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**The gate-keepers of independence: an empirical study of the
care manager role in relation to direct payments**

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**Submitted for the Degree of Masters of Arts in Disability
Studies**

Date of submission

1st September 2010

Abstract

Direct payments have the potential to support independent living. They promote disabled people's right to live autonomous lives where choice and control is retained. In theory, these principles sit central to the care manager role. However, the reality is that care managers are frequently cited as hindering access to direct payments. It was predicted that this would be the case; as professional hegemony is embedded within community care practice. This study aimed to gain insight into perspectives of care managers to understand how and why they hinder uptake.

To achieve this, the study explored the role and responsibilities of care managers using three methods. Firstly, an analysis of existing research material; secondly via an online survey; and thirdly through discussion in one to one interviews. The care managers surveyed asserted a variety of reasons that hinder their ability to implement direct payments. These included: the perception that direct payments were unsuitable for certain service 'user' groups; lack of training and understanding; inappropriate financial support; and concerns that employing a family member as a PA

would risk breakdown of the family role. However, the study revealed that care managers used justificatory discourse to mask explicit and implicit assumptions about disabled people and their ability manage a direct payment. The study also explores the opportunity of the personalisation agenda to move the care management role away from the associations of professional hegemony towards a role that uses co-production as equilibrium to the power imbalance that currently exists.

The study concludes by asserting that, as predicted, care managers continue to hinder the uptake of direct payments because they practice within the individual model of disability. The study upholds the care management argument for training and support to develop understanding but it also asserts that any attempt to educate care managers is futile unless the profession engages with a social model of disability.

Acknowledgements

I would like to start by thanking my academic tutor and dissertation supervisor Professor Colin Barnes for the patience, guidance and support he has shown me during my MA at Leeds. I would like to thank Dr. Laura Hemmingway for encouraging and guiding me through year one and Dr. Alison Sheldon for supporting me as my personal tutor.

I would also like to convey my appreciation to the care managers who freely gave their time to take part in this study. To my family, who never once faltered in their belief in me. Finally, I would like to say a special thanks to Mike who I am forever indebted to for his endless encouragement and cups of tea!

Abbreviations

CSCI	Commission for Social Care Inspection
DoH	Department of Health
DP	Direct payment
ODI	Officer for Disability Issues
PA	Personal Assistant
WAG	Welsh Assembly Government

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Chapter One: The paradox of social 'care'

Introduction

This introductory chapter outlines the study into the role and responsibilities of care managers in relation to direct payments. This section will provide a summary of the research problem and details how the key questions will be answered. We will look at the methods used to collect data and move on to talk about the terminology used throughout the study. Finally, we will discuss the structure of the chapters that follow. We shall begin with the background of the research problem.

Background

The inauguration of the Community Care (Direct Payments) Act 1996 (CCDPA, 1996) marked the culmination of decades of campaigning by disabled people. Hitherto, disabled people were unable to make decisions and arrangements for support services and were often incarcerated in residential accommodation without the autonomy to direct their own life path; this proved disabling and disempowering (Morris, 1993). Disabled people successfully argued that offering them the option to receive cash to purchase support services promotes their right to choice and control over their lives. In contrast to institutionalised 'care'; support purchased by direct payments is delivered in the

community and can be used to meet the assessed needs of disabled people. This includes the services of a carer via an agency, a personal assistant (PA) and the right to purchase equipment (Stainton and Boyce, 2004).

Direct payments promote a shift away from traditional paternalistic welfare services. This is because by permitting care managers to offer disabled people cash in lieu of directly provided services you are handing the power to disabled people (Brammer, 2010). The law originally gave local authorities the power to make cash payments directly to disabled people aged between eighteen and sixty five (Office of Public Sector Information, 1996). However, this was extended in 2000 to include those over sixty five following campaign by the British Council of Disabled People who successfully argued that to exclude those over sixty five was discriminatory (Evans, 2003). Further updates to the act in 2000 permitted direct payments to be made to carers and disabled people aged sixteen and seventeen (Office of Public Sector Information, 2000). Importantly, since 2001 care managers have a *duty to offer* direct payments to all eligible disabled people (Office of Public Sector Information, 2001).

Some critics argue that the amount of responsibility that direct payments places on recipients who become employer and commissioner of their own support package is tantamount to a 'reverse disablism'. This is because the responsibility that disabled people are exposed to as direct payment recipients is more than non disabled people would ever be expected to bear (Gillinson et al., 2005:80). Notwithstanding, direct payments have been hailed as the most progressive reform of community care services since the introduction of the National Assistance Act in 1948 (Barnes, 2002). There is political commitment to increasing access to and implementation of direct payments as the primary source of social care provision (see, DoH 2005; DoH 2006; WAG, 2006; ODI, 2008). Direct payments lay down the foundation of the personalisation agenda for social care in the UK, and are now viewed as a fundamental part of social care provision (Samuel, 2009).

Furthermore, and perhaps more importantly, disabled people maintain that the choice and control that direct payments offers them has significant effect:

“I am exercising choice and control, having the right to choose who gets me up and who puts me to bed” (Glasby and Littlechild (2002:86).

“You can start to relive your life in the way that you want to....I have got freedom now which I felt for years I didn't have” (Stainton, 2002:753).

Direct payments are now seen as pivotal to improving independent living for disabled people in the UK (ODI, 2008). The campaign for independent living emerged in the UK when the British disabled peoples' movement began to publicly express that 'services were: paternalistic; institutional; second class; too medically orientated; and out of touch with their real needs' (Pridmore, 2006:2). Encouraged by the politicisation of disability in the American Independent Living Movement, disabled people in the UK began to seek alternatives to the traditional interpretation of disability (Barnes and Mercer, 2010).

The outcome was a collective movement that argues that disabled people should be able to experience the same life opportunities as non-impaired people. It is critical to grasp that independent living is 'a manifesto for empowerment, self determination and a way of being, it is

not a 'service' (Gillinson et al., 2005:9, my emphasis). Services *such as* direct payments can facilitate independent living:

....there would be no Direct Payments without independent living.

We believe that the purpose of Direct Payments is to enable Independent Living. In other words it is to ensure that disabled people are able to live like everybody else, with equality of opportunity (Evans, 2002:1).

Conversely, despite the political recognition that disabled people have the right to live independently, and the understanding that this can be achieved via vehicles such as direct payments; the uptake of direct payments in the UK is comparatively lower than directly provided services (Pridmore, 2006). Research suggests that only 3.2 percent of adults in receipt of community care services choose direct payments (Glasby and Littlechild, 2009), and the demographic of recipients of direct payments remains fragmented (Riddell et al., 2006). This is particularly evident in Wales where only 1.48% of disabled adults receiving community care services are direct payment recipients (Social Interface, 2007).

Research has identified a diverse range of reasons that hinder uptake. These include: ambiguous legislation (CSCI, 2004); socio-economic barriers (Leece and Leece, 2006); lack of effective support services (Department of Health, 2006), the availability and retention of personal assistants (Glendinning et al., 2002); the politics of devolution (Riddell et al. 2006); and concerns relating to risk and control, (Evans and Carmichael, 2002). However, one of the most consistently cited barriers remains the role and perspectives of care managers (Lomas, 2006).

Aims and objectives

Indeed, the paradox of social care is this, it is argued that care managers hinder direct payment uptake (ibid). Yet the social work profession suggests that direct payments are in line with its core values and principles (Ellis, 2007). To understand this dichotomy, this study will explore the perspectives of care managers within a Welsh local authority with the aim to gaining their viewpoint on their role and responsibility to supporting the implementation of direct payments. The study seeks to understand how care managers interpret their role and identify if this interpretation affects whether or not they ration access to direct payments.

The reason for focusing on this topic relates to the researchers experience as a care manager who implements direct payments and the conflicting ontological experience of being part of a disabled family who has experienced the oppressive nature of social service gate keeping (Topliss, 1979).

Hitherto, we have identified that previous research has substantiated that the perspectives of care managers can hinder direct payment uptake. In order to gain better insight into this dilemma, this study will seek to answer three key questions:

- What are care managers responsibilities with regard to the implementation of direct payments for disabled people within a Welsh local authority?
- How do care managers interpret their role with regard to the implementation of direct payments for disabled people?
- How do these interpretations influence disabled people's access to direct payments?

Data collection

This study aims to answer these questions in four stages. Firstly, it will critically evaluate existing literature to establish what research already exists in relation to care manager perspectives. Secondly, a self-completed survey will be distributed to all the care managers within the sample local authority. It is hoped that this will generate quantitative data for analysis. Thirdly, participants will be invited to take part in a one to one in-depth interview. It is anticipated that this will produce more detailed qualitative data. The final stage involves analysis of the data collected during stage one to three. Once this data has been compiled, this study will be submitted for the award of MA Disability Studies. Following this, it is anticipated that a summary report will be compiled for dissemination.

A note about terminology

This study is underpinned by a social interpretation of disability and therefore it is felt that the terminology used throughout the study is complicit with this elucidation. Clark and Marsh (2003) discuss the social and individual dichotomy of disability and assert that the language we articulate reflects our implicit attitudes. Attitudinal values are credited with contributing to the broader oppression of disabled people (Barnes and Mercer, 2003). Therefore it is felt that the underpinning philosophy

of this study is explicit. Furthermore, Oliver (1994:4 cited by Williams-Findlay, 2009:23) warns that

....language is also about politics, domination and control.

