

Remodelling Services for New Contexts

Responding to Community Mental Health Need in Malta

by

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A Dissertation
Submitted to the
Faculty of the Social Sciences
in fulfilment of the requirements
for the Degree of Doctor of Philosophy

University of Leicester
February 2002

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for
Maria
Greta & Gustav

may rich reward repay
all you gave up on the way

Remodelling Services for New Contexts - Responding to Community Mental Health Need in Malta
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Abstract

‘Active Remodelling for Congruence’ (ARC) has been developed by this author as an approach to systematically adapt exogenous models and policies to the context of an adopting country. Models are not imported whole, but analysed into components. The separate adaptability of each component is examined with respect to characteristics of the receiving context.

Simultaneously, a context-congruent service framework is derived and proposed for the delivery of community mental health services in Malta. ARC is used to adapt models from overseas, especially UK. ARC is thus tested out and refined.

Congruence on the *services* level is sought with four other levels, each of which is therefore first appraised. The Maltese *country context* is portrayed through history, cultural expectations, comparative welfare and the progress of public policy and management. The *user* world is examined through questionnaire interviews designed by leading researchers into community mental health needs, met and unmet, family impact of illness and quality of life. Prevailing and desirable *values* are identified and applied. Recommendations for service are then made, congruent also with the *organisation* level, or local management capability. Rather than reactively fitting with them, congruence creatively questions contexts too, appealing to values.

Relatively weak Maltese resources and capability contrast with strong – though surprisingly undeveloped – potential in family and civil society. A *flexible case management* is recommended that can ‘change gear’ into less or more resource intensive alternative models. This prudently limits assumed responsibility and cost, sharing them with civil society, and invests in managerially supported targeting, streaming, prioritising, minimising bureaucracy and promoting independence.

Relevant issues are thus identified, preparing ARC for use in other country contexts. Finally, bridges are suggested to contemporary readers between intellectual disciplines, cultures and ‘epochs’ (namely, post-modernity, modernity and pre-modernity) hoping that such research can be viewed with less fragmented and less unsure minds.

Foreword

Globalisation intensifies the process of policy importation and dissemination of service models. International agencies are becoming more prominent as agencies of a networking and regulation process that facilitates and accelerates the movement.

Britain has become respected as a model to imitate in community care. Its services are intensely discussed, extolled and denigrated at home and abroad.

Malta is an island in the middle of the Mediterranean that both holds the oldest freestanding building in the world and is one of the very latest to join the queue for membership in the European Union. Malta is now taking committed but unsteady steps towards improving mental health community care and it often looks to British services as models.

Malta's particular context and experience are analysed as a pilot study, to test out a method, styled 'Active Remodelling for Congruence' (ARC), for promoting *wise* adaptive adoption of policy models originating from other country contexts. The case study regards mental health community care and Malta, but ARC is presented as a method applicable to policy transfer in general, helping in a process that is increasingly needed in today's globalising environment.

I have incalculable debts of gratitude to acknowledge, starting with our patrons, the mental health service users and their families, including the enquiry interviewees. It gives me great satisfaction to get to know them and to work along with them. I was very lucky in having had none other than Pauline Hardiker as my supervisor, and Roger Smith who very ably took over when she retired. I thank Joe Oliver, Grainne Fadden, Max Marshall and Austin Lockwood for allowing me to use their rating scales and to discuss with them about their work and ideas and to make use of their findings. I am deeply grateful to Jane Aldgate and the staff of the School of Social Work at Leicester University for their solid support, as well as Linda Gask and other members of the

Academic Unit and library at the Royal Preston Hospital, Joe Bonello and others of the Dorset Community NHS Trust, Mark Agius and other staff at the Luton NHS Trust, Mark Harris and others at the North Sefton & West Lancashire Trust and Sandy Macmillan and John Bull of Leicester Social Services. I thank the Ministry for Social Policy for their grant in support of the research project and the many at the University of Malta who allowed, facilitated and supported my studies, particularly my closest colleagues Maureen Cole, Edgar Galea Curmi, Natalie Kenely, Marceline Naudi, Claudia Psaila and Edward Zammit. I am indebted to Bob Deacon and Kwame Owusu-Bempah for their sterling suggestions.

My enquiry gave me the opportunity to collaborate with many staff, volunteers and friends who give service to users. I will only name the tip of the vast iceberg – contributors and leaders in the service who were members of the National Mental Health Commission at the times I was part of it: Hon. Lawrence Gonzi, M Therese Camilleri Podesta', Doris Gauci, J R Saliba, Rev. A Abela, Joe Borg, Joe Busuttil, Liliana Caruana Colombo, David Cassar, Kate Gonzi, Connie Magro, Joe Mifsud, Cornelius Mulvaney, Alfred Theuma, Joe Vella Baldacchino, Ray Busuttil, Alfred Darmanin, Tony Guillaumier, Elaine Bonello, Hon. Dolores Cristina, Rita Formosa, Joe Gerada, Marisa Micallef Leyson, Mark O'Callaghan, Paul Sciberras and Monica Xuereb. Other persons who I worked with at the Pilot Area were Caroline Attard, Doriette Bonello, Mary Cachia, Philip Camilleri, Ruth D'Amato, Carmen Delicata, Miriam Grech, Josianne Mifsud, Mario Sammut and other staff at the Health Centre and Day Program; as well as A Amato Gauci, Alfred Baldacchino, Rev. A Gouder, Mandy Tabone and Louise Xerri. I am deeply grateful to interviewers Chris Abela, Camille Busuttil, Antoinette Buttigieg, Natasha Cefai, Jesmond Debono, Vicky Grech, Tania Micallef, Michelle Psaila, Vicky Said, Pat Scicluna, Katia Vella and Romina Veneziani; and data inputters Mary Grace Agius and Malcolm Micallef.

My wife Maria, besides back-translating my questionnaires and proof-reading, showed near-infinite understanding and loving support. Like my children Greta and Gustav, she gave up a lot, while they grew up with this task never quite out of mind. My warm thanks to such a formidable array of people, including the numerous unnamed. May our collaboration achieve its aims.

C Pace

University of Malta, September 2001

Abbreviations

A	See A, B, C, D
A, B, C, D	Residential prestige categories, indicating descending order of prestige assigned to each Maltese locality by averaging the rating given to it by respondent residents in Boswell (1994). (Localities not included in Boswell's results were assigned a rating by the author in terms of apparent similarity).
ACT	Assertive Community Treatment
ARC	Active Remodelling for Congruence (or, alternatively, Adaptive Remodelling for Congruence)
Autoneed	A schedule to assess needs, met and unmet, of persons needing long-term mental health care.
B	See A, B, C, D
C	See A, B, C, D
CMHT	Community Mental Health Team
Col %	Column Percentage, occurring in statistical tables, such that whole column of percentages adds up to 100%, even where only the total count, and not the total percentage, is shown.
CPA	Care Program Approach
D	See A, B, C, D
FBQ	Family Burden Questionnaire; later styled, in this dissertation, as Family Impact Questionnaire (FIQ).

