connelly, 1982; Willcocks et al., 1987; Sinclair et al. 1988; Levin and Sinclair, 1989). It is fair to conclude that it is very easy to produce surveys which indicate that the vast majority of clients or patients are entirely happy with whatever service is being provided (Salvage et al, 1988), but difficult to get a more balanced picture (Wallace and Rees, 1984).

This paper concentrates on the views of old people, a particularly compliant set of users. The first part of the paper reports on a small pilot study of client views of a community psychogeriatric service. The second part considers practical reasons for differences in the way clients, carers and service providers perceive community care. Finally the differences are related to theoretical aspects of the distinction between care and control as experienced by clients and care staff. The discussion is rooted in Billis's model of work levels in welfare bureaucracies (Billis, 1984; Billis and Rowbottom, 1987).

Clients' and carers' views of a community psychogeriatric service

At the time of the study the service considered had 30 full and part time staff (21 fte) and a case load of about 250 clients. The service used Dant and Gearing's third model of case management for most clients - co-ordination of care in addition to the delivery of services (Dant and Gearing, 1990). Staff assembled packages of care and monitored the results but in addition they offered a service or fulfilled a nursing plan. They did not operate within fixed budgets but were constrained by staff shortages in other services. As long as clients were on their case loads staff visited them at intervals varying from daily to approximately every six weeks.

The households

The study is based on 30 households who were chosen in two stages. First staff asked their clients if they would give an interview and second the interviewer rang up or called and made an appointment. The respondents were therefore drawn from 129 clients who were asked by staff whether they would agree to be interviewed by a researcher. In 97 households a client or carer agreed to be interviewed, 23 said no and nine were either in hospital or were judged by staff to be unable to cope with the interview. Shortage of time meant that only 30 households out of the 97 who agreed to an interview were actually seen. The final choice of households was not random but depended on the rate at which staff relayed acceptances or refusals from their clients. No obvious bias

resulted except that clients of the psychologists were over represented and clients of the physiotherapists were under represented.

Clients or carers were seen by appointment. The households interviewed were varied in composition. Eight were single person households, 15 were elderly couples, in three a mentally ill son lived with his parents or mother, three were three generation households and in one a great niece was the carer. Fifty people were seen in total, 25 clients (17 women and 8 men) and 25 carers (13 women and 12 men). The majority of those interviewed were over 75.

As well as being noticeably older than the average, the households interviewed were also high users of services. A majority were either long term users of the community health and social services or had picked up one or more services during the referral process. Only nine clients were receiving no other service or had received none before going into hospital. One carer had recently discontinued the bathing service. The remaining 20 clients were all current users of day centres, day hospital, home helps, meals on wheels, district nurses and/or the incontinence service. Two households were visited by volunteers. In 12 households someone had been in hospital during the previous year. The people interviewed therefore had considerably more experience of services than might be expected in a randomly selected group of older people where less than 10% are likely to be users of services (Arber et al., 1988; Evandrou, 1987).

Interviews

The survey asked no direct questions about client satisfaction or perceptions of service quality. The purpose of the interviews was to listen to clients and carers talking about the way they coped with the problems of daily living. However, since all those interviewed were either clients or carers they were also asked how they came into contact with the community psychogeriatric service, or a named member of staff, and what staff did for them when they called. In the context of help with problems, they were asked which other services they used. If the client or carer attended a day centre then the issue of transport was raised. There were also more direct questions on whether a service had helped with a problem and whether the client or carer had been in hospital in the previous year. Clients and carers were encouraged to talk about the ways they coped and to tell stories about their experiences. Interviews were taped and the content analysed in terms of experiences of services (see below).

The indirect method was adopted because questions about satisfaction with services can be interpreted in several ways by respondents. They frequently reply to a simple question about a service, such as "How do you feel about", as if the question implied other agendas such as:

"Are you satisfied, given that you know it is the best you can get?" or

"Are you grateful for what you have been given?" or even,

"Are you going to be impolite enough to say what you think about the service?".

With elderly clients the chances are high that they will answer in terms of politeness or gratitude. They are giving a public account, the socially accepted version (see Cornwell, 1984: 12-17; Douglas, 1971: 242; Wilson, 1987: 56-60), but they may also have private accounts that are very different. A clear example of the difference between the socially acceptable, or expected, response and the reality as seen by the client was given by one elderly mentally ill woman when it emerged that she had been in hospital during the previous year. She quickly disposed of the subject of hospitals with a comment which could be taken as patronising:

Interviewer: How was it in --- Ward?