Within the later halve of the 21st century, disability has become a politically active issue. Parallel to these political developments has been the advancement in the way we view impairment and the social construction of disability as a form of oppression (Barnes and Mercer, 2003). Indeed, the disability movement has educated society to understand that people are *impaired* by biomedical function and become *disabled* by the barriers that society constructs (Edwards, 2005).

Therefore, within this context; the use of the term 'disabled people' within this study refers to 'people with impairments who are disabled by socially constructed barriers' (Clark and Marsh, 2003:2). Conversely, the opposing view of *impairment* as the *cause of disability* has become known as the individual model of disability (Oliver, 1996). Therefore, as the term 'people with disabilities' implies that the 'disabling effect rests within the individual person rather than from society' (Clark and Marsh, 2003:2), the use of the term is rejected and will not be used in this study.

In addition, this study is being conducted by a non-disabled student; consequently, this study *cannot* draw upon a personal experience of the oppressive nature of disability. This study recognises that the research problem has significant implications on the lives of disabled people; therefore secondary data will be used to represent the viewpoints of disabled people.

Finally, it is felt important to clarify the use of the terms 'care manager', 'social worker' and 'care management assistant' within the study.

Historically, the role of social worker has been accredited as a generalised title for workers implementing community care legislation, however, the introduction of the NHS Community Care Act in 1990 marked a substantive change in Social Work practice. Social workers became care managers and took on a more managerial gate keeping role (Clements and Thompson, 2007). As a result, the title care manager is now used to identify a homogeneous group of qualified and unqualified social care staff who practice within the framework of community care legislation. In 2005, the title of 'social worker' became protected under Section 61 of the Care Standards Act 2000. The title denotes that the person has an academic social work qualification and is a registered as a social work 'professional' with the General Social Care Council. The title of 'Care Management Assistant' identifies that the

respondent is unqualified but is part of the homogeneous group of care managers (General Social Care Council, n.d.).

Organisation of the project

This dissertation is structured to offer the reader an accessible understanding of the research problem. Hitherto, chapter one has provided an introduction to the development of direct payments and the presenting issue of low uptake across the country. The chapter also outlined core aims and objectives. Chapter two critically analyses existing literature that discusses care manager perspectives.

Specifically, it evaluates and identifies key research that discusses the role and responsibilities of care managers. It concludes by validating that care managers continue to be a barrier to the uptake of direct payments, and argues that despite rhetoric by professionals who claim to be partisan to the emancipatory based values of direct payments; that the social work profession continues to block access to direct payments via managerial and bureaucratic gate keeping.

Chapter three discusses how data was generated. It explores the methodology of this study and gives particular attention to the underpinning ontological and epistemological rationale of the researcher.

Chapter four analyses the key themes that emerged during data

collection and compares this against the literature review outlined in chapter two. It argues that care managers continue to rationalise their perspectives and discuss barriers to improving uptake via a discourse of complacency. Chapter five continues with analysis of the data, it concludes by asserting that care managers practice is underpinned by Lipsky's notion of street level bureaucracy. Critically, this chapter also discusses an emerging barrier expressed by care managers. This barrier relates to the use of family and friends as PAs and the care management perspective that this is in conflict with socially constructed norms of the family role.

Chapter six analyses the implications of the survey and interview findings in relation to direct payment development and the personalisation agenda in the UK. Finally, chapter seven concludes the study with a summary of the findings of the research data.

Chapter Two: The gatekeepers of independence

Introduction

This chapter will explore the correlation between the care management role, gate keeping of services and direct payments. The discussion of existing literature in this chapter is framed by the research questions and focuses on: care manager responsibilities with regard to the implementation of direct payments; how care managers interpret their role with regard to implementation; and how this interpretation affects disabled people's access to direct payments. We will begin by looking at the 'professional role'.

Professional role

Despite the fact that community care professionals and policy makers indicate that direct payments can enrich professional practice and facilitate services underpinned by greater choice and control (Ellis, 2007); one of the most consistently reported barriers to the uptake of direct payments remains the perspectives of care managers (Lomas, 2006; Glasby and Littlechild, 2009).

Without a doubt direct payments are a challenge. They confront the conventional boundaries of the care management role; where control

about planning and commission of support is transferred to disabled people. This change in the power relationship between community care professionals and disabled people has forced commissioners, politicians, social care staff, families, carers and support agencies to rethink conformist norms of impairment and disability (Davey et al., 2007). Historically, disabled people have been viewed as 'dependent', 'inadequate' and in need of 'expert' intervention. As a consequence of such assumptions, community care services have been developed under the impression that disabled people are objects of the state (Morris, 1993:11).

Albrecht (1992) argues that society assumes impairment is a social 'problem' that requires a response. The response by community care commissioners has been the development of the 'disability business' via the proliferation of 'expert' professionals. The professional role seeks to 'intervene' with the view to offering 'solutions' by seeking to maximise bio-medical function through rehabilitation or by constructing 'dependency' and hegemony of welfare services. Illich (2005) discusses intervention by 'professionals' and asserts that the care manager role is a 'disabling profession' that forms part of the broader social construction of disability.

Indeed, the care manager role is a paradox; it claims to be partisan to a social model of disability via the delivery of empowerment, human rights and anti discriminatory based practice. However, the reality is that care managers 'assess' bio medical function using 'crisis, complexity, and risk' discourse. Care managers have a legal obligation to match these 'risks' against set eligibility criteria and it is this control that often leads to gate-keeping and rationing of services such as direct payments (Trevillion, 2007:939).

In line with socio-political strategy; care managers are responsible for extending access to direct payments to as many people as possible. They are also expected to discuss direct payments as the first option for service delivery following assessment and during review (DoH, 2006). Care managers are obliged to offer direct payments to disabled people who meet authority eligibility criteria; have the capacity to manage; consent to receive; and are willing to receive cash in lieu of directly provided services. However, changes under the Health and Social Care Act (2008) mean that since 2009 care managers now have a responsibility to proactively extend direct payments to those who lack capacity to manage a direct payment via an appropriate representative (Brammer, 2010). Furthermore, care managers have a responsibility to ensure that they provide information on direct payments so that they are:

...supporting service users' rights to control their lives and make informed choices about the services they receive (Care Council for Wales, n.d:8).

However, the reality is that care managers often abdicate their responsibility to increase direct payment uptake through gate-keeping and service led assessments (Oliver and Sapey, 2006). We shall now move on to discuss how gate keeping manifests within care management practice.

Managerial and bureaucratic gate keeping

Rummery and Glendinning (1999) discuss gate keeping within the care management role in two ways: *managerial* gate keeping such as eligibility criteria, procedural guides, direct functioning of teams; and *bureaucratic* gate keeping on street level such as denial of right to assessment, information and through service led assessments.

Managerial and bureaucratic gate-keeping of direct payments is evident throughout care management; from basic information sharing to supporting disabled people to implement, manage and review their support plan (Glasby and Littlechild, 2002).

One of the most basic care management responsibilities is to understand what services are available to services users (Care Council for Wales, n.d.) However, Stainton's (2002) research identified that twenty eight percent of care managers are unaware of direct payments. This is a significant barrier when you consider that care managers are often viewed as a primary source of information for disabled people (ibid). Another example of bureaucratic gate keeping is evidenced by disabled people's experiences:

“I then [sic] had trouble convincing social services that direct payments existed... my social worker was scared, didn't really know what to do.” (McMullen, 2003: 19 cited by Carlin and Lenehan 2006:115).

Managerial gate keeping is identified in research conducted by Priestley et al. (2007). The study considered the uptake of direct payments across the UK and found that there was widespread feeling that the uptake of direct payments was hindered by micro level policy and lack of political will to push direct payments forward. It is clear that the care manager role is hindered by fragmented understanding and knowledge of direct payments and this has a distinct correlation with uptake. Indeed, some

care managers suggest that their lack of clarity means that they are unable offer direct payments at all:

“I just don’t understand it. It’s not user friendly. Because I don’t understand it, I don’t think I can explain it” (Clark et al. 2004:41 cited by Lomas 2006: 239).

Research shows that care managers who lack confidence are less likely to encourage people to use direct payments (Lomas, 2006). Priestley et al. (2007) also suggest that the issues identified with knowledge and confidence can be viewed as either training or compliance issues.

Training issues are easier to address through investment and clearer focus on development areas. Indeed, one of the ways to improve the confidence of care managers is through focused training and the use of lead experts or champions within teams. Champions raise awareness, manage concerns, act as points of contact and support care managers through new packages and advise on complex issues as they arise. It has been reported that the use of a direct payment champion can increase direct payment uptake by sixty nine percent (Valios, 2008).

The right to take risk

Hitherto, we have considered the failures of the care manager role to support direct payments within the context of better training requirements or as the result of managerial or bureaucratic gate keeping. However, the issue of compliance is slightly more complex and can be seen in many areas of practice. Care manager concerns about risk and the possibility of harm to recipients are also cited as a reason that hinders uptake (Priestley et al., 2007)

Care managers often express 'anxiety and ignorance' when supporting disabled people to implement direct payments (Glasby and Littlechild, 2002). There appears to be an ongoing belief amongst some care managers that disabled people are not capable of managing direct payments and a resistance to devolve power. Therefore, care managers fail to comply with direct payment legislation (ibid). This is echoed by the Commission for Social Care Inspection (CSCI, 2004:5) who argue that this 'anxiety' relates to professional hegemony and suggest that care managers often hold:

....restrictive or patronising attitudes about the capabilities of people who might use a direct payment and a reluctance to

devolve power away from professionals to the people who use the service.