FIQ	Family Impact Questionnaire, adopted in this dissertation as an alternative name to the Family Burden Questionnaire (FBQ)
GP	General Practitioner
HAS	The NHS Health Advisory Service.
LQOLP	Lancashire Quality of Life Profile
LSS	Life Satisfaction Scale (in LQOLP)
LTC	Long-Term Care, or, person needing such care.
MMDNA	Malta Memorial District Nursing Association, an NGO conducting generic home nursing for government, on contract.
MOP	Mental Outpatient (Clinic)
PDI	(Problem) Persisting Despite Intervention within the Autoneed Scale – see Table 8.3.9 and accompanying text.
PHC	Primary Health Care
QOL	Quality of Life
SDF	Service Delivery Framework. See part 5.2.
SHO	Senior House Officer, here a generically-trained doctor who holds a senior grade within the specialist psychiatric team.

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Chapter 1

Introduction: Designing context-friendly services without re-inventing the wheel: Malta's mental health community care viewed as a case study open to post-positivist perspectives

A mental health reform, consisting mainly in the introduction of enhanced primary care and a psychiatric team in a pilot area, improved hospital care and a rehabilitation hostel, was initiated in Malta five years ago. This dissertation attempts to contribute to the review of this reform on three levels that can be called, somewhat loosely, theoretical/conceptual, contextual and quantitative. However, its interest is broader than that of the Maltese case, of the planning and provision of mental health community care. Increasingly, countries learn from each other, yet must not import models indiscriminately but must both adapt models to its particular context and acknowledge their own particular strengths and potentialities.

On the theoretical level, therefore, this dissertation proposes a model to assist a policy adaptation and design that seeks congruence with the local context. The approach is labelled Active Remodelling for Congruence. Components and attributes of standard models of practice, as well as their variants, are drawn from the literature. This dissertation's scene setting also attempts to describe the attributes of the Maltese context from such aspects as level of resources, capacity, strengths and weaknesses in the local services, family and community as providers of service and support, and cultural expectations. Particular attention is given to ways in which Malta's system compares with the various attributes that could be grouped under the loose

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appellation of 'new managerialism'. The approach that is advocated rests on the belief that model design and adaptation should be not only evidence-based but also 'congruence-based'. Having analysed both service model variants and contextual variants, the approach attempts to find the best-remodelled service to fit the existent (or achievable) context.

More concretely, the enquiry is, in its core, an attempt to find out how far, and with what adaptations, the community care and mental health services reforms that took place in the UK especially in the last decade, would wisely be applied in Malta. UK is the 'obvious model', in view of the heavy local use of British literature and training content and the wide-ranging though not universal ex-colonial inheritance. Maltese literature about the welfare state, Maltese policy documentation and practice guidance, clear direction as regards community care and sustained synthetic reflection about the value to Malta of the British experience – all these are as sparse as British sources are, in contrast and to Maltese eyes, rich and developed. This dissertation aspires to contribute to the filling of this gap, to help save us from the twin dangers of wanting to re-invent the wheel and of importing models indiscriminately. Aspects of wider international comparative work enhance the Malta-Britain comparison. This, it is hoped, can contribute some insights that can be of use both to approaches in the development of 'latecomer' countries, and to the self-understanding of the British and other more advanced systems.

The theoretical, conceptual and contextual enquiry delineated above will be enriched by the writer's participant-observation as member of the National Mental Health Commission and various of its service developing subcommittees, at various times, with the same commission's permission, and various types of direct involvement in the local mental health effort.

A needs assessment was also made, as part of the evaluation and basis of recommendations. It took the form of a quantitative enquiry in three phases:

- 1) Two samples of users of Mental Outpatients (or Pilot Area enhanced mental health services) were assessed on the Lancashire Quality of Life Profile, Fadden's Family Burden

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Questionnaire, together with new questionnaires about service satisfaction and their support network, towards the beginning of the reform.

- 2) A utilisation study was made of the pilot area enhanced mental health services through the five years of the reform, describing the volume and pattern of use of the service.
- 3) A 13-user sample of the pilot area services interviewed on met and unmet need using the Autoneed scale.

An ethical stance in favour of the disadvantaged is adopted. A brief but important part of the synthetic discussion attempts to see how this can fare amid cognitive and ethical issues such as that of the contested nature of need, some aspects of post-modern thinking and shifts in deeply felt values within the Maltese community. The discussion converges on a general assessment of the readiness of the Maltese environment for developed and reliable community care, suggests lines for policy and service model choices, but falls short of prescribing any 'one and only' model. In the process it will highlight needs and propose solutions related to the still unappreciated importance of reliable and synergetic community care for sustainability, the need to mobilise a strong family and a potentially strong community contribution, and of specific aspects of good management. It also advocates the adoption of 'social' and empowering, rather than narrow or medical views of need, of a coherent philosophy and structure of effective synergy among health and the many and fragmented social agencies. In its search for a culture-friendly synthesis, it uses the historical past to help understand the present and explicit value discussion to help connect with deep traditions yet while adapting and applying them to new insights and challenges.

The various chapters explore and bring together various strands. Malta and its context are introduced in Chapter 2, against the backdrop of international developments in mental health services, especially in Britain. Chapter 3 will present the main conceptual framework – Active Remodelling for Congruence: an approach that first analyses service models and contexts, and then remodels services in search for the best between service and context. But other frameworks will be presented to aid understanding. Goldberg and Huxley's framework will be supported by Pauline Hardiker's, classifying service levels in relation to sub-populations and basic service approaches.

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The enquiry's intercultural preoccupations overflowed into history, ethics and knowledge theory. The writer must admit that deciding how to relate to British culture has been a major strand in his own search for personal identity. He wishes to share this search for identity with readers, being convinced that it is paralleled by the quest for clear identity of many. Many people, and many peoples, in this globalising world, want to learn from the experience of other countries in fields in which the latter appear to be more advanced. However, this often leads them to look more carefully into their own roots, cultural, ethical and historical, to safeguard their own wholeness. Postmodernist theory, in one of its versions, tells us that personal 'syntheses' can be depthless and pastiche can reign supreme. The present writer felt the need to give a response to some postmodern views about ethics and valid knowledge in the context of a Mediterranean island whose culture seems simultaneously both to still have a pre-modern coherence and to have gloried in post-modern incoherence long before it was so labelled. Chapter 3 sets the questions briefly, while also explaining the basic ethical stance embraced. Ethical and knowledge theory questions are allowed to rest till Chapter 10.

Chapter 4 presents the Maltese welfare state, delving in distant history to start with, then venturing into comparative social policy and welfare state, health service and community care reform. It aims at crystallising the context's main characteristics. This 'history' is then rounded off with a brief critical review of the mental health community care reforms as they actually turned out in Britain and Malta. Chapter 5 reviews a strand of literature, attempting to find evidence-based characteristics of basic components of case management and its alternatives. Chapter 6 applies Active Remodelling for Congruence to the Maltese context. Sets of components and variant elements of case management are matched with the local context characteristics. An adapted case management is proposed as a result.

Chapter 7 presents the methodology of the enquiry into needs. Chapter 8 presents and initially discusses the quantified findings, describing need, quality of life and family situation characteristics, as well as service utilisation and needs met and unmet. Chapter 9 attempts a synthetic view of the world of the user and the local context, and makes suggestions for a service model appropriate for the Maltese context.