Son: Oh she won't want to talk about that.

Client: They're all very nice in there and they do their best. That's the answer you want dear.

Another problem with direct questions is that clients may hold contradictory opinions (Wilson, 1991). In terms of the public account they are content with the service offered because they have low expectations and low feelings of entitlement. A private account may indicate that they are acutely aware that the service does not meet their needs and that it is not a high quality service. Direct questions are likely to be answered in terms of low expectations and so the service will be reported as good. The indirect approach is more likely to uncover a critical understanding that a service, though all that can be expected, is not what is needed.

There is also the problem that clients may not trust an interviewer. They may think any criticism will result in withdrawal of a service, however inadequate it is, or they may even think victimisation will follow criticism. This is a special risk for those surveying elderly mentally ill people who may have paranoid fears as well as normal insecurities. Even without this added hazard they may see questions on services as an emotional area where the wrong response could be harmful (Brannen, 1988), or they may simply wish to be polite.

Analysis

The aim of the analysis was to classify clients' and carer' views of the services they received and to find out what it was they liked of disliked about the service or the method of delivery.

Opinions, statements, stories or other mentions of services were classified as to whether they indicated positive, neutral or negative comments about services. Larger studies might wish to use a five point scale rather than three, and to divide up satisfaction into different categories.

The three point scale was chosen because it is important to recognise the social conventions which apply to the caring services. As mentioned above, simple politeness may demand that services which are received free or are seen as stigmatising are spoken of favourably. The aim of a threefold classification of responses is to allow for this. A client or carer was only counted as feeling positive about a service or a staff member when their response was warmer than simple politeness would normally demand. For example, statements such as "She's very nice" were counted as expressions of the normal polite way of talking about staff in the health and social services, and recorded as neutral unless a contrast was either implied or drawn directly with the staff of another service (Cornwell, 1984; Wilson, 1987:). The case quoted above where the son made it clear his mother had disliked her stay in hospital and the researcher is fobbed off with a socially conventional reply is counted as negative. On the other hand, "She's a good friend" from a dementing client who had finally remembered she did receive regular visits from her family aide is counted as positive. Overt criticisms of individual staff or services were counted as dissatisfaction. People also had other less direct ways of criticising services. When stories of abuse, delay or insensitivity were recounted and left to stand on their own without comment they were classified as negative responses to the services concerned.

Results

Positive views

The community psychogeriatric service was liked by clients and carers (there were 29 positive mentions as against 8 neutral and four negative). This is in contrast to many other services (see below). The main reasons for appreciation, as they emerged from an analysis of the interview tapes is set out in the following paragraphs.

As far as carers were concerned, the most important contribution of community psychogeriatric staff was to demonstrate that someone respected their work and cared enough to help in some way or another. The importance of this feeling in improving the quality of life for carers cannot be underestimated. Here the distinction between "cared for" and "cared about" is of vital importance. When the relationship with staff was good, carers and clients felt cared "about". In Parker's terminology tending included 'a sense of being cherished and loved' (Parker, 1981: 29). This mattered for lonely or isolated people. The literature on home help and

other domiciliary services also stresses this aspect of successful service provision (see Goldberg and Connolly, 1982: 76-77; Latta S.M., 1982, Johnson et al., 1988).

The affective aspects of formal services have been unfavourably contrasted with informal care (Qureshi and Walker, 1989:203-242). Very often this may be fair comment. Observation, the survey responses and the lack of attention to affective aspects of service delivery in the literature indicates that formal care is often too impersonal to have a favourable impact on clients and carers. The recent finding by Bebbington and Davies (1990) that community care makes little difference to outcome may be linked with this aspect of service delivery. Certainly, since services often have a limited impact on the practical side of living it is essential that they have a positive psychological impact. Without it they are unlikely to improve motivation to continue to care. It is helpful that the Local Government Training Board has now recognised the importance of affective issues in the effective delivery community services (Stewart and Walsh, 1989)

The same point may be made with reference to clients. They too mentioned affective aspects of the service. Like carers they were most enthusiastic when they felt that staff who visited them were like "friends", or in one case like a son. This could in theory lead to impossible expectations of staff. However there was only one example of a client or carer who was making excessive emotional demands. The limitations of the client/care staff relationship seemed well understood but a friendly service which accorded respect to client or carer views meant a great deal.