The oppressive notion that disabled people are unable to 'cope' with managing a direct payment extends to the right to take risks. For example, care managers have expressed that it is their responsibility to 'protect' service users from harm. One of the key elements of the direct payment philosophy is risk enablement through the choice of whether to 'vet' or check the credentials of employees. Indeed, recipients of direct payments do not have to vet the employment or possible criminal history of PAs; only fifty percent of direct payment recipients vet PAs, and forty six percent request references. This matter is a particularly contentious issue amongst care managers with ninety per cent arguing in favour of vetting PAs via Criminal Records Bureau (CRB) checks and it is suggested that references from previous employers should be compulsory (Samuel, 2009). Equally, 85% of PAs are comfortable with being vetted for their job (Adams and Godwin, 2008). However, this is in stark contrast to the wishes of disabled people who assert that risk and the choice to take risks should be considered as fundamental to their human rights (Glasby and Littlechild, 2006).

Some care managers argue that the risks that disabled people take when they use a direct payment compromises their 'ethical duty to empower....and their professional and legal obligation to prevent harm' (Ellis, 2007:407). In addition to concerns about possible risk to the recipient, research asserts that care managers believe that giving money in lieu of directly provided service is a risk which can lead to misuse of public funds:

Can I risk [Direct Payments] . . . on behalf of clients?' (Fruin, 2000:17 cited in Glasby and Littlechild, 2009:136).

Care managers rationalise this opinion through the use of 'justificatory discourses to legitimise access to direct payments'. It is suggested that the issue of risk is used within justificatory discourse as a way of gaining control of service provision (Ellis, 2007:411). Indeed, Brown (2010:9) explains that:

....risk in relation to this innovation [direct payments] was clearly part of the reasoning and rationale given for the professional resistance encountered.

Understanding capacity

There is further evidence of justificatory discourse relating to risk when considering capacity of direct payment recipients (Ridley, 2006). A change to the mental health legislation in 2005 has created a responsibility and duty that care managers should assume that disabled people *have* capacity until proven otherwise. However research has revealed that 58% of mental health practitioners assume disabled people do not have capacity prior to assessment (Pitt, 2010).

Despite the clarification of capacity within the 2005 Mental Capacity Act, care managers continue to argue that the legal obligation to ensure that recipients have the capacity to consent, and are willing to receive a direct payment is problematic (ibid). Research has revealed that people with mental health difficulties are rarely offered a direct payment, as it is felt that the service is neither appropriate nor relevant to those who experience mental health difficulties. Care managers 'justify' this gate keeping by asserting that there is a lack of motivation amongst the service user group to engage with direct payments. Conversely, this is contradicted by people with mental health difficulties who express an interest in direct payments as an option for support (Ridley, 2006).

In contrast to the negative perspectives expressed, research has also shown that care managers were keen to move away from the traditional paternalistic side of care management. For some care managers the reward of autonomy for recipients outweighs many of the concerns outlined. Indeed, care managers often assert that it is more preferable that disabled people have greater control and autonomy of their lives, even if this results in loss of control within the care management role (Stainton, 2002).

A 'threat' to the 'profession'

The idea of giving cash for care is thought to be synonymous with the principles of modern social work; which include values of autonomy and empowerment. Indeed, Ellis (2007:406) argues that;

‘the roots of direct payments in the struggles of disability organisations for the right to independent living mean that they sit comfortably both with anti discriminatory social work....and the social work ethic of promoting self determination’.

Despite these assertions, Glasby and Littlechild (2002a) suggest a unseen reason why care managers show resistance to implementing direct payments. They suggest that care managers are apprehensive

about direct payments as it reinstates the historic link between care management and the draconian actions of the poor law. Historically, the care management role has sought to distance itself from this law by separating the provision of money and supporting disabled people. Indeed, Glasby and Littlechild (2002a: 8) argue;

‘.....that against this background, the introduction of direct payments in 1996 must be seen as a radical departure from current social work practice, re-establishing the professional links to its pre 1948 history’.

Within this context, what Glasby and Littlechild point out that the care management role has a history that needs to be considered and that work to improve care manager perspectives needs to consider the impact of such a litigious history.

Other concerns raised by care managers include apprehension that direct payments threaten professional roles. Response to the inauguration of direct payments range from acclamation from the disability living movement that its investiture was a pivotal moment in British social policy, to concern from local authorities and unions that direct payments are ‘little more than privatisation by the back door’

(Hasler, 1999:7 cited in Glasby and Littlechild, 2006:19). This dichotomy of concern has also been evidenced by the views of care managers; some welcomed direct payments suggesting that the policy offered a way of implementing the traditional values of social work (Stainton, 2002), whilst others doubt the capability of disabled people to manage their own support package and criticise the policy by asserting that it is a 'step too far too soon' (Fruin, 2000:17 cited in Glasby and Littlechild, 2006:19).

Discussion

This chapter has reviewed existing literature in relation to care management and direct payment implementation. Indeed, it has revealed that care managers continue to be noted as a key barrier to uptake fourteen years after the inauguration of the direct payment act. Despite the fact that direct payments uphold anti discriminatory and anti oppressive paradigms of social work practice; implementation is hindered by care managers who gate keep services via managerial and bureaucratic means. Reasons for such gate keeping include concerns about risk, control and threats to the professional role.

The proceeding chapter will outline the method used to gather new research data.

Chapter Three – Investigating care manager perspectives

Introduction

This chapter will discuss the methodology that underpins this study. It will outline the methods used to gather care manager perspectives and provide an overview of the justification for the chosen methods.

It is noteworthy that in line with academia this dissertation is written in the second person (Page, 2009). However, as this section contains information about personal experiences of the researcher during the study, it seems prudent to write in the first person for this section.

Research background

Bell (2001) explains that good research outlines its implicit and explicit understanding of the research problem and the key to avoiding prejudice within data collection. Research academia frames this declaration within the philosophy of ontology. Ontology refers to 'assumptions that underpin theories about what kind of entities exist' (Abercrombie et al., 2000:246). A good researcher is aware of the conditions that their implicit and explicit assumptions manifest, egress and extend (Blaikie, 2009). In addition to ontology, it is important to outline the theory of how our knowledge develops; i.e. what scientific model or theory

underpins our assumptions? Research philosophy explains that 'the theory of how people come to have knowledge' is defined as epistemology (Abercrombie et al., 2000:120).

Within this context, the rationale for this study stems from the ontological perspective that disabled people have the autonomous right to choice and control when deciding what support they may require as active citizens. I work as a care manager who implements direct payments and my ontological assumptions have developed through discussion with disabled people; observation of oppressive welfare practice; and a personal passion for equality. This viewpoint is in conflict with the insight that despite asserting the principles of independent living; care managers are hesitant to implement direct payments and implicitly and explicitly gate keep the service. I have come to understand this through the epistemological viewpoint of professional hegemony (Illich, 2005). Indeed, I have developed an explicit objection to being partisan to the oppression of disabled people's rights through welfare practice.

I have developed my understanding of disability as a political issue through the adoption of the social model of disability (Oliver, 1996). This epistemology has helped me understand how and why I have ontological assumptions about professional hegemony and disability equality. It has

also helped develop my understanding of the research problem. I am aware that direct payments offer care managers the opportunity to engage with the social model of disability. This model is now an 'integral part of their overall commitment to human rights, anti-discriminatory practice and empowerment (Butler and Pugh, 2004 cited in Trevillion, 2007:938). Furthermore, I recognise the limitations of the care management role in relation to a social interpretation, and understand the irony that 'professionals' are part of the social barriers that disabled people experience:

'...social work is, at best, irrelevant or, at worst, a profession that is likely to actually stand in the way of people getting their needs met'(Barnes et al., 1999; Johnstone, 2001 cited in Trevillion, 2007:939).

The notion of social workers 'standing in the way' of disabled people accessing services is evident in the way they gate keep direct payments (Ellis, 2007). This presents disabled people with yet another socially constructed barrier. Disabled people have the right to access appropriate and emancipatory based support such as direct payments but this access is often blocked by professionals who control service allocation and eligibility (Morris, 1993). This study attempts to gain an

insight into the beliefs of care managers to establish possible reasons for this, and offer pragmatic recommendations to overcome some concerns.

Risk and Ethics

In addition to outlining the study rationale, there are key risk and ethical considerations that should be considered. The British Sociological Association (2002) supplies a framework to guide researchers through ethical considerations. These include: voluntary participation; permission; confidentiality and anonymity. To meet these standards I conveyed to care managers that participation was voluntary; explained participation constituted permission to use data; outlined how the data would be presented, and advised that a report that would be passed to senior management.

Confidentiality and anonymity were particularly important considerations. I agreed to produce a summary report to the chief executive to reciprocate permission to carry out the study. Therefore, the quality of data collected would be jeopardised unless I guaranteed anonymity. In addition to protecting the participants from conflict with their seniors, it also protected me from potential conflict with my work colleagues should

the findings of the research be deemed controversial (see Babbie, 2005).

Collecting perspectives

Data to investigate the research problem occurred in four stages. The first stage critiques existing literature; the second stage involved compiling and distributing self completion questionnaires to care managers and the third stage consisted of one to one interviews with care managers. The final stage was the analysis of the data gathered. We shall now explore these methods in more detail.