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Chapter 10 revisits the ethical and knowledge theory questions delineated in Chapter 3. It proposes a basic approach to them that responds to postmodernist positions, having searched for an answer that is rooted in components that are central to mainstream literature in the social sciences. Simultaneously, it offers a bridge between post-modernity and pre-modernity that could help people in search for a reasonably happy synthesis between the past and the present. At the same time, it hopes to give a sense of proportion in the weighting to be attributed to findings and conclusions.

Intercultural questions can hardly be satisfied with positivist answers. But no one can aspire to achieving a parallel to Braudel's (1981-84) ideal of 'histoire totale'. A humble dissertation about community care cannot achieve seamless understanding – still less when viewing the issue inter-culturally – any more than seamless community care has been achieved to date. It is firmly hoped, however, that the 'bridges too far' beyond the tight foundations of a positivist account strengthen the validity of the findings. They should help by putting them in a perspective that is open to broader and challenging post-modern eye openers. Postmodernist writers tell us that 'closure' is impossible. Chapter 10 is built on the conviction that a valid closure must take an open-ended turn.

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Chapter 2

Setting the Scene: Reforms, Abroad and at Home

In this chapter we set the scene. First, Malta is introduced for the benefit of the unacquainted reader. The second introduction is that of the Maltese mental health reform, initiated in 1994. In this reform, Malta did not re-invent the wheel, but was applying processes that were taking place internationally. The overall story of Malta's reform is, therefore, recounted against the background of welfare, management, health and mental health reforms that took place elsewhere, with special reference to Britain.

2.1 Introducing Malta

The republic of Malta consists of three main islands with an area of 315 km², situated at the centre of the Mediterranean, half way between its east and west extremities, and one quarter of the way between Sicily and North Africa. With a population of 376,513 (1997) it is the fifth most densely populated country in the world. Its strategic position and its excellent natural harbours attracted the dominant powers of the region throughout history. Its location between what we today call north and south and, in several ways, east and west, has placed it at the cross currents of cultures. Two golden ages in its archaeology reflect times when it was internationally an important centre of culture: megalithic times and during the rule of the Knight of St John (1530-1798). The Maltese language achieved its most basic grammatical structure and vocabulary during the Arab's domination of the Mediterranean but accrued much

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of its present vocabulary and syntax from Romance languages after 1091, very much like Anglo-Saxon English did after 1066. Both dates represent a victory by a Norman nobleman that threw robust cultural bridges from the two 'islands' concerned to the European continent.

Napoleon's annexation of Malta was soon followed by popular rebellion and a request for British protection. During the British presence (1800-1964) the colonial power's interests were dominant, and both the desired political autonomy and industrialisation were delayed. Malta became one of Britain's biggest overseas military bases, prosperous in time of 'wars and rumours of wars', reverting to popular poverty in peacetime. 'Cultural colonialism' entered the fray with reform attempting to limit the power of traditional elites. The use of English (concurrent official language) and vast British influence on culture, education, most professions and the political set up are now a fact of life and identity. In many ways they are an asset and a strong bridge to the international world. While Malta is now often described as top of the queue for EU entry, along with another ex-colony, Cyprus, and the ex-members of the Soviet empire, it still cherishes its intercultural vocation. As it thoughtfully stands on the brink of the forced choices imposed by a globalising world, its government is directing its energies to jump in, while the opposition wants a Swiss-type status outside the EU.

Maltese health services and Maltese state social care services tend to follow British models¹. This is largely due to the century and a half of colonial rule, during which health services and education in general (though, less so, non-government social care and legislation) followed a British model. A large proportion of the lecturers of health and social services professionals have received British training, and text-books and professional books from Britain are much more readily available than ones from continental Europe and the US. The obvious track to take in development is usually the British track. But the gap in development and level of provision between Britain and Malta is often obvious too. More difficult to define is the gap with locally Maltese, Mediterranean, Southern European and Latin traditions, together with

¹ A very detailed description of the components and resources of the British mental health services at present exists in the form of a 'purchaser's manual', namely Conway et al 1994. By informing the purchaser what there is, with what rationale, with what effectiveness and with what costs, it provides a robust account of what there is 'on the ground', practically in all the aspects of the reforms that we shall briefly follow.

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less easy to identify Semitic features, in culture, customs, legislation, provision and attitudes that exist, and that make Malta the multicultural complex, that it is.

In many ways, this multicultural complex is an integrated culture, a large set of gestalts, deeply compatible and viably unified. In many ways, too, the unity is a project, and it is in many ways the vocation of leaders, political, cultural, professional and academic, to help develop a 'Maltese way' inspired both from the home-grown and the exogenous. This task is largely the mission of this dissertation: *to find models that fit and enhance Maltese identity and realities*. We shall follow the 'obvious way': see British models as starting point, and see what we can adopt, adapt, replace. British models are taken as the most 'available' example of what is, in many ways, happening internationally (See Dolowitz D P & Marsh D 1997).

2.2 Malta's community mental health services till 1994

Writing for *Scientia* (pp. 51-62) in 1950, Paul Cassar describes 'Problems of Mental Health in Malta'. Paul Cassar is an ex-superintendent of Mt Carmel (Psychiatric) Hospital and is a fellow of the Royal Historical Society with a profusion of articles and books about health and welfare to his name. In 1949 he echoed a 1945 call by the local branch of the British Medical Association for Mental Outpatients to be shifted to the general hospital. The stigma and fears of worse attached to its location at the mental hospital was preventing the more numerous neurotics from seeking help. Besides, the shift would encourage (pp. 54-55):

free intercourse between psychiatrists, physicians and surgeons than there is at present with the result that their respective outlooks on illness will become broader. The false dichotomy of body and mind will thus be neutralised as the psychiatrist will tend to make more use of the service of the physician, while the latter will not hesitate to refer to the psychiatrist those 'mixed cases' in whom illness is both of an organic and a functional nature. ...illness will be studied from all angles instead of from one narrow viewpoint – a pitfall into which specialists, whatever their line, are liable to stumble.

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He goes on to describe how general practitioners missed or trivialised the neurotic symptoms suffered by nearly one third of their patients (quoting the figures of Donnan, 1947). He also appealed for the introduction of the psychiatric social worker.

When the first psychiatric social worker (the present writer) started working in 1981, mental outpatients had recently shifted to the general hospital. It further shifted to sessions in four 'polyclinics', or area health centres, around the island, in 1984. Soon, a hospital halfway house became the rallying point of the rehabilitation efforts of various disciplines, facing uncertain support and zero community resources beyond the psychiatric social worker, occasional occupational therapist home visits and the mental outpatient clinics.

2.3 British and international developments and reforms

Since information about British and international reforms is widely accessible, only a broad overview will be attempted of this time when very important changes took place.

Because of demographic changes, rising expectations and also sustainability problems, mental health community care achieved central importance in the second half of the twentieth century for several reasons. However, a feeling was developing in the early eighties that this was often taking place with 'unseemly haste', featuring examples of inadequate preparation, unreliable follow up, untackled danger and at times downright unethical under-provision and even cynical dereliction of duty.

Meanwhile, important changes took place in primary care, that is, the generalist health care provided by the general practitioner service. Britain has been an example of the international trend (see Fry & Horder 1994) of giving a greater role to primary care in the mental health services which, as such, did not involve the creation of new models of team structure and

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function, as has happened in specialist care. The structure of primary care since World War II has changed dramatically (see Grundy & Grundy 1974, and Fry & Horder 1994), and this was intended to improve, rationalise and environmentally adapt the system of delivery of care for general health and all the health specialties.