Services which were non-directive were also seen as very important. Good staff were prepared to listen. They did not force clients or carers into decisions they might not wish to take. While there were situations where clients or carers accepted coercion, the overwhelming message from the interviews was that becoming a client jeopardised independence. Control in terms of institutionalisation was feared and direction was resented.

Despite the emphasis on affective aspects, staff who actually provided a service such as cooking meals or sitting with a client when the carer went out, or achieved something concrete like an Attendance Allowance application, were appreciated for what they did.

Medical services were not expected to operate in the same way. It was enough to be treated with respect rather than friendliness. As a result GPs were mainly mentioned positively but there were some problems with hospital doctors (see below).

Day care was the most popular of the other services mentioned. Seven clients were going to some form of day care, either a council centre or a family aide club. Four clients liked it and three could not remember what it was like or that they went. All

the five carers involved were in favour, though one felt rather jealous at going nowhere himself.

The distant mental hospital which served the area was generally viewed with dislike but one carer found that his dementing wife ate more in the mental hospital and came out fitter ("with more go in her"). He was pleased with the respite care offered but angry and insulted that he had to sign a paper saying he would take his wife back after the respite period before the hospital would accept her.

Neutral views

Eight people were neutral in their views of the community psychogeriatric service. Six found their CPN pleasant but could not see why s/he came to visit them. It appeared that irregular, unannounced visits to monitor or give an injection (rudely referred to as the 30 minute cup of tea) were not understood or appreciated by clients or carers. One carer and one client were neutral about their family aides who did not appear to be making much impact.

The home help service was mainly viewed neutrally. Seven households were receiving some input and one other had been allocated a home help but the service was discontinued because the maisonette was so dirty. One carer was against the service, mainly it seemed on racist grounds (her home help was black). The rest were neutral. There were three mentions of short hours. These might have been interpreted as criticisms but seemed more to be a neutral recognition that high standards could not be expected. Personal observation of the standards of hoovering and dusting suggested that more criticism might have been expected.

Negative views

Only four people expressed negative views about the community psychogeriatric service. Two had found the therapy they were offered for depression was unhelpful and one saw no point in family aide visits which provided no obvious service. In the final case a carer did not think that the physiotherapist was any use to her husband because she could not come daily and her husband only did his exercises if an outsider encouraged him. This household had a family aide visiting twice a week so with better staff liaison the exercises could have been done three times a week.

Thirty one clients or carers expressed overt criticisms of other services. In considering this high rate of discontent, it is important to realise that carers and mentally ill old people are a very vulnerable group. People who were almost at the end of their coping capacity found it hard to deal with irregularity, unpunctuality, broken promises, long waits and an uncaring approach.

The ambulance service was the most universally condemned. Long waits or actual non-arrival were greatly disliked. Cases of cancelled ambulances turning up all the same were also mentioned as upsetting by some clients or carers.

Irregularity and lack of any punctuality were also problems with the district nursing and bathing services. The inability of nurses or bath attendants to arrive on the day they had said was also very upsetting to those active carers who were still able to get out and resented waiting in all day. There was also the point that for bath attendants a visit once a week or even once a fortnight was not felt to be adequate.

All the people surveyed who had anything to say about timing wanted shorter waits - for everything from hospital appointments to aides for daily living and social security matters.

Low expectations appeared to be the norm for community services. However attitudes to the hospital service were different. Something better was to be expected and when there was no improvement or cure or staff behaved insensitively, the sense of grievance appeared greater. As one said of the nurses on a local geriatric ward "You could see they didn't enjoy their work. They were not dedicated, not dedicated".

Lack of information and lack of respect in hospital treatment were also quite common. One carer was still deeply resentful and upset by a consultant who he said had treated his wife "As if its a bit of meat on a slab, and its going off you know". Some GPs were also seen as lacking in understanding, failing to give information and being too busy. However it is important to note that the majority of clients and carers were happy with their GPs.