Stage one – reviewing existing literature

Blaikie (2009) explains that examining existing literature is fundamental to understanding and validating the research problem from a variety of sources. I noted the advice of Becker and Bryman (2005) who assert that the most reliable sources of literature include articles, journals, books and professional magazines. These sources are trustworthy as they have been scrutinised by noteworthy academics and professionals. Although professional magazines do not go through the same scrutiny process, I felt that they are an important part of the literature review as they can provide current attitudinal data.

As a researcher who has previously studied the uptake of direct payments at undergraduate level and a care manager who is exposed to the research problem; I anticipated that the literature review would be straight forward. However, I found my pre-existing knowledge complicated my critique and I failed to follow Blaikie's (2009) guidance of framing my review around the research questions. Therefore, my literature review amounted to several revised versions and took longer than I expected. This resulted in a delay in getting my surveys out to care managers.

Stage two – Self completed surveys

The second stage of investigating perspectives involved surveying care managers. Having researched several methods to collect data (see Babbie, 2005; Blaikie, 2009; Creswell, 2008). I decided to adopt a cross sectional method. This involved sampling a small number of care managers to gain insight to a larger population of care managers (Babbie, 2005). I decided to that most efficient way to collect data was via an email survey. The primary justification for this was cost. As I work in the sample local authority I have access to the relevant email addresses. I opted to use an online survey tool as the geography of the care managers' offices would have made personal collection difficult and costly.

I was aware that self-completed surveys tend to have a lower participant return rate (Bryman, 2008). Therefore, in order to encourage participation I attended team meetings to promote the survey, and also the local authority direct payment forum where members of each teams attended. I had a return rate of 53%, and a survey completion rate of 89%. According to Babbie (2005) a response rate of 50% is considered acceptable rate for effective research. Initially I believed that 11% of care managers did not fully complete the survey, however, when I analysed the data I discovered that I had set up the online tool to allow care managers to move on from a question without fully completing it. I was fortunate that most care managers had completed the survey correctly, and although something to be aware of in the future; I did not feel that it jeopardised my findings or analysis.

The demographics of participants were interesting for example: 25% of respondents work with people who have physical impairments; 23% older people; 20% learning impairments. Indeed, it is interesting to note correlation between the demographic of participants to the survey and the demographic of people who use direct payments (Davey et al., 2007). Disappointingly, there was a 0% response from the mental health care managers. This appears to be a consistent research problem. Research commissioned by the Welsh Assembly Government

in 2007 (Social Interface, 2007) had the same difficulty with 0% response rate from mental health care managers. Babbie (2005) explains that researchers should be mindful that the data collected is more likely to be from those partisan to the topic. In hindsight, I should have considered demographics more. If I were to repeat the study I would spend more time with care managers from the lower uptake demographic to encourage participation.

One of the biggest difficulties with the survey was that the online tool limited me to ten questions. In an attempt to overcome this difficulty I decided to use attitudinal scales asking a broad question with several specific answers. I also decided to use the 'forced choice method' to avoid participants opting for the neutral option (Winstanley, 2009). This resulted in some care managers selecting 'other' or expanding their point, which made collecting the response in a quantitative form problematic. However it did provide some interesting qualitative data that I was able to use when developing my questions for the one to one interviews.

Stage three – one to one interview

As part of the self completed survey, I requested volunteers to participate in one to one surveys. I had a return rate of 26%. I

anticipated that I would have more control over completion rate but sickness, annual leave and diary priorities meant that I was only able to complete ten (71%). I was particularly concerned about the return rate for one to one interviews and was seeking a return rate of 50%. Babbie (2005:271) warns against 'response bias' when return rates are low, and I am conscious that the demographic of respondents was bias as 50% of the respondents were care managers working with young adults with physical impairments.

Although, I was concerned about the uneven demographic of respondents, I decided to use the information as I felt the responses were of good enough quality. It is noteworthy that had I been relying on one to one interviews only that it is likely I would not have been able to carry on with the research as the return rate would have been too low to offer effective data analysis (Babbie, 2005). Furthermore, I decided to use a semi standardised approach to the interviews. This allowed me to follow a similar pattern of discussion but meant that I could expand on certain points (Sarantakos, 2005). I recorded interviews by Dictaphone and interviews were transcribed. On reflection, I feel that I should have used a more structured approach to the questions. There was little consistency in responses and I feel that if I had been more specific in my question schedule then I would have had uncovered better quality data.

Copies of the transcribed interviews are available on request and the interview schedule is available in Appendix B.

Stage four – data analysis

In order to analyse the data collected during the surveys I used an attitudinal scale known as the Likert scale. This allowed me to collect the perspectives of care managers by requesting that they identify where their perspective sits on an attitude continuum (May, 2001). As I used an online survey tool, I was able to see the results of the self completed survey immediately as quantitative data. However in order to analyse the data collected during interviews I coded the responses by themes. This helped clarify the points made and also meant that I was able to access qualitative statements to compare with the data gathered during the literature review and surveys.

As I had chosen to use a semi structured method for my interview, some data was not suitable for comparison, however I was able to use the qualitative data to support the quantitative data and identify patterns of information (Babbie, 2005). Comparing my core aims to the findings highlighted that whilst it was clear the issues identified in the literature review were validated; there were concerns being cited that I had not

identified. This provided me with the opportunity to discuss and analyse a new area of the research problem.

From an academic perspective, I found analysis the most challenging part of the study. I hold strong values in relation to professional hegemony and direct payment uptake. This caused me some difficulty initially as I tended to have bias to data that was partisan to my values. I also struggled on times to identify data that demonstrated implicit perspectives. However, once I had become aware of this, I was able to address the issue by being explicitly objective.

Discussion

This chapter has outlined how data was generated. Overall I was pleased with the return rates for the survey, however disappointed about the low uptake for one to one interviews. I was initially concerned about the fragmented demographic of participants however, feel that the data quality was of a good enough standard to proceed. I learned a great deal about the importance of appropriate questions and in the future would consider using a more structured approach to my interviews so that I can gather more specific data relating to the research problem. Furthermore, I feel that some additional research into the 0% uptake of

care managers who work within mental health teams is needed. We now turn to Chapter four which discusses the findings of the study.

Chapter Four: Fourteen years later

Introduction

This chapter explores the data gathered during the self completed survey and the one to one interviews. Focus is given to the key themes of suitability; rationing information and concern relating to a two tier social care system. We now turn to the former theme of suitability.

Suitability

Legislation such as The National Assistance Act 1948 and the NHS Community Care Act 1990 state that care managers have a responsibility to assess an individual's needs before deciding eligibility (Clements and Thompson, 2007). The reality is that care managers often make assumptions about who is suitable to receive services prior to assessment (Pitt, 2010). As part of the survey, care managers were asked whether or not individuals were 'suitable' to receive a direct payment based on impairment; 100% felt that direct payments were suitable for adults who had a physical impairment; 94% felt direct payments were suitable for people who had a sensory impairment; 86% for older people; 76% for adults who have a intellectual impairment; 71% thought direct payments suitable for carers; and 69% suitable for adults who experience mental illness or distress. Similar to the demographic of

care managers who took part in the survey, the division of perceived suitability reflects the general uptake of direct payments across the UK (Davey et al., 2007).

The data also revealed some draconian assumptions about disabled and older people. For example, the assumption that older people are fragile and unable to 'cope' with a direct payment:

...It's [direct payment] too much responsibility for older people. They are frail and need our help, not us giving them more stress (Care management assistant, older persons team).

The data also identified the assumption that because a person has a sensory impairment that they cannot manage paperwork or other duties associated with being an employer:

...difficulty for people with sensory impairments to manage (Social Worker, Older Persons Team)

And the assumption that all people who have intellectual or mental health impairments lack capacity:

...only people who have capacity therefore difficulty giving to learning disabilities (sic) and mental health service users (Social Worker, Older Persons Team).

Some care managers express their concern within the context of medical model discourse, but there was recognition of socially constructed barriers. This was particularly evident in one area: capacity and ability to manage a direct payment. Although 38% of care managers felt that direct payments placed too much responsibility upon recipients, they consistently expressed that they felt direct payments were the preferred and/or more suitable option for people. However, 34% of the care managers' surveyed expressed concern about how an individual would manage the paperwork and responsibility of being an employer.

Direct payment legislation states that the disabled people can be recipients of direct payments with or without support (WAG, 2004). The care managers surveyed expressed unease at implementing direct payments for those who do not have family or friends to support them:

If you have got somebody who has no family or friends or has but [the family is] not willing to take on that responsibility.....you can see how direct payments would make a difference to their lives but

yet you can't do anything about it because there's no support there
(Social Worker, Hospital Team).

The same care manager identified a solution to the problem and expressed frustration that the service was not in place already:

It's managed accounts; I think we need to shift ourselves basically and get it sorted. We have a solution to the problem, it's there on our doorstep but we are slow on the uptake (ibid).

A managed account is a service where the individual retains the responsibility of being an employer and the autonomy to make decisions about the support package delivery. The direct payment is made to a third party who can manage bank balances, timesheets, payroll etc (WAG, 2004). Importantly, disabled people retain the right to choose to use a managed account. Although one care manager was unaware of their legal responsibility and felt that the choice to use a managed account rests with care management. The same care manager stated:

...It's about our professional judgement. If we think that a service user cannot manage but we feel a direct payment would offer the best service option then we should be able to offer a direct

payment but *only* via a managed account (Social Worker, Older Persons Team, my emphasis).