Changes to improve specifically mental health primary care have been almost exclusively in process or function rather than structure or, following our logical framework, in *practice* or *good practice*, rather than in model. However, there have been the following important *model* changes:

1. The shift from the '*monoprofessional model*' to the '*interdisciplinary team model*' of primary care (see World Health Organisation 1990).
2. The *inclusion of counsellors* in the primary care team (see Sibbald et al. 1993).
3. *Models of interfacing* of the primary team with the specialists (See, Jackson et al 1993, Strathdee 1984, Stansfeld et al 1991, Kendrick et al 1991. Re US see Orleans et al 1985, Falloon & Fadden 1993).

Basic Process Changes in Primary Care to Improve Mental Health Care

The main changes in rationale, process and good practice can be given under two headings. First, as regards rationale or basic philosophy *it is recognised that a very high proportion of emotional morbidity should be dealt with, appropriately and effectively, at primary level.* Essentially this does not deny that specialist care could in many, though not all, cases be better for the individual recipient, but that it would be too costly to implement for the general

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population. The Goldberg-Huxley Model, which will be presented in the next chapter, see primary care practitioners, in their gatekeeping function, as the activators of a filter.

Second, *the potential of primary care to give appropriate and effective care*, both in its level-related functions of care and treatment, and in the filter-related functions of action and referral *is enhanced by*

--improving the team's skills in detection, management, treatment and referral related to psychiatric morbidity through training

--broadening the spectrum of skills in the detection, management and treatment and referral through the use of protocols - brief charts which the practitioner can look up, improving decision-making beyond what can be achieved by the unaided memory, while being brief enough to fit in the rapid world of general practice (where the average consultation time in the UK is calculated at six minutes).

General Changes in Secondary or Specialist Care in the Community

The running down and closing down of British mental hospital from the sixties onwards was a key component in the shift of the centre of care from hospital to community (see Wagenfeld et al. 1982). It was notably accompanied by an important shift on the secondary or specialist level. Specialist services internationally, largely since the fifties, can be said to have moved through the following stages:

- Outpatient clinics situated within mental hospitals.
 - Outpatient clinics moved out to general hospitals (for the reasons cited above by Dr P Cassar)
 - The simultaneous development of the composition of the caring teams, starting off from a service manned only by doctors, under the consultant (with the nurse serving in a largely
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‘handmaiden’ capacity); to grow into an interdisciplinary team, with the notable addition of the psychiatric social worker and occupational therapist and, in many cases, also of the psychologist.

- The later move of the ‘outpatient clinic, this time to the health centres. Here, the secondary team moves out to meet the primary (Gask & Hannay 1991). It is important to remember that in the UK the health centre is the territory of the free-lance or self-employed general practitioner, though it represents a framework that is regulated and almost totally financed by the state health system. The first shift was important enough, but it is the latter one that has itself earned the title of ‘shifted outpatient’, or, ‘shifted outpatient clinic’.
- The development of the community mental health interdisciplinary team can be said to have developed into four main variants, if we classify by stage of care:

1 Crisis intervention teams

2 Acute Care teams

3 Long-term care teams (including case management teams)

4 Mixed models.

To the third one among the latter we shall mainly turn our attention.

Developments in Models of Care for the Long-term Mentally Ill, particularly Case Management Models

This dissertation will focus mainly on the care of the long-term, severely mentally ill. Its other major concern will be to appraise *the process of development of community services in general*. It will therefore interest itself in levels and facets of the services other than those for Long-term Severely Mentally Ill insofar as their structure and their process of development is integrated with those of the services for the Long-term Severely Mentally Ill. Thus, in this

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section, while focusing mainly on services for Long-term Severely Mentally Ill, we shall view these in the context of services for crisis intervention and for acute care, and the ways in which these structurally and functionally relate.

As we have said, in the 1970s and 1980s the optimism for deinstitutionalisation gave way to shock at the low level of care in the community. Often, the care which long-term patients received outside the institutional walls left much to be desired (Bachrach 1976.). Neglect often meant large-scale dropping out from care and 'follow up' by professional carers, large-scale homelessness, lack of adequate specialist cover even for patients living in hostels specialising in the care of the mentally ill, and their lacking the necessary care .

Against this backdrop, community specialist teams developed in response to the twin demands of cost reduction, both in terms of inhuman suffering and indignity, and of finance and welfare resources. Answering the calls of these often ill-matched twins, specialist teams changed and developed in an effort to become more effective and efficient in the care of Long-term Severely Mentally Ill.

As one would expect, this became a period of significant experimentation and growth. However, it would not be wrong to say that, much that was new, whether good, bad or unclear, was hung on the heavily burdened peg of 'case management'. Case management, having originated in the US and developed largely since the seventies, came to be regarded as largely the treatment of choice for the Long-term Severely Mentally Ill. Case management at times came to mean different things to different people, but we can follow S Onyett's minimalist definition (1992, p. 3), applicable to all case management, which registers a widespread consensus, namely:

Case management is a way of tailoring help to meet individual need through placing the responsibility for assessment and service co-ordination with one individual worker or team. The core tasks of case management are: ...Assessment... Planning... Implementation... Monitoring... Reviewing.

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On reflection, one realises the core tasks are simply common to any professional health care, whether mental or otherwise, hospital or community. In fact, case management has become the flagship for much current practice in this field. While case management is defined in terms of practices that are very widely current and normal, assuming into itself much that is in circulation in present practice, many comparative evaluations have been published, that pitted it against control treatments that could not be defined as case management, yet incorporated many of the practices that could have taken place within case management. However, the definitional *differentia* that distinguishes case management from other, previous, methods, is the co-ordination of care by one person or team. Traditional institutional care created no big problems of co-ordinated management. Care was given by persons who were staff employed by the same organisation, under one management, under one roof, and often severely limited in its variety and far from holistic. The rationale of case management was to restore co-ordination by placing it in the hands of one practitioner or team of practitioners. The latter exercised a co-ordinating and overseeing function, strengthened by statutory duty and power. This gave a recognisable face and an accessible ear to the power of the purse, making devolving both the monitoring and an appreciable level of responsive decision making to a spot very near to the service user.

The spread of the idea of case management was rather gradual in the United States. In Britain it became a key tool in the large scale of 'centralised decentralisation' that burst upon the scene through the twin white papers of 1989 (*Caring for People* and *Working for Patients*) and the subsequent National Health Services and Community Care Act of 1990. The introduction of case management became one of the six goals of radical and wide-ranging reforms in community care. Being central in UK and US community care, case management will be central to the present enquiry. In asking what model of service would be good for the Maltese context, much of the attention will be taken by an effort to evaluate case management as a tool that is effective and appropriate to the context.

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2.4 Malta's mental health reform: changes in primary and secondary care in the pilot area

On March 17, 1994 a press release was issued by the Ministry for Home Affairs and Social Development announcing the setting up of a National Commission for Mental Health Reform (later, for Mental Health). The Belgian Ministry for Public Health had offered help, and Minister Louis Galea asked for this to support the designing of a mental health reform that he felt to be long overdue. A joint scientific committee supported the newly decentralised Department of Health Policy and Planning to produce a draft policy document, and the new Commission's first task was to discuss it. The draft policy document was the department's first deep planning exercise, and represented a welcome step forward from the hurried and piecemeal planning that was often all that could be produced previously. The document's comprehensiveness of vision led it to address issues of management, financial management, and training, while every set of proposals was accompanied by critical success factors that would help direct and safeguard progress.