Respite care is often seen by providers as a simple restorative break. Carers in the sample had a more complex response. Respite in terms of hospital or part III admission was mostly seen as a mixed blessing. Clients were often thought to come out worse than they went in. One came out of hospital with bedsores (the only case in the sample but not an exception). Two others were reported to have lost clothing and jewellery while in residential homes.

Responses and service delivery

Previous work on service delivery suggests that the most common reason for recording a positive response arises from the very low expectations that clients and carers have of the services available. Goldberg and Connelly (1982: 75-76) in their survey of research on domiciliary services noted that low expectations and gratitude were likely to result in positive responses.

In the survey reported above, carers, or clients with insight into their condition, usually did not feel that their problems were solvable. They were not measuring community care services against

their needs but more as a marginal addition, welcome to a greater or lesser extent. Staff who respected their opinions and valued them as individuals were seen as supportive and contrasted with those who did not.

Another reason for seeing services in a good light was desperation. Clients and carers were referred late in the process of dementia or mental illness. Their difficulties were usually extreme. Not all had insight into their condition but they could appreciate a service that was delivered with respect and kindness. There is no doubt that many of the elderly people interviewed were genuinely grateful for what they got. They belonged to a generation which did not grow up expecting anything to be provided for them by local government or the NHS. Two were able to contrast the meagre services they received with even lower provision for relatives or friends in other parts of the country.

There were also cases where what was provided was of real assistance. It was easier for family aides or home helps to get a mention under this category. They performed obvious services like cleaning, shopping and respite sitting. Nurses and other professional staff were less likely to be seen as obviously helpful by this group of clients and carers because therapy, monitoring and advice were not always valued.

Other services which might have been useful were not because they could not be provided frequently enough, or predictably, or to a high enough standard. Bathing, physiotherapy, the ambulance service and respite care all fell down on these counts.

Finally, it is very important to note that surveys of clients only cover those who tolerate the service. The rest may not know what is available. They may have refused referral, or refused, or discontinued services. They have voted with their feet or otherwise opted out. Counting positive responses therefore greatly overestimates the acceptability of a service.

The conclusion of this section is that elderly clients and carers are well able to assess the quality of the different health and social services which they receive, even though they may not understand the organisational structures behind them. They are able to articulate their likes and dislikes and can voice highly relevant criticisms of services they regard as poor. In general they have low expectations and are very tolerant of poor services but they do wish to be treated with respect and they like to be able to regard care workers as "friends" even though such friendship has a limited scope.

The mismatch between client and provider perceptions

It would be possible to end the discussion at this point. However it seems relevant to consider the issues raised by the survey of

clients and carers in terms of differences in perceptions of services. The discussion draws on three years of participant observation of the community psychogeriatric service rather than a direct survey of staff attitudes.

The practical reasons for the gap in perceptions between clients and staff are discussed under the headings below. Some are obvious, others less so, but all need to be taken into account when listening to clients and carers, or when thinking how to move a service in the direction of a client-centred approach.

Assessing need or assessing for a service

Referral is followed by an assessment of need. In the service discussed this assessment was carried out by qualified staff using a multi-disciplinary assessment form. While staff were assessing need clients and carers rarely thought that their needs could be met. This is hardly surprising. There is little evidence to suggest that services meet needs in any very real sense. Smith (1980) has shown that service providers often assess for a service rather than looking at the overall needs of a client. (see also Hunter et al (1988) for descriptions of allocation and assessment in different services).

The hope is that the new community care advocated by Griffiths (1988) and in Caring for People (Cm 849, 1989) will change all this and that holistic assessments will lead to flexible client centred packages of care (Cm 849, 1989: 18-19). Where this works the results may well be very much better than what has usually passed for care in the community up till now. The institutional barriers to such a change are however very great. Much will depend on the level of training of those doing assessments and the resources they are able to deploy.

Process versus package

Staff are involved in the process of delivering a service. This process may bear little relation to what the client or carer actually receives - the service package. Clients on the other hand are mainly concerned with what they get. The difference between process and service offered is particularly marked in care management where enormous amounts of work go into contact with other agencies. Even simple referrals for meals on wheels or home help will almost certainly need phone calls as well as paper work. Obtaining a day care or day hospital place is likely to take several steps in terms of forms filled in, presentation to a panel, letters to the GP and so on. Any phone calls can find the switch board blocked, the person unobtainable or the agency on answerphone. The task of mobilising care may seem a simple matter of contacting the necessary agencies but the process is rarely straightforward. When services are cut or overstrained it may be impossible to get what the care manager knows is necessary. The

client may get no service or less than he or she wants. Failure can be particularly time consuming and stressful to care managers.