However, a recent court case, *H v X City Council* [2010] EWHC 466 (Admin) clarified that local authorities *do not* have the power to enforce managed accounts. The judge at the case argued that the:

...condition that the payment should go through an intermediate account is inconsistent with the nature of direct payments (British and Irish Legal Information Institute, 2010: note 56).

It remains questionable as to whether or not local authorities are really dealing with the real barriers to uptake. Those who critique professional hegemony and political rhetoric argue that professional gate keeping is encouraged through the discretion allowed to professionals when assessing whether an individual is willing and able to consent and/or manage a direct payment (Barnes and Mercer, 2010). It is anticipated that recent changes to direct payment legislation exemptions will go some way to improve the loophole of discretion (DoH, 2009).

The data also identified that some care managers see the benefits of direct payments and expressed that direct payments should be available to all:

I feel direct payments are suitable for all client groups (Care Management Assistant, Community Support Team).

In addition to data relating to suitability, the survey also revealed some interesting perspectives about care managers and access to direct payments. We shall now turn to this topic.

Rationing information

The Department of Health (2006:82) asserts that care managers have a responsibility to ensure that direct payments are 'discussed as a first option with everyone, at each assessment and each review'. However, research carried out by Clark (2004) found that care managers often fail to offer information on direct payments until crisis point. Of the care managers surveyed within this study, 92% stated that they understood that it was their responsibility to discuss direct payments following the assessment of an individual's need, but 20% of care managers stated that they did not discuss direct payments at assessment. Only 17% of care managers stated that they discussed a direct payment at review.

Some care managers asserted that their role was not to discuss direct payments as they were there to review:

...existing services [and] not there to introduce new services
(Social Worker, Review and Monitoring Team).

I do not offer at review as I am there to review existing services
only (Care Management Assistant, Review and monitoring team).

The denial of discussing alternative support options is not only against the Department of Health's assertion but also goes against the code of practice that care managers adhere to (Care Council for Wales, n.d.).

Some care managers recognised that they should be doing more:

I do feel I should be offering DP on every occasion. I feel I do this
in most cases but should really be improving on this (Social
Worker, Older Persons Team).

Some care managers attempted to justify the lack of discussion by citing work based pressure as a defence for not acting on their responsibility:

...[I] am inconsistent due to time and discharge pressures (Social Worker, Hospital Team).

In addition to the bureaucratic gate keeping by care managers, there was evidence of managerial gate keeping:

...due to the economic climate we are not allowed to offer DP without speaking to our team manager first. (Care Management Assistant, Adult Disability Team).

Similar to the research conducted by Ellis (2007), this study substantiated that care managers often make the decision on whether disabled people should have a direct payment or direct service.

Therefore, they did not offer any information at all:

...people need support and things sorted out for them...they don't want to be lumbered with more responsibility... (p. 413).

... [Direct payments] take time, you can't rush.....the family is stressed; the [service user] is stressed they just want to get out of hospital; the ward is stressed and you know putting an agency in is a fast way of meeting their needs. (Social Worker, Hospital Team)

Indeed, as Ellis (2007) explained, the care managers surveyed also expressed justificatory discourse to defend decisions:

We're...dealing with a crisis so it's not the right time...I think the best time is when they're home and the review team are seeing them....when things have settled (p. 413).

The community team discuss direct payments at review when the service user is back home (Social Worker, Hospital Team).

However, as we have already noted the assumption that the community team will discuss direct payments at review is misguided:

... [reviews are] only to check the current services we're providing and make any changes, so it's [the direct payment option] not relevant really (Ellis, 2007:414).

Disabled people argue that the retention of information on direct payments by care managers is a 'deliberate strategy' (Clark, 2004:81).

Despite the fact that 98% of care managers surveyed acknowledged that their role was to offer information, only 21% of care managers felt that

this information should be offered at review. In fact, some care managers believed that was the responsibility of disabled people to ask for a direct payment:

... if people *tell me* they want to change to direct payments that is not an issue and can be carried out (Care Management Assistant, Review and Monitoring Team, my emphasis).

This data appears consistent with the notion that care managers often view direct payments as the last option, or present direct payments as the alternative following expression of dissatisfaction of directly provided services (Clark, 2004; Ellis 2007). The care managers surveyed offered a variety of justifications for the lack of information being offered to disabled people. This includes the suggestion that the lack of available printed information hindered their ability to discuss direct payments. Interestingly, although 92% of care managers viewed their role as verbal information providers, they contradict this acclamation by expressing that leaflets, websites and information packs are what are needed to deliver information on direct payments.

...information packs/leaflets would be a good start (Social Worker, Community Support Team).

...people need...step by step guides; people like to have a leaflet that they can read when we leave (Social Worker, Older Persons Team).

Some care managers discharged their responsibility to provide information all together by suggesting that this role should be done by a third party or advocate:

I would prefer some aspects of Direct payments to be explained by the [support service] (i.e. the impact of becoming an employer) (Social Worker, Older Persons Team).

The perspectives of the care managers surveyed are not isolated. Davey et al. (2007) also found that care managers felt that they were unable to fulfil their role in relation to providing information on direct payments. Whilst there is no dispute that information is extremely important and is part of 'The seven needs of Independent Living' (Greater Manchester Coalition of Disabled People, n.d.); it does seem extreme that care managers ration discussion about direct payments due to lack of written information. It is not clear from the data whether the concerns of the care managers relates to accessibility and/or alternative forms of information

such as Braille or whether it related to general leaflets. What is clear is the sample local authority needs to invest in this area.

Two tier system

In addition to concerns about the misuse of cash, some care managers articulate that direct payments have created a two tier social care system where the type of service provided is dependent on whether disabled people are in receipt of direct payments or direct services:

...I have seen care plans that give direct payments for walking someone's dog or planting flowers – now someone who is in receipt of homecare or an agency isn't going to get that level of support (Social Worker, Older Person Team).

Many of the care managers surveyed cited the flexibility of direct payments as a core benefit yet continued to allude that this flexibility hindered their rationale to support direct payments as they felt it compromised the equity of service delivery:

...it really frustrates me that someone who gets direct payments can use that money to employ a PA who can do cleaning and domestic work but someone who has homecare does not get the

same service and often has to employ an external agency. It's not fair (Social Worker, Hospital Team).

The reality of the situation is that rather than *create* a two tier system, direct payments continues to *expose* the failings of traditional directly provided services and depict the effects of fragmented care management. Indeed, it was these shortcomings that were the catalyst for direct payments (Zarb and Nadash, 1994). Some care managers recognised the shortcomings:

...the old service which is you know home care coming in just isn't up to scratch ... they [disabled people] don't want to give someone a shopping list and tell them to go and do it themselves. They want to be able to go out to get their own fruit and veg....and that's what direct payments can do (Social Worker, Hospital Team).

This opinion was not isolated to the care managers surveyed. Research by Pearson (2006) also found that care managers embraced direct payments as the alternative to inadequate and inflexible directly provided service:

I feel a lot of people go for direct payments because it is more flexible and it is the only option to inflexible traditional services (p.16).

Interestingly, some care managers expressed concern that direct payments were creating additional demand on Social Services:

We have lots of people who've stayed away from our door because they didn't want our services, but with the option of having a direct payment, want to [deal] with us, it's generated demand for direct payment service (Team Manager cited in, Pearson, 2006:17)

...so it is not replacing or making delivery cheaper because if they didn't have direct payments they wouldn't have the service at all (Social Worker, Adult Disability Team).

Conversely, what care managers and local authorities should be focusing on is ensuring that appropriate assessments and support levels are in place. This can be observed via effective financial monitoring (Lewis, 2005). The monitoring that is done is based on financial accountability under the local authority's responsibility to 'ensure that

public funds are spent to produce the intended outcomes' (WAG, 2004:32). Potential complications with direct payments can be overcome via quality assessments that are clear about what direct payments should be spent on and followed up with monitoring to identify any areas where a direct payment recipient may require support (Lewis, 2005). However, the research data from the sample authority identified a mistrust of the capabilities and efficiency of financial monitoring officers:

...It's how the money is spent once we have given people the money I am not sure we have been on the ball enough really (Team Manager).

...they [the local authority] need to have specialist direct payments people in finance who can keep a handle on it really because at the moment the feedback from finance is that they can't cope with it (Senior Social Worker, Adult Disability Team).

Notwithstanding these challenges, it was also evident that some care managers have already considered strategies to overcome difficulties:

...there may be concerns about the money being misspent but an outcome focused care plan and regular reviews should overcome this (Social Worker, Older Persons Team).

Discussion

This chapter has explored some of the key themes that emerged from the data obtained in the survey and during the one to one interviews.

The data appeared to be consistent with existing literature and provided us with statistical information to gain more insight to the problem. The data appeared consistent with Rummery and Glendenning's (1999) typology of gate keeping and highlighted that the sample local authority needs to develop its commitment to direct payments. In conclusion, it was predicted fourteen years ago that care managers would be a barrier to direct payment uptake (Oliver and Sapey, 2006). This chapter has confirmed that this remains the case.

Chapter five – Making up the rules?