The Commission soon proved the worth of its interdisciplinary and inter-sectoral composition by making profuse amendments that were accepted before its publication. While it planned for an improvement in hospital management, it is the document's community aspect that will most draw our attention. A pilot area, comprising the villages of Qormi, Zebbug and Siggiewi, would be used to test out new services based at the Qormi health centre. These would consist of a primary health care team and an enhanced mental outpatient's clinic. However, specialist or psychiatric social workers and community-deployed psychiatric nurses would still be based at the hospital and come to the area on a visiting basis. A third component was to be the crisis intervention team based at the general hospital.

In order to more clearly visualise the reform as planned, it would be good to compare it with standard international services, taking Britain as our source of benchmarks. A careful look at the document and especially a look at the reform's initial activities reveal that the greatest intended focus was on primary care. In fact we can say that, throughout the history of the reform, the Health Division (the new name for the Health Department, now decentralised into

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several component departments) was working to come to terms with the required balance between health and social service, hospital and community. One ingrained tradition that the more interdisciplinary and inter-sectoral commission came across was that of equating community care with primary care. This is not surprising in a department in the throes of breaking free of a system in which secondary or specialist was hospital-based. In it, the only outreach into the community was either in the form of the health centres primary care GPs, or done by 'somebody else'. The latter included specialist doctors in their private practice, the contracted out community nursing belonging to a Non-Governmental Organisation (NGO) or the department's social workers. The commission's interdisciplinary input contributed to a strengthened emphasis on deinstitutionalisation and community care and a gain for this perspective came when the government decided to largely finance a halfway house in the community run by Richmond Fellowship (Malta). The latter became perhaps one of the most nationally visible parts of the reform. The controversy of having ex-patients from the mental hospital living in the community was more capable to challenge opinions and hit the headlines than the solid upgrading of what could be described as an enhanced mental outpatients service with related primary support in the catchment area of one health centre.

Among the most memorable events of the start of the reform were the seminars with Dr Linda Gask, the foremost British researcher on mental health in primary care, clearly showing where the main thrust was intended to be. In important ways, primary health care is the Achilles' heel of Malta's health services. Free GP service for the poor existed since before the Knights of St John's arrival, surviving in the form of the District Medical Officer service until it was interrupted in 1977 by the doctors' industrial dispute with government. While free hospitalisation for all was introduced in 1979, the only free GP service there is is the government health centre GP service, which replaced the District Medical Officer (DMO) system in 1977. A dispute about a relatively minor issue escalated into a 10-year strike/lock out in which most Maltese specialists and many GPs left Malta and practised abroad. Commentators interpret the reaction to a perception that this was the socialist government's thin end of the wedge on the way to nationalising or otherwise forcefully incorporating the GP service. Following the return to power of the Nationalist government and the reinstatement of all the previously locked out doctors in 1987, the incorporation of general practice into the

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national health service seemed like a piece of unfinished welfare state business. A very detailed agreement was made with the Medical Association of Malta on all points – except the price. Minister Galea did not have enough money to pull the same trick as Britain's Bevan when he 'stuffed (the doctors') mouth with gold! The unfinished business of primary care remained unfinished.

Short of such an agreement, patient registration and the resultant continuity of care could not be assured at the pilot area's health centre. Health centre doctors reacted to Dr Gask's seminar with enthusiasm. 'Interface' meetings became the buzzword, as occasions for liaison psychiatry, during which health centre GPs could discuss their cases with the psychiatrists, who were quite generous with their time. However, the primary level effort was beset by many problems. Failing the official agreement on patient registration, GPs were exercising continuity of care only on a voluntary and unofficial basis. While UK figures show emotional problems to be the second commonest reason for visiting a GP, after respiratory problems, figures for recorded mental health contacts at Qormi were very low. Who would talk to a GP about emotional problems at one's next visit one would have to start the story all over again with a new doctor? Besides, attendance at interface meetings necessitated coming outside duty hours, which did not prove sustainable. A serious setback was when the medical director of the health centre, who was an enthusiastic leader of the primary care effort, was transferred to another health centre 'due to service exigencies' of, admittedly, a serious nature. As a result of other transfers, the personnel enthused with the Gask spirit became fewer and farther between. Unfortunately, what started off as an opportunity to nudge a health centre's GP service into an enthusiastic high gear soon lost much of its spirit, though social workers still continued to get good referrals from the GPs, obviously just as deeply concerned about their patients' welfare.

A letter by a correspondent who signed 'MD' (1995) conveyed many health centres' doctors' consensus about their work conditions. Many people would go to their private GP for serious problems, then go to the health centre for routine or trivial complaints. Health centre doctors are often sought for certificates required for sick leave or free medication that they have to provide without the knowledge that comes only from continuity of care. They feel on

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insufficiently sure ground in the face of persons who insist on certificates abusively or take free medicines wastefully. By 2000 so many health centre GPs dropped out that only a minority of health centres could still be open on a full day and night basis, adding further obstacles to consistent mental health care at that level.

By contrast, secondary care, in the form of a mental outpatient's clinic shifted to the health centre, proved robust and popular. The fuller nature of its case records, its shorter queues and warmer and better personal acquaintance from the nurses doubling as receptionists contrasted with the crowded queues and short contacts characteristic of the mental outpatients clinic at the general hospital.

Unsolved transport problems stopped the psychiatric nurses accompanying the psychiatric firm at mental outpatient from doing home visits. Social workers related more in network than in team fashion. While three recruits volunteered for the primary team, psychiatric social workers were almost throughout the period too rare to attend with any regularity, and the primary team social workers were soon directed to fill the specialist team gap for the purposes of the pilot area. In other words, the health centre social workers fulfilled a wide role indeed. Not only did they take primary team type referrals of persons who addressed the health centre for health related problems: they also advertised their availability for generic non-health related and mixed social work needs at the service of the local populace. Added to this, they networked to stand in for the specialist social workers with both acute and long-term patients.

Vigorous social work was carried out with these client groups, including a good number of persons needing long-term care. The primary-cum-secondary-cum-generic role with a largely networking relationship with both primary and specialist practitioners may have been the fruit of experimentation and a reaction to limitations. However, it stands in some contrast with the team roles both as designated in the policy document and the structures generally advocated for reliable long-term community care. Deep reflection is required before deciding to resume or widen its use when the pilot area experience is generalised. This point will be revisited in Chapter 9. One point to also note was the weak link made with private practitioners. Though state primary health care is, as we have seen, beset with weaknesses, private family doctors are

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in many ways a big strength in the Maltese health services and Maltese society. GPs are highly trusted and their service is reasonably affordable to most people. Private GPs have not, to date, been in any deep way brought into the pilot area reform.