Clients do not see any of the care management process. They only receive or fail to receive a package of care. It is easy in such circumstances for clients or carers to feel that nothing worthwhile is being done for them. Carers may get the impressions that nobody cares about them or values their work. This will be particularly true when staff are brusque or come to see clients as demanding or manipulative (see below).

Time - provision relative to need

There is a mismatch in time between hours of service offered and hours in the week. The time spent caring - or simply living for single mentally ill or dementing people - amounts to 168 hours a week. Services assist with between one and perhaps 20 of those hours. From the provider's point of view the service is a full time job which covers a variety of clients. It may even be more than full-time if staff are putting in unpaid overtime, as many community care workers do. However, for most clients the input they get is only marginal unless they get large amounts of day care and night sitting.

Timing of intervention

Timing may be less problematic in cases of physical as opposed to mental frailty. In mental health work referral can be slow. On the client side the stigma of mental illness or senility is strong in old age as at earlier ages. Also, old people may fear "help" will lead to loss of independence or forced institutionalisation, or they may be ignorant of what is available. From the point of view of clients this slowness to get in touch and unwillingness to accept services is understandable. From the staff point of view it can be frustrating and easily interpreted as stupidity or stubbornness.

Delivery processes

The biggest problems with the delivery process as far as the divergence between client and provider perceptions are concerned are over delays and poor timekeeping. Staff are likely to feel that delays are regrettable but for the reasons set out below, inevitable. Clients do not see the reasons. They may see the service as slow or they may feel devalued and discriminated against.

Delays can arise because of poor organisation, the culture of the service or because cuts have increased waiting lists. Poor organisation, bad record keeping and lack of communication within or between agencies can lead to delay. This will be particularly true of poorly organised case management.

Rate of response is also related to service culture. A quick response may be something that is not considered normal. Once waiting lists build up it may be almost impossible to get them down. Normal response times become measured in months and "urgent" means "weeks". This is hard on clients. As one said "Well I know you have to wait for everything these days, so I was really glad the commode came in six weeks". Finally cuts, or the failure of budgets to grow as fast as the client group, can stretch existing services. Delays, inadequate provision and poor morale result.

Time keeping is another issue. The ability of staff to make and keep appointments can be very important to clients who, despite being old, do still have a sense of time and still want to plan their days. In contrast some staff, particularly those trained in institutions, see the freedom to use their time as they wish as one of the most positive aspects of work in the community and resent any attempt to tie them down to a fixed schedule. These practices are a matter of culture and of management control.

Staff attitudes to clients

An aspect of the delivery process which the survey showed to be of great importance to clients but which is much less salient for providers, is staff attitudes to clients and carers. It is very easy for staff to slip into the habit of dividing clients into "nice" and "grateful" versus "difficult" and "manipulative" (Satyamurti, 1979). Clients are not usually going to see themselves in these terms. Secondly, for any special needs services, there is the issue of who really is the "client". Is it the client or is it the carer?

The question of who is the client is a difficult one. Caring for People, with its emphasis on the need to support carers (Cm 849, 1989: 9), gives a strong impression of services targeted to support the activity of caring. They are only incidentally to enhance the well being of the cared for. From the point of view of government policy there are dangers with this approach. Professionals who see the carer as the client can be more willing to institutionalise an elderly person who is a heavy burden on their carer, whether the carer is a spouse or a child. Referrals to residential or long term hospital care may rise as more weight is placed on the carer as client.

The conclusion from this section of the paper is that for practical reasons connected with the way services have to be organised the views of the users and providers of services are unlikely to harmonise except at the most superficial level. The two groups are effectively not talking about the same thing. (See also Dean, 1991 for examples of the mismatch in understanding of common terminology by clients and service providers).