Introduction

This chapter focuses on the data collected during the study that suggests care managers appear to implementing direct payments through street level bureaucracy. It also considers the most consistently cited issues from the data gathered from care managers. This is the concern from care managers in relation to the role of carers, family and friends as PAs.

Street level bureaucrats

Care managers argue that ambiguous legislation and social policy prevent them from implementing direct payments (Davey et al., 2007). 66% of care managers who completed the survey stated that they had not received direct payment training, this figure was considerably higher than other research such as Stainton (2002) who reported a much lower figure of 47%. Lack of training or information on direct payments was a reoccurring theme throughout the findings:

...the training has been minimal. For years there has been no ongoing training. They implemented a new policy, everybody was

brought up to date on the policy and that's it, no training (Social Worker and Team Manager).

Similarly, some care managers expressed that they had attended training but it had been inappropriate and/or did offer care management guidance rather an update of policy:

I have attended training; however this training did not offer what I needed. The DP policy is too sterile - we need a care management guide to implement policy not a policy for policy makers (Social Worker, Older Persons Team).

This lack of information and training is clearly linked to a lack of confidence expressed by care manager as 57% stated that they lacked confidence or were unsure about how to implement direct payments:

I have no confidence in implementing direct payments, even though I think they would provide a good alternative option (Social Worker, Community Support Team).

Ellis' (2007) research into direct payments links care manager ambiguity and lack of confidence to Lipsky's (1980) theory of 'street-level bureaucracy'. Lipsky's theory argues that care managers who do not understand policy develop their own subconscious eligibility criteria. This 'self' interpretation leads to inconsistent practice. Lipsky highlights that social policy is only made effective by those who implement it. Within the context of direct payments, Lipsky shows us that care managers are key to uptake and their perspectives influence not only their practice but also the consent of disabled people to choose direct payments as a way to receive support.

The concept of street level bureaucracy was evident throughout the data collected. Care managers assert that they work through challenges as they happen rather than develop understanding of policy:

...you basically meet a problem, try to figure it out and you remember that for next time, so its trial and error really (Social Worker, Hospital Team).

Care managers recognise that their lack of understanding leads to personal interpretation. One care manager highlighted the problem by linking street level bureaucracy to a postcode lottery:

...the problem is, until we get a clear consistent advice or guidance, we continue to interpret things our own way. I review packages where I know that people have been given the wrong advice.....It's a postcode lottery in this authority (Social Worker, Older Persons Team).

Indeed another care manager highlighted how basic some of the lack of understanding is and offers real insight into why some care managers shy away from offering direct payments:

...we need to know really basic things like what can we use DP for? Some authorities use it for gardening, cleaning, they pay expenses such as meals – we have no guidance. How can you offer a direct payment if you have no idea about how it should be used? (Social Worker, Older Persons Team).

It is evident that care managers gate keep direct payments because they do not understand how they should implement them and thus avoid the topic. The lack of confidence and ambiguity expressed by the care managers surveyed is not isolated to the sample authority. Indeed, the perspective is also evident in a variety of other research:

“It’s daunting to offer something that you don’t fully understand yourself.” (Clark and Spafford, 2002:252 cited by Glasby and Littlechild, 2009:139).

“It is my lack of practical experience in direct payments that affects my confidence in this area” (Lomas 2006:242)

57% of the care managers surveyed argued that part of their role as a care manager is to develop direct payment policy. Hitherto, care managers cite what is wrong with policy but there is little evidence within the data to suggest a desire to overcome these barriers:

...the care management role needs to be more politically active.

This includes the development of policy. We should be informing policy developers of the opinion of the 'shop floor'. However, policy developers and principle officers need to listen more. I do not feel that that we are listened to - but that’s just the way it is in within local authorities.....isn’t it? (Care Management Assistant, Older persons Team).

Indeed, some care managers saw a place in the care management role to development direct payment policy:

...Information can be fed into policy development by frontline workers (Social Worker, Review and Monitoring Team).

As we have discussed, the availability of a specialist direct payment team can increase the uptake of direct payments by as much as 68% (Valios, 2008). The care managers surveyed stated that they would feel more confident about implementing direct payments if they had a single lead officer that could offer consistent information:

...we need a lead officer that we can turn to (Social Worker, Older Persons Team).

...I think if people felt they had the backing, [i.e.] a named person to go to with their queries or concerns and got more involved in direct payment development (Social Worker and Team Manager).

Money worries

In addition to the need for training and support, care managers also identified that there was a need for consistent financial management and monitoring of direct payments. 45% of the care managers surveyed were concerned that direct payments would be misspent. The issue of

direct payment misuse was apparent throughout the research data. One of the care managers surveyed suggested that some disabled people *only seek* a direct payment as they have debt and view direct payments as income:

...we have had lots of cases of people in debt who only want direct payment and of course the term direct payment ...well it has connotationsof being a type of income (Social Worker, Adult Disability Team).

This was also evident in research conducted by Pearson (2006:19), but the major difference was that the care manager in this case expressed clearly that they would ration access to direct payments:

...your assessment may be that there's an ulterior motive for it. I work in an area – a very poor area, poverty is rife. And there's quite a few cases where its [direct payments] an income to the family and in those cases we'll say no.

Some care managers used discourse such as 'fear' when discussing concerns over misuse. One care manager expressed that the culture

within the sample local authority was based on the assumption that disabled people misspend direct payments:

...there is a belief in this LA (local authority) that people will misspend [direct payments], people are reluctant to implement [direct payments] as they fear they will be misspent (Social Worker, Sensory Support Team).

70% of those surveyed rated their role in ensuring that money is spent to meet needs as important or very important. 50% stated that their role was important or very important to ensuring that only 'trustworthy' people received direct payments. Interestingly, despite the assertion that the role of a care manager is to manage how money is spent, 60% stated that they were not concerned about who was liable if a support packages that uses direct payments breakdown.

It is inevitable, as with many areas of life that people may take advantage of a situation however, Glasby and Littlechild (2009) assert that there is no evidence to suggest that direct payments are misspent. Despite this, one care manager took their concern about debt a step further:

...I think that if a service user has debt that means they are unable to manage their finances and should not have a direct payment.

They should only be offered a direct service or a managed account (Social Worker, Older Persons Team).

Apart from the above statement being unlawful (WAG, 2004; British and Irish Legal Information Institute, 2010), the assumption of linking debt to poor financial management is not a fair postulation. Due to the social barriers that disabled people face in employment, disabled people often live on low incomes and/or are in receipt of state benefit. It is more likely that disabled people will live below the poverty line (Barnes and Mercer, 2010). Research indicates that 74% of disabled people have credit card debt and 53% depend on an overdraft to meet the additional costs *associated with* impairment (Kober, 2005). Therefore, to rationalise gate keeping of direct payments on the basis of debt seems nonsensical as to do so could potentially exclude a significant number of disabled people. Furthermore, direct payment legislation dictates that a recipient must not be treated any differently to those who elect to receive support via a directly provided service (WAG, 2004). As such, it is difficult to envisage that a care manager would gate keep in-house homecare services because a recipient had debt. This point suggests that the articulation by Glasby and Littlechild (2002a) that care managers resent the connection

of professional practice and 'cash for care' persists. This was tested within the research data. For example, 7% of care managers agreed that their role was to promote independence of individuals by giving 'cash' in lieu of direct services. In contrast, when the word 'cash' was removed from the question 87% of care managers agreed that it was their role to support disabled people to access direct payments to promote their independence.

Employing family as PAs

In addition to concerns about misspending direct payments, the care managers surveyed also expressed concern about the choice of PA that direct payment recipients employed. Similar to research by Social Interface (2007), 57% of care managers articulated that they were hesitant to implement direct payments as they were concerned that disabled people would employ family to carry out duties that they were already doing as part of the family role. Direct payment legislation explains that disabled people can use direct payments to employ family members with the exception of:

...a spouse (husband or wife), from a partner (the other member of an unmarried couple with whom they live), or from a close relative

(or their spouse or partner) who live in the same household as the direct payment recipient (WAG, 2004:24).

Section 97 of the guidance issued by the Welsh Assembly government argues that this restriction is:

...is intended to apply where the relationship between the two people is primarily personal rather than contractual, for example, if the people concerned would be living together in any event (ibid).

Within this context, there is an assumption from care managers that family members who are employed to carry out PA duties 'should' be carrying out these duties 'in any event' as part of the traditional family role:

...I have found [within this local authority] that there is an issue regarding family member being paid for support that they were already providing as informal carers (Student Social Worker, Review and Monitoring Team).

Some care managers failed to link the right to choose a PA as part of the fundamental philosophy of direct payments, instead linked the choice of a family member as a PA as abuse of the 'system':

...there's an opportunity for abuse within the Direct Payment system because you can employ friends and family (Social Worker, Adult Disability Team).

...people could be employing family and could not be doing the hours they're doing (Care management assistant, Adult Disability Team).

...you get the feeling that [the service user] has abused it to pay family members for perhaps things they were doing anyway (Social Worker, Adult Disability Team).

Research conducted by Carers UK in 2008 found that 74% of direct payment recipients employed a friend or someone they already know. 45% employed a family member and 65% of recipients felt that the direct payment guidance should be changed so that it is easier to employ a family member (p.9). However some care managers appeared more concerned with the shift in boundaries and family roles:

I know of a case where sisters have been living together supporting each other as a family unit and then along comes direct payments and suddenly all the dynamics change – its employer and employee. It destroyed their relationship (Social Worker, Hospital Team).