SPECIAL NOTE

**This item is tightly bound
and while every effort has
been made to reproduce the
centres force would result
in damage.**

Chapter 3

Conceptual Frameworks, Values, and Issues of Basis

Though it is a case study about Malta, this dissertation wants to propose and test out an analytical framework that can be used in any country that wishes to import service models and policies that have worked elsewhere. It is hoped that the framework could provide a focus to the task of adapting, changing or substituting for these policies or models in the process, so that they can fit the needs of the new country context. This chapter does not focus on Malta in any way. Rather, it raises questions while eliciting and compiling concepts within frameworks and methods to facilitate the task in a way that is applicable, one would hope, to various countries, to various types of models and policies, in various domains.

The proposed central analytical – but equally synthetic and operational - framework, labelled ARC or Active Remodelling for Congruence is presented in section 3.2. ARC is a new framework, originated and developed over some time by this author. In a way, it says or asks nothing new and is very much akin to already-existing lines of enquiry which, however, it puts together in a novel way to serve the particular purpose of model adaptation, developing and fitting. ARC here is explained with special reference to small countries, but it is applicable to all countries, whatever their size, since all indulge in some level of policy importation.

ARC is then supplemented, in section 3.2, by a secondary framework that marries together of two frameworks that, like it, analyse service and need in terms of levels. Goldberg and Huxley originated the first one, in their studies of populations and services in the mental health

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field. The other is that of Pauline Hardiker, used to classify social services for children and families. Both sound descriptive, a mere classification. But both have a prescriptive ‘punch’, implying what could or should be good practice in their respective fields. Even through their neat classifying, they serve as a peg on which we can hang our clear thinking, normally motivated by a concern for good practice. A third framework, originated by the NHS Health Advisory Service, HAS, is also proposed – in a way, as a successful marrying together of basic features from both Goldberg and Huxley’s health-oriented, and Hardiker’s socially oriented frameworks.

Like the combined Goldberg and Huxley and Hardiker frameworks, ARC does not suffice for the enterprise. Like them, it jumps from the descriptive to the prescriptive. In doing so, it raises questions of ethics, values and visions and questions on the validity and foundations of knowledge. The post-positivist view of science is very conscious that any theory is inseparable from its value and cognitive underpinnings. The approach of this dissertation is also strategic in the sense that, like a strategic plan, it seeks practical ways to arrive at a future matching a vision that looks at the facts of today, shapes a dream for tomorrow, and does this in the name of inspiring values.

Yet even in today’s emerging paradigms of science, a relative or provisional division is made between the positive and the foundational stages of an enquiry. Value and foundational questions will therefore be confined largely, and for the sake of keeping them apart from the empirical level of the enquiry, to the present chapter and to Chapter 10. This chapter will end by raising, and listing, the value and foundational questions as they appeared to this writer at the stage when the enquiry project was taking its first shape, and which Chapter 10 will attempt to respond to.

3.1 The Active Remodelling for Congruence framework- A New Framework to facilitate the Adaptive Adoption of Policy originating from other contexts

The problem

All countries carry out some sort of 'policy importation', or 'policy transfer' (see Dolowitz et al., 1997) from other countries. It does not pay to re-invent the wheel. Smaller countries, ex-colonies and countries that are at a developing or transitional stage face a greater problem in doing this adaptively. Such countries often have a limited planning capability. This is perhaps most serious in small countries, where what needs to be done is almost as complex as in big countries, while the capacity for policy design and adaptation is much more limited. Such countries are often caught up in the dilemma of either not adopting any new policies, or of adopting them virtually 'lock, stock and barrel'.

It would be a very regimented world if all were forced to buy and carry the same type of gun, with the same lock, same stock and same barrel. It would be a more varied world - though not necessarily safer - if you can look at the model you are offered, and have the liberty to say, for example, 'yes' to the lock and still be able to say 'no' to the stock. It would be even better and more flexible if, besides accepting a part and refusing another, you can be creative about the still other parts or aspects. Edward de Bono, the creative thinker, coined the word 'Po' to mean a provocatively different version, something that forces us out of our accustomed ways, as a means of nudging our minds into thinking something new. Talking of small countries, "Po" could mean taking up the suggestion by a group of Belgians to a friend of theirs from Luxembourg. They suggested that, theirs being a small country, Luxembourg soldiers on manoeuvres should carry guns with barrels in the form of a letter J. A straight barrel would mean that the bullet would cross the frontier into another country. How about that for a provocation? However much these Belgians savour the rare experience of taunting a friend from a country that is smaller than theirs, a creative thinker can still use the derailing of thought caused by similar provocations to shake our thinking into envisaging novel solutions to old problems. If when offered the barrel we say 'Po', it means we that we neither adopt nor

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refuse, but that we want to vary part of the model and, more than that, do it in an innovative way.

The proposed solution and its rationale

What is proposed is a way to describe policies and service models to policy makers in ways that facilitate the task of adapting or remodelling them to fit new contexts in new, adopting countries. In order to achieve this task, the present author has originated and developed a model that is being called "Active Remodelling for Congruence" (ARC). Congruence, that is, agreement or coherence with the receiving environment is the goal that is sought in the process of remodelling. The process is active in Edward de Bono's sense (De Bono, 1985, p. 40) of not being the use of knowledge to simply understand or read what is out there already or what somebody else is saying. Active knowledge is one that creates, comes up with new solutions and ideas, prepares the way to new intervention or change.

Active Remodelling for Congruence admits that, in looking for good models to adopt, we should not only look for Questions of Evidence, often dealing with research about effectiveness and outcome with respect to a set environment. We should also go into Questions of Congruence. Questions of Congruence are understood as operating on one or other of the interfaces among the 'four plus one' levels into which we may divide the operative environment of services and policies. The first level is the U-Level, which is the User's world, signifying the service user's needs, and the living and working setting in which the user's needs occur. The second level is the S-Level, the Service level, which is what we are setting out to design, in order to best serve the user in the context. The third or O-Level is the level of organisation. It indicates the organisational and back-up system, its resources, processes and capacity, that ensure that the service is provided. The highest level is the C-Level, or (Cultural, Political) Context level of the particular country. To these, however, is added the V-Level: that of values – both the values that operate in the system under study, and the ones that motivate and direct the person who is analysing for the sake of policy development.

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Congruence is therefore to be sought at each interface of this 'V-USOC Analysis', namely the U-S (User World-Service Interface), S-O (Service-Organisation), O-C (Organisation-Culture) and even C-U (or Culture-User World); but also possibly *between any pair of levels*, such as O-U (between the User's world and the type of service organisation), or C-S (between the country context and the service model used) (see Figure 1: The 'Four Plus One' or V-USOC Levels and the main interfaces of 'issues of congruence' used in Active Remodelling for Congruence.) The Values level, on the other hand, can be said to interface with, or to affect (and be affected by) each of the other levels.