Theoretical aspects of services provision - care and control

While some of the barriers to understanding between service providers and users could be resolved by better management and better information there are others which are more intractable. From a theoretical point of view it is essential to look at the long running conflict between care and control in service provision. The following discussion refers more closely to personal social services than to health care. In health care the power of doctors and the very limited knowledge available to patients has meant that the distinction between care and control has less meaning. Government rhetoric favouring a service which is more responsive to patients (Cm 555, 1989: 4-5) is unlikely to change the ways that in-patient services operate in this respect. However clients often fail to distinguish between community care staff from different agencies. It is therefore relevant for health professionals who work in the community to consider how their activities are regarded, just as much as it is for social service and voluntary sector staff. The following paragraphs argue that the use of Billis's theory of levels of work (Billis et al., 1980; Billis, 1984; Billis and Rowbottom, 1987), can explain why community care workers may see themselves as caring, although their activities may at the same time be experienced by clients as controlling.

It is important to distinguish between types of control. Day (1981) points out that many clients prefer firm direction and are willing to hand over certain decisions to a qualified professional. In this case control is part of the client/practitioner relationship and may be exercised with the tacit consent of clients. Equally it may not (Rhodes, 1986; Mayer and Timms, 1970). There was no evidence in the present survey that old people preferred a directive approach. Other types of control originate outside the direct client/worker relationship. It is these that are discussed below.

Billis's theory of work levels states that work in the caring services can be categorised in terms of a series of different levels of response to social problems. At Level 1 the correct way to respond is clearly laid down - the output is prescribed. The work of a receptionist or a home help may fall into this category. At Level 2 work involves decisions on how to deal with a series of similar problems. Part of the output may be prescribed but judgement and discretion are needed. Most of the work of community care professionals is at this level. Levels 3,4, and 5 deal with increasingly complex management problems. It must be stressed that the theory is about work not staff. Individual staff may, and usually do, perform at different levels. This is one reason why almost all workers combine aspects of care and control in the work they do.

Service organisations are structured so that the work they do is simplified at lower levels in the welfare bureaucratic hierarchy. For example, at the point where clients and community care staff interact a series of cases is referred to staff who have

relatively clear procedures for dealing with them. At these levels (Billis's strata 1 and 2), the client is either the person referred or the carer or both (see below). The aim of the worker is to do the best for the client. However "the best" usually has to be defined in terms of the services available. Also the client has to present as a 'case' or as having needs which conforms with what the service can offer. On these two points the client, who is also the consumer, is likely to sense control as well as care. In addition staff may feel pressured from above and, acting as street level bureaucrats, they may routinise certain decisions in their own interests rather than in the interests of their clients (Lipsky, 1980). Again clients may experience this as control not care.

Although clients and carers are the obvious consumers of the service, the white paper Caring for People introduces government and taxpayers as consumers of the services of level 2 workers more explicitly than before. The work of case or care managers who co-ordinate services on behalf of individual clients belongs mainly to level 2. Care managers who follow the model favoured by government (Cm 849: 20) will be budget holders (see Dant and Gearing, (1990) for different models of care management). Part of their remit is to maximise care in the community, to support carers and to minimise expenditure on expensive residential care. The consumers of this aspect of their work are government ministers with a policy of reducing the growth of public expenditure and taxpayers or community charge payers who are assumed to want to cut down on the cost of frail older people. Rivlin and Wiener writing on America, also point out that case managers are an important means of controlling costs in long term care of old people (Rivlin and Wiener, 1988: 99, 240).

According to Billis policy considerations become increasingly important at higher levels of work. At level 3, (first level management), there is a need to make decisions about different ways of dealing with a relatively similar series of problems. In terms of frail older people, the service is still concerned with them, but as a client group (Webb and Wistow, 1987: 104-105) rather than as individual clients. Individuals may not get the services they want because considerations of equity and priority come before individual need.

Level 4 and 5 identify work which is usually done by senior managers and central policy makers. At these levels the problems which present themselves do not relate to individual clients or even client groups. They are about the way society (or politicians via the social system of the ballot box) choose to deal with aspects of the social structure which they have labelled as problems.

As a broad generalisation, social services are not in existence in order to change the structure of society (see George and Wilding, 1984: 187-220 for a good discussion of this aspect of social

services). They will not therefore deal with the causes of problems. On this interpretation, society as a whole commonly expresses concern about the outcomes of the distribution of resources (e.g. poverty), but apparently prefers to set up services which will diffuse discontent, rather than change the existing pattern of resource distribution. At higher policy making levels therefore, the purpose of action is to show that government and society care about social problems. The provision of social services legitimises common definitions of social problems and helps to contain them in socially acceptable ways. The consumers of services at this level are either society as a whole or politicians in central and local government.