...payment [used to employ] family can be complex...issues [with] boundaries (Social Worker, Older Persons Team).

It is unclear from the research data if the concerns of care managers relate solely to the belief that to employ a family member compromises the traditional family role and can cause difficulties and/or family breakdown, or whether such perspectives mask an implicit assumption that some disabled people are abusing the policy. For many years disabled people have fought the notion of services being focused on family and friends as it maintains the construction of dependency (Hasler, 2004; Elder-Woodward, 2007). Research has identified that the most effective way to support carers is by providing services to disabled people (Glendinning and Arksey, 2008 cited in Beresford 2008).

However, it is important to acknowledge the bias of policy makers in relation to carers. Unpaid carers contribute the equivalent of £87 billion

of unpaid care each year and the commodification of carers is evident throughout social policy (Beresford, 2008). From a broader perspective, some of the comments of the care managers may mask implicit concerns about the privatization of social care. Indeed, this concern is reflected by influential collective organisations such as Unison (2005).

Notwithstanding these assertions, what is clear is that supporting disabled people's autonomy to decide who they purchase support from, be that family or not, is empowering. Whilst there is research that discusses PAs developing friendship with direct payment recipients (see Woodin, 2006) there is little information available to evidence the short and long terms impact of employing family or friends as PAs and more work needs to be done in this area.

Discussion

This chapter has discussed how care managers argue that ambiguous legislation and policy affects their ability to implement direct payments. We have also seen how this uncertainty has led the development of street level bureaucrats who 'make up the rules' as they go along. Care managers argue that they have sought appropriate and reliable training but remain dissatisfied with the low level of support from managers and training departments. It is unclear from the data whether the issue

relating to training is a true training or compliance issue (Priestley et al., 2007). Further study needs to be done to clarify this.

We have also seen that there is clear evidence that care managers are hesitant to implement direct payments as they work within a culture that believes that there is a risk of direct payments being misused or misspent. Furthermore, care managers are concerned that disabled people who choose to employ family members as PAs are at worst abusing 'the system' and at best are risking breakdown of family relationships. In contrast to concerns in relation to ambiguous legislation, the law has provided clear guidance on the use of direct payments and family members. Regardless of this, care managers continue to assert suspicion of those who choose to employ a family member.

Chapter Six – Personalisation: a chance to move on?

Introduction

Hitherto we have discussed the findings of the survey and interviews. This chapter will explore the potential impact that the personalisation agenda can have in relation to the care management role and direct payments. We will begin with a brief overview of personalisation.

Infancy, adolescence and adulthood

Direct payments are now viewed as a significant variant of the personalisation agenda and as part of modern social policy in the UK. In contrast to service led social work practice, personalisation places individuals at the centre and supports people to guide their support planning (Carr, 2010). Leadbeater (2004:19, cited by Lymbery and Postle, 2010:5-6) argues that personalisation is a:

...new script for public services, where service users have more control over the services they receive and more choice about both what they are and how they are provided'

As the personalisation agenda progresses, direct payments are moving away from being part of the direct service 'v' direct payment choice and is being incorporated into broad agenda of self-directed support (Glasby and Littlechild, 2009). Self directed support ensures that decisions about support are controlled by disabled people. It ensures that assessment for support is transparent and that any assistance with support planning should be done in collaboration with the individuals' closest networks. Self directed support also seeks to ensure that disabled people control financial resources and spend this as they choose (Duffy, 2008 cited in Carr, 2010:6).

The concept of self directed support is not new and schemes such as the Independent Living Fund (ILF) have been in place for decades. Direct payments and the subsequent personal and individual budgets are variants of this type of funding (Renshaw, 2008). In contrast to direct payments where cash is in lieu of directly provided social services, personal budgets are an annual upfront allocation of cash from social services. Personal budgets can be taken as direct payments or the funding can be held by social services to pay for directly provided services. Individual budgets vary as the funding stream is from a combination of sources such as: Social Services; Disability Facilities Grants, Independent Living Fund and Access to Work (Samuel, 2009).

Personal budgets are seen as the next step to direct payments. Indeed, Winter (2008, cited in Glasby and Littlechild, 2009:107) discusses the personal experience of evolving from directly provided service to personal budgets in her compelling analogy:

...with hindsight, receiving direct services felt very much like infancy (with no choice and control over your life). In contrast, direct payments felt like adolescence (because of the way they were sometimes operationalised, you have the money to go to the shop, but you had to buy what was on list and bring back the change with a receipt). In contrast, although it was initially very hard work, receiving a personal budget felt like adulthood.

If we consider the perspectives of the care managers surveyed within the context of Winter's (2008) analogy, then we could argue that their perspectives demonstrated practice within the stages infancy and adolescence but appeared less aligned to adulthood. For example, some care managers' demonstrated practice with the infancy stage:

I haven't discussed direct payments because I have years of experience to know that the best thing for [service user] is

homecare where the supervisor make sure that they are 'looked after' (Social Worker, Hospital Team).

There was an overwhelming amount of evidence within the research data to demonstrate that care managers practiced within the 'adolescence' stage. Whilst the care managers articulated the emancipatory principles of direct payments, they contradicted this with concerns about financial misspending and misuse of direct payments for services not on the care plan (or 'shopping list' so to speak). Care managers consistently requested a more stringent auditing and monitoring processes:

...service users must be monitored more closely; when I review direct payments cases, I expect that by using a combination of the review and audit [paperwork] that the service user proves that they are only purchasing services listed on their care plan (Social Worker, Older Persons Team).

...I really feel that we need to be managing and auditing cases more. Sometimes, people are using their direct payments for things that are not on their care plan.....it's a nightmare to sort it

out retrospectively (Care Management Assistant, Adult Disability Team).

The care managers surveyed expressed that they are not ready to move towards 'adulthood' or personal budgets and considered them a 'step too far':

'I know that there is this push around being person centred, personalisation and personal budget etc.... but 'the hierarchy' need to sort out direct payments first. We haven't even had the proper training in direct payments; we need to walk before we run! (Social Worker, Older Persons Team).

These are critical points. The sample local authority is located in Wales and the uptake of direct payments is substantially lower than counterparts in England (Davey et al., 2007). In England, personal budgets are emerging as a standard way to deliver social care (Renshaw, 2008). The Welsh Assembly Government has hitherto expressed interest in personal budgets (WAG, 2006). There are trials ongoing in Wales and it is expected that personal budgets will become part of social care delivery at some point in the future (Wales Alliance for Citizen Directed Support, 2010). In order for the personalisation agenda

to evolve, care managers will need to embrace the principles of both direct payments and the concept of personalised social care. It is suggested that the core ideals of personalisation reflect the central values of social work practice (Carr, 2010). However, Carr warns that personalisation requires:

...significant transformation of adult social care so that all systems, processes, staff and service are geared up to put people first (p.3).

Carr's advice has familiarity and resonates the warning of Oliver and Sapey (2006) who assert that for direct payments to be accepted as an integral part of social care, that a substantial overhaul of care managers' views of disabled people is needed. Similarly, this study verified that fourteen years after the inauguration of direct payments that professional hegemony of disabled people persists. Indeed, some of the care managers surveyed continue to view disabled people as incapable, dependent and in need of state intervention. Care managers need to move away from a culture where they dominate disabled people's right to choice and control to a system where individuals are empowered to assess their own situation and instigate their own support. This calls for a radical change of the existing care management role (Leece and Leece, 2010).

The role of care manager remains undefined within the personalisation agenda (Scourfield, 2010). However, one of the key issues that emerged from this study is the way that the care managers carry out assessment. It is acknowledged that the care manager role extends beyond assessment and a great deal of attention has been given to the role of care management within personalisation (see Ferguson, 2007; Renshaw, 2008; Leece and Leece, 2010; Lymbery and Postle, 2010; and Scourfield, 2010). However, for the purposes of this study, and due to wording limitations, we shall focus solely on the role of the care manager and assessment as an example.

The changing role

Lymbery and Postle (2010:10) discuss the evolving role of the care manager within 'the new world of adult social care' and in particular the changing role for care managers during assessment. As we have discussed in chapter four, care managers often make assumptions about suitability of direct payments for 'service user groups'; pre determine assessment outcome; and fail to inform of and/or offer direct payments. Rather than be part of the gate keeping process required within Fair Access to Care Services (FACs) (Clements and Thompson, 2007), the gate keeping identified by this study is not of social services per se but of direct payments as a service option. The hegemony

expressed during assessment appears to be underpinned by an individual interpretation of disability. This is concerning as assessment is a core component of community care and is 'crucial in enabling disabled adults to obtain support; it identifies whether a person is eligible for support and what is required' (Leece and Leece, 2010:7).

In addition to the evidence within existing literature which argues that assessment for social service support is service led rather than needs led (Barnes and Mercer, 2003), the care managers surveyed cited unease in relation to a lack of equity between direct payments and directly provided services. There was also concern that in an unstable economic climate that funding should be rationed so that only the most basic needs were met. Therefore, care managers tended to steer assessment towards directly provided services that offered more basic support services. Once care manager asserted:

...It seems unfair to me that someone can be assessed for direct payments and receives a service that does their shopping, takes them out to.... say rugby or football and other people cannot because there is no money in the pot. I think in this current climate that we should be rationing direct payments and providing only

personal care services. I make it clear to people that the priority is personal care (Social Worker, Older Persons Team).

It is suggested that one of the ways to overcome professional hegemony during assessment is self assessment. Disabled people argue that they are best placed to assess their needs and that the power imbalance that currently exists during assessment should be displaced. However, self assessment is illegal under current community care legislation as disabled people are not 'allowed' to determine their own eligibility. Nonetheless it is anticipated that true 'self directed assessment'; that is when the individual is placed at the centre of the assessment process and takes the lead for determining needs and outcomes may help alleviate some professional hegemony (Leece and Leece, 2010).

Conversely, Lymbery and Postle (2010:11) highlight that social care commissioners need to 'think beyond the apparent simplicity and reliability of self-assessment as a solution'. They also argue that the care management role has an explicit relationship with gate keeping and asserts that issues relate to poor assessment. They also suggest that the process of care management led assessment should not be underestimated as self assessment assumes that all disabled people

informed about pragmatic support services. This is also supported by Priestley (2004:260 cited in Renshaw, 2008:284) who explains that:

‘...many disabled people have been historically disempowered by dependency-creating welfare services and may lack the confidence or knowledge to make informed choices about the support they need’ (Priestley 2004, 260).

One of the suggestions to rule out power imbalance during assessment may be assessment done in partnership or ‘co-production’ (Renshaw, 2008). Needham and Carr (2009:1) define co-production as ‘active input by the people who use services, as well as, or instead of, those who have traditionally provided them’. This could be further developed through partnership with care managers and centres for independent livings (CILs) (Renshaw, 2008). Within the context of this study, but not suggesting that it is a ‘one size fits all’ solution; co-production, if done in collaboration with CILs could alleviate some of the hegemony by professionals as disabled people’s rights could be advocated by external agencies. Indeed it seems that co-production provides a framework for care managers to re-engagement with the core values and skills of assessment (Needham and Carr, 2009).

Notwithstanding these suggestions, the research data from this study allude that care management is underpinned by an individualist interpretation of disability and therefore care managers also need to engage with a social model of disability. For example, some care managers sought to rehabilitate impairment rather than address the social barriers:

... sometimes you get a referral for [direct payments] to help with shopping *because of* say MS....but you know that what someone needs is say....physio, so I signpost people back to the health service. People think that direct payments are a magic wand solution (Social Worker, Adult Disability Team, my emphasis).

Stevens (2008) suggests that care managers have difficulty assessing within a social interpretation as they are presented with too many 'versions' of the social model of disability and the peers they turn to for clarification often hold vague understanding. Furthermore, social work education has failed to fully inform on the oppressive nature of disability and care managers often rely on other forms of discrimination such as racism and sexism to articulate that they are partisan to anti discriminatory practice. This is exacerbated by confusion of the individual v medical model of disability (Oliver, 1996). Therefore,

professionals hide behind their ambiguity and perhaps expand the irony that they are part of the oppression they profess to work in objection to:

...social workers, nurses and allied health professionals have used the 'medical model' to distance themselves from its negative associations of control, but this has resulted in their failing to address their individualised approach in state welfare provision (Stevens, 2008:200).

Discussion

This chapter has explored the potential that the personalisation agenda has in relation to the findings of this study. Direct payments are a key element of the personalisation agenda and the data from the care manager surveys has identified areas that need to be addressed so that personalisation becomes central to social care in the UK. This is particularly apparent in the area of community care assessments where the data evidenced that care managers are rationing access to direct payments at assessment via lack of information, assumption of suitability and concern relating to service equity.

This chapter concludes that personalisation, if implemented correctly has the opportunity to help care management move away from working

within an individual model of disability and engage with a social model practice, this may be achieved by embracing concepts such self directed support and co-production.

Chapter Seven: Fight against the inevitable or embrace reform?

Introduction

This chapter will bring together the research problem with the theoretical and empirical findings. Finally, this chapter will summarise the implications of the findings and the uptake of direct payments.

Training or compliance

This purpose of this study was to investigate the perspectives of care managers in relation to their role and responsibility with regard to the implementation of direct payments. The study sought to understand how care managers interpret their role and gain insight into how these interpretations affect disabled people's access to direct payments. To achieve this, the study investigated the perspectives of care managers in three ways: firstly, by critical analysis of exiting literature; secondly via an online survey which provided quantitative and qualitative data; and thirdly through one to one interviews with care managers which provided qualitative data.

This study found that despite direct payments being part of the British social care system for fourteen years that uptake remain comparably lower than direct services and that the demographic of direct payment

recipients remains fragmented (Davey et al., 2007). As anticipated, one of the most consistently cited barriers to direct payment uptake is the hegemony of care managers in relation to their role and responsibility to implement direct payments (see CSCI, 2004; Lomas, 2006; Ellis, 2007 and Glasby and Littlechild, 2009). The study found that care managers have specific responsibilities in relation to widening access to direct payments, this includes discussing direct payments as a first option following assessment and during reviews (DoH, 2006). This study found that some care managers are failing to fulfil this element of the role.

Care managers frequently defended the gate keeping of direct payments within the theoretical data (see Stainton, 2004; Ellis, 2007 and Glasby and Littlechild, 2009) and in the empirical data (see chapters four and five). They argued that they did not have the right knowledge or information to be able to implement direct payments. Priestley et al. (2007) argue that justifications relating to knowledge should be considered as either training or non compliance issues i.e. does the research problem relate to training, or are care managers using knowledge to justify their failing to comply with their roles and responsibilities?

Similarly to Ellis' (2007) research, the care managers argued that they were confused by direct payment policy and displayed the traits of 'street level bureaucrats'. There also appeared to be a discourse of complacency from care managers who felt that the responsibility to implement direct payments lay with another team or was the role of another service. The care managers argued that the sample local authority should include their perspectives within the development of direct payments but also appeared to be passive in relation to the expansion of direct payments.

The review of literature and care manager survey also revealed concern relating to financial support services. The issue of financial monitoring is argued as a critical part of direct payment uptake, not only for care managers but also to ensure that direct payment recipients are receiving the appropriate level of support to manage the responsibilities of being an employer (Lewis, 2005). The care managers surveyed expressed that they were unable to fulfil their role and responsibility to care manage direct payments due to the lack of quality auditing and financial monitoring.

One of the most prevailing issues was the elucidation that direct payments (as a concept) is responsible for a lack of equity of services.

Some care managers failed to link the shortcomings of directly provided services and direct payments (as outlined by Zarb and Nadash, 1994). The care managers surveyed argued that direct payments create a two tier social care system and allude that lack of equity compromised their professional values, thus they are hesitant to implement direct payments (also see Leece and Leece, 2006; and Williams, 2006). There also appeared to be a growing concern in relation to direct payment recipient choice of PA. Research identified that a significant number of disabled people choose to employ family and friends as PAs (Carers UK, 2008). This was problematic for care managers who suggest that the employment of family and friends is either an abusive use of direct payments or is a risk to the family role.

This study has confirmed that social care commissioners and policy makers face substantial challenges in the pursuit of increased direct payment uptake. The care managers surveyed express that they wish to improve their knowledge and understanding of direct payments and many of the concerns raised have the potential to be resolved. For example, the research data has shown us that direct payment uptake could be improved via: quality staff training that has a care management focus (Ellis, 2007); and/or the implementation of a direct payment lead officer (Valios, 2008).

The findings of this study support the suggestion that the most significant barrier to direct payment uptake is that care managers continue to practice within the boundaries of the individual model of disability (Oliver and Sapey, 2006). Despite the fact that social work education has attempted to adopt the social model as a standard theoretical viewpoint, it has failed to implement a true social model culture (Stevens, 2008). This claim is consistent with the assertions of Morris (1993) who argues that community care has been developed on the foundations of draconian assumptions of pity and dependency. Furthermore, despite acclamations of being partisan to a social interpretation, the reality is that care managers have difficulty aligning their practice with a social model. Indeed, the findings of the research appear to uphold the assertion that professional hegemony is embedded within community care practice (Oliver and Sapey, 2006).

No way back

The theoretical and empirical data of this study support Illich's (2005) notion of care management as a disabling profession. It has also identified that care managers are preventing disabled people gaining access to a service that has the potential to enable independent living. However, the personalisation agenda in the UK presents commissioners, policy makers and care managers with the opportunity

to engage with the social model of disability and contribute to the reform care management practice. There is no doubt that direct payments are here to stay; they are embedded into the future of a more personalised social care system in the UK (DoH, 2007). This leaves care management with a dilemma; does it continue to fight against the inevitable or embrace the opportunity to be part of the reform of care management and develop a role where the key values of empowerment, autonomy, choice and control can be delivered?

As we have observed via Winter's (2008) analogy, the relationship between the care managers surveyed and direct payments remains in the adolescence stage. However, there are 'green shoots' of hope that some care managers are on the peripheral of adulthood:

...it's about time that my colleagues realise that there is no going back, direct payments are here to stay! They [direct payments] give people the opportunity to grab life and get on with living the way they want to; an opportunity that most of us take for granted (Social Worker, Hospital Team).

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Appendix A – Interview Schedule

1. What has been your experience of implementing direct payments?
2. What do you feel are the benefits of direct payments?
3. What are your responsibilities in relation to implementing direct payments?
4. What do you feel is your role in relation to implementing direct payments?
5. Research suggests that care managers are hesitant to implement direct payments for a variety of reason. Do you agree? If so, what do you feel the reasons are?
6. How do you think direct payments could be developed?