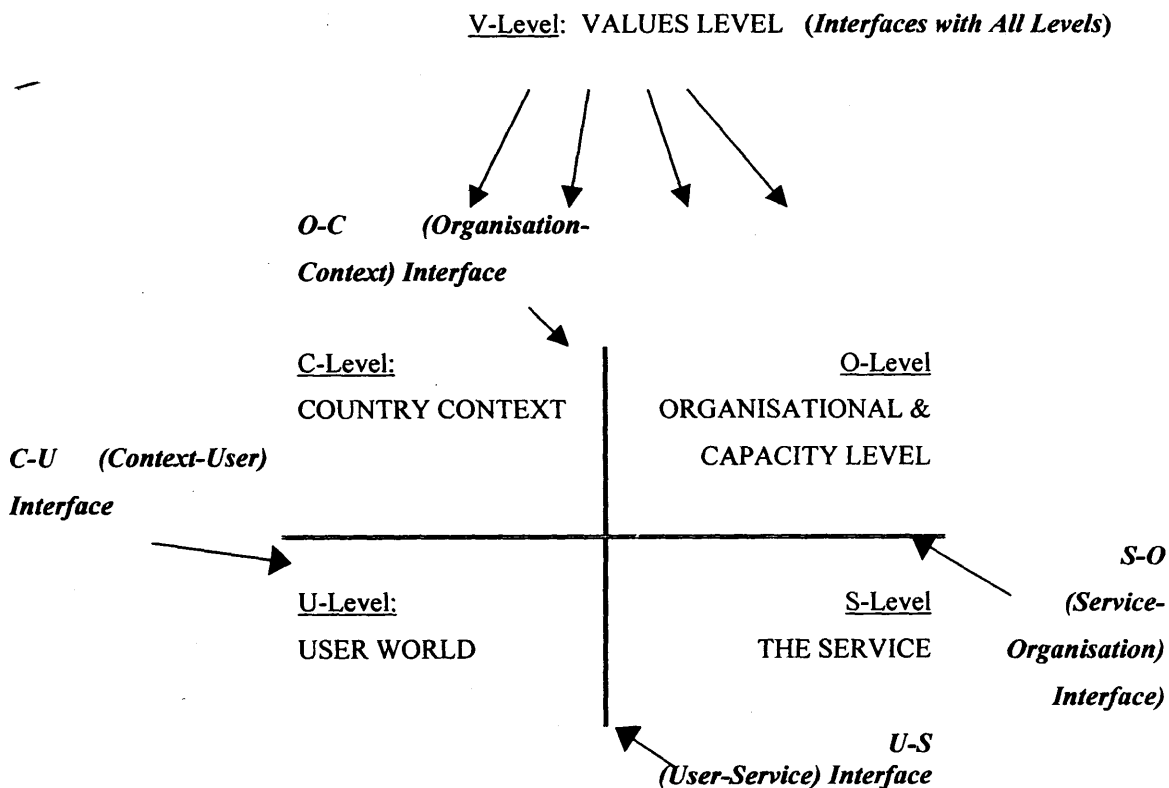


Figure 1: The 'Four Plus One' or V-USOC Levels and the main interfaces of 'issues of congruence' used in Active Remodelling for Congruence

Such remodelling is also based on the belief that most, if not all, service models, are made up of components that need not be imported all together, or lock, stock and barrel. Models can be taken apart, down to their components. Components probably cluster into groups that cohere together more than others do, because they internally dovetail together, on a functional or

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meaning level; or because they are an answer to the same contextual characteristic. But analysis into components can help bring out and make explicit which issues the existent components respond to. Having done this, one can then proceed to ask if other variants, or clusters of variants, could be a better answer in the new context one is considering.

In this dissertation we use the ARC method for a particular problem of policy transfer and remodelling. The focus will be on mental health policy, and the *question will most particularly though not exclusively focus on the desirability of importing the case management model as a way of following up persons with mental health problems in the community*. The Malta case study explores how far Active Remodelling for Congruence can be cast in terms that are not related to just one context, but can be validly generalised to any country or even to any policy or model.

One way of putting it is that an aim is to see if one can produce something in the shape of a 'buyer's manual' or 'Policy Remodelling Guide' regarding a particular policy or service model. In this case the 'buyer's manual' will be about case management. It will aim at being of use to anybody considering introducing case management to a new country context, different from the country context or contexts where it originated. The author is suggesting that policy adoption and re-adaptation can be facilitated through the production of such 'Policy Remodelling Guides'. If this can be done successfully for case management, then one can do it just as successfully or more successfully for whatever policy.

O 1.	Policy and Governance
O 2.	Strategy and Plans
O 3.	Leadership
O 4.	Resources
O 5.	Processes
O 6.	People

Table 3. 1: A version of the Components of the Organisation Level (applying the 'Enablers' in the Public Service Excellence Model, Public Futures, 1998).

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The advantage of such guides in the literature would be that prospective adopters, especially in countries with a low policy design capability, would have their work very substantially facilitated. It would of course, require their increased comparative knowledge of their own context. But the 'manual' or 'guide' would help them to ask the right questions. This would help them improve their comparative understanding of their context, in a way that accumulates and improves their policy adoption and remodelling capability in the future, applicable to new policies in different areas.

In fact, what a policy redesigning guide would do is to move through the following five steps:

- 1. Identify the policy, programme or service model being considered for adaptive importation and explain its rationale as seen within its native context.**
- 2. Compile background information, such as by analysing the characteristics of all the levels (Values, User World, Service. Organisation), and gathering evidence-based data and building up functional analyses.**
- 3. Analyse the policy model as well as other competing or variant models into components.**
- 4. Identify the issues expected to affect the choice of model components to adopt. With the help of a two-way diagram, identify the design features which each issue is expected to affect.**
- 5. Reflect on each issue, proposing adaptation to it in the affected model components. Build these up into a coherent design that is up to the desired level of specificity**

The steps in the above scheme will be applied to case management in Chapter 6, on the way to finding out what would be a good variant of case management that would fit with the Maltese context. But this will only happen after the Maltese context has been delineated in Chapter 4. Table 3. 2: Synoptic ARC Levels, Themes and Dimensions Chart represents the

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<u>Levels</u>	<u>Core Themes</u>	<u>Key Dimensions</u>
<u>U1-Level:</u>	11 Need Assessment	
<u>The Inner User World</u>	12 Quality of Life	
	13 Empowerment	
<u>U2-Level:</u>	21 Family	U 1. Popular values, expectations, perceptions
<u>The Wider User World: Family, Community and Civil Society</u>	22 Community	U 2. Community
	23 Religion	U 3. Family
		U 4. Neighbourhood
		U 5. Gender roles, especially in caring
	51 Civil Society	U 6. Civil Society
<u>S-Level:</u>	31 Service level	C 1. Rationales of caring models
<u>The Services:</u>	32 Primary Care	
	33 Specialist Care	
	34 Primary/Specialist Interface	
	35 Therapies	
	36 Resources	
<u>O-Level:</u>	41 Targeting	C 2. Systems of management, especially in the public sector
<u>Managerial capacity:</u>	42 Management	
	43 Co-ordination	
<u>C-Level:</u>	52 New Management	C 3. Welfare state as a whole
<u>The country context:</u>	53 Welfare State	C 4. Philosophy re role of govt, and mixed economy of care
	54 Governance	C 5. Mode of consensus building
	55 The Market	C 6. Philosophy re role of government.
		C 7. System of mixed economy of care
		C 8. Purchaser/provider split
		C 9. Internal markets
		C 10. Privatisation, role of private sector
		C 11. Contracting out
	55 Political economy	C 12. Economic and institutional frameworks, constraints
		C 13. Elites, political economy level
		C 14. 'Other' factors and events leading to macro-level change.

Table 3. 2: Synoptic ARC Levels, Themes and Dimensions Chart

final upshot of several attempts to list the dimensions on which to delineate or characterise each of the five levels, namely the Values, User, Service, Organisation and Context level.

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What is given does not claim to be a grid for a five-level analysis that applies to all types of service. Rather, it is the streamlined version of what progressively emerged to be most useful for the study of context-congruence of community mental health services as undertaken by this dissertation. No doubt, if applied to different service types or other contexts, it will have to be partly modified.

v01	values in general
v02	good of the client
v03	good of the most vulnerable
v04	quality of life
v05	human dignity
v06	empowerment
v07	strengths approach
v08	needs-led approach & personalisation
v09	respect for diversity
v10	congruence
v11	contextual appropriateness
v12	prevention
v13	effectiveness, efficiency
v14	workers' dignity, good conditions, security of employment
v15	acceptability
v16	equity
v17	tolerance
v18	influential religious or traditional values

Table 3. 3: Dimensions or focal components of level V (Values); a fuller list than that on the more streamlined and selective Table 3.2.

The original approach had been to multiply the components of each analytical level, each component representing a dimension on which that level might vary. What has emerged through progressive streamlining is a framework that locates on each level a number of Themes and Dimensions that turn out to be central. Table 3. 2, in effect, maps out the core Themes and Dimensions of the dissertation as a whole, while setting the stage for its key service Issues to emerge later (see especially Chapter 9). Key dimensions used on the U- and C-Levels (User and Country Context level respectively) are also given. The V- or Value level is represented more fully in Table 3. 3: Dimensions or focal components of level V (Values); a fuller list than that on the more streamlined and selective Table . But Table 3. 2: Synoptic

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ARC Levels, Themes and Dimensions Chart was adapted to its particular subject. Meanwhile, exploration has found it useful to split the U-Level, or User World into two. An Inner world (U1-Level) centres around 'Need Assessment, Quality Of Life and Empowerment'. A Wider world (U2-Level), on the other hand, interfaces or even overlaps more with the Context Level, centring on what turn out to be strong traditional values and strengths, namely, Family, Community, Religion and Civil Society. Table 3. 2, in this way, puts together prominent items in our conceptual framework. They are proposed as applicable to congruence studies of other services and in other contexts. No doubt, whoever so transfers their use will also do some adaptive modifications. But it is hoped that the applier will be spared most of the false starts and laborious groping that went into the progressive streamlining of the table into a reasonably handy tool.

3.2 Goldberg-Huxley, Hardiker and Health Advisory Service (HAS) frameworks: classifying populations and services by appropriate level of service

It used to be acceptable to say, 'Ladies shouldn't cry, but so many of them do.' An equally outrageous but sober statement would nowadays be that providers should not classify people at risk by service given, but so many of them do. Service should be led by need, not the other way round, but efficiency calls for the shaping of service to somehow classify need. Being referred to receive service will often lead one to be 'processed' along a path that involves classifying and routing. An interesting discussion of the strengths and weaknesses of the 'people processing' perspective is found in Lauffer et al. (1984, pp. 91 ff.). Of course, in an ideal world, providers classify services by people's needs, just as surely as big men cry, too, if they need to, not because of a classification.

One very influential classification encountered in the epidemiology of mental health classifies populations by the level of service they are considered to need. The service levels are the classical ones of primary, secondary (specialist care in the community) and psychiatric in-patient care. A good system is one that activates a number of filters that ensure that the user is at the appropriate level of care. A filter acts as a gate-keeping agent. It helps by selecting

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which persons should go to the next level, and which should not, and moving them to the appropriate level. Filters selectively open or close doors. However, they can do this both correctly and incorrectly. Misfiltered people will end up at the wrong level.

LEVEL 1:	IN THE COMMUNITY:	260-314 /1000/year
1 ST FILTER	illness behaviour – seeking help from primary care services	
LEVEL 2:	ATTENDING PRIMARY CARE:	230 /1000/year
2 ND FILTER	ability to detect disorder	
LEVEL 3:	IDENTIFIED BY DOCTORS:	101.5 /1000/year
3 RD FILTER	referral to mental illness services	
LEVEL 4:	USING SPECIALIST MENTAL ILLNESS SERVICES:	23.5 /1000/year
4 TH FILTER	admission to psychiatric beds	
LEVEL 5:	PSYCHIATRIC IN-PATIENTS:	5.71 /1000/year

Table 3. 4: Estimate of annual period prevalence rate of mental disorder, per 1000, per year, on five levels with four intervening filters (Goldberg & Huxley, 1992, p. 4, adapted)

We are referring to Goldberg and Huxley's classification (Table 3. 4), which may seem surprising in that it represents not only three levels of service (plus the community level), but four. Their synthesis of studies of populations revealed that in fact there are large pockets of population that are misfiltered. Their epidemiology figures reveal that every year 260-315 per 1000 of the general population suffer from some type of mental illness, mild or severe, implying that they should receive treatment at least at primary level. Out of these, only 230 pass through the first filter – that is, exhibit 'illness behaviour', meaning that they seek help at least at primary care. But the second filter – the GP's ability to detect the disorder – detects only about 101, missing more than a half, who are either not treated or simply treated for physical disorder. The figure gives populations for specialist outpatient and in-patient care.

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LEVEL OF INTERVENTION↓	WELFARE MODEL: THREE CONCEPTIONS OF THE ROLE OF THE STATE			EXAMPLES/ EXPANSION
	Last Resort: Safety Net	Addressing Need	Combating Social Disadvantage	
BASE LEVEL (Populations)			Community Education	<i>Welfare and preventive/ educational services for the whole population</i>
FIRST LEVEL (Vulnerable groups and communities)			Community Development	<i>Diverting 'at risk' groups away from service need</i>
SECOND LEVEL (Early stresses)		Social Case-work, Social Care Planning		<i>Interventions in short, temporary crises to restore independent personal and social functioning</i>
THIRD LEVEL (Severe stresses)	Remedial interventions			<i>Risks of significant harm, family breakdown or entry into the 'looked after' system</i>
FOURTH LEVEL (Social Breakdown: in care)				<i>Therapy, damage limitation & permanency planning with social breakdown, children looked after.</i>

Table 3. 5: Needs and corresponding Levels of Intervention and their links with different conceptions of the role of the state (Hardiker et al., 2000, graphically adapted).

Strictly speaking, all filters can 'mis-allocate', and misallocated populations occur not only when persons belonging to level 3 or higher remain on levels 1 or 2, as shown in the figure,

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but also when persons belonging to a lower level are misplaced at a higher level. Figures for these are, however, not included in Goldberg and Huxley's figures.

Goldberg and Huxley's implied prescription is 'thou shalt not misfilter'. In Hardiker's 'grid' it is, 'thou shalt prevent the costlier alternative'. The choice of level of care is determined by benefit, but also cost. Treating a child through residential care will often be costlier both to the user (in terms of intrusiveness and life disruption) and to the provider (mostly in terms of resources and finance). The rule is therefore not to use 'heavier' services when 'lighter' services would be just as effective.

Service divisions attempt to make classifications that are valid both for the user and for the service. But while users can carry all their personal qualities about with them without any fragmentation and with undiminished 'holism', every service division becomes a threat to holism. The flexibility, diversity and change in the user have to be channelled into broad service divisions that need to be stable and administratively distinct. But administrative classifications, on the top level, will have