In terms of frail older people, services exist to ensure that risks are avoided and society is not revealed as uncaring. Old people who are identified as being unable to care for themselves, or as being too much of a burden on their carers, have traditionally been defined as needing institutional care. It is hardly surprising that many fear referral to the caring services and see it as a prelude to the loss of liberty. Even referral to community care services can restrict the independence of clients or carers if staff are directive, or if they do not make appointments and expect clients to wait in for their visits.

In summary, the consumers of the various levels of social service (including health) care provision can be characterised as a hierarchy weighing down the lower levels. Society or central politicians will blame local politicians or service managers for failures to control problems or legitimise action. Local systems will blame the front line workers. Workers themselves will act in ways that minimise risks to clients and risks to themselves. The full weight of the structure is borne by clients and carers. They may share the socially legitimated perception of services as caring but at the same time they can feel the loss of independence which arises from control from above. In addition they have to reconcile the very great practical differences between their perceptions of services and the perceptions of community care staff.

Conclusions

Renewed emphasis on user satisfaction is likely to lead to more surveys of clients and carers. However if surveys are to be useful in improving services, as opposed to merely validating the existing provision, it is essential to use semi structured interview schedules, to eliminate direct questions on quality and to allow clients and carers time to speak about their experiences. The methodology must recognise that public and private accounts of satisfaction with a service may conflict and be prepared to accept both. The constraints of politeness and gratitude also need to be taken into account. This can be done by recording normal polite responses as neutral and reserving the positive category for more

specific expressions of approval. Many apparently positive responses will then be classified as neutral.

Recipients of the community psychogeriatric service surveyed did not feel their problems could be solved. As far as most were concerned the practical help provided by health and social services made only a marginal difference to their very difficult lives. However, clients and carers mentioned good personal relations with staff as something they valued more often than they mentioned the practical help that came from thinly spread community care services. In other words it was being cared about rather than being cared for that made them feel supported in their daily lives (Parker, 1981).

As a corollary, successful case management for dementing or mentally ill older people in the community demands a relationship of trust between client or carer and the staff involved. Unless such a relationship is established it is very difficult to get the client to accept services or to use them in a constructive way. Simply being tolerable to the client or carer is not usually enough to achieve a good outcome with this client group, though it may be adequate for the delivery of certain services such as bathing or chiroprody. A further point is that staff who make appointments or come at regular times are able to provide a feeling of security and reliability.

The findings are from a small sample of clients and carers using a specialised service. If they were replicated, and there seems no reason why they should not be, the question arises of how far clients views should influence the planning and provision of a service. Services which are seen by clients as having little value, such as the monitoring role of CPNs, may be judged as highly important by managers. Similarly services which managers think are useful, such as family aide or home help work, may be seen by clients as intrusive and upsetting if they are not delivered in a considerate way. It follows that management practices which make it easier for staff to feel valued and to value their clients will have a big impact on the way clients feel about what is offered to them.

Differences in the perceptions of service delivery must be spelt out to staff so that they can begin to see criticisms by clients in a more constructive and less threatening light. If this is not done any criticism is likely to produce a negative response from staff who are probably already stressed by lack of resources.

It is also important to understand the theoretical framework of service delivery. Direct users of the service, clients and carers, are not the only consumers. At each succeeding level of work in the organisation of a welfare bureaucracy the concept of the consumer becomes more complex. Taxpayers and politicians, both central and local, are consumers of welfare services but their demand is for services which control those aspects of society

which have been labelled as problems - service costs must be kept down, government concern must be legitimated and votes must be won.

Staff and clients are both affected by the conflicting demands for control and care. Dealing with this conflict overtly, rather than simply pretending it does not exist, is unlikely to help clients and carers who will still experience control, but it might assist staff in understanding the difference between their points of view as service providers and the way their activities are perceived by users.

If the results of one survey are repeated, it follows that the processes of service delivery, as opposed to what is actually offered, are more important than has previously been supposed. Management and training structures which encourage staff to take a positive and non-controlling view of their clients will be more valuable than minor extensions of service. They will almost certainly be more cost effective.

Notes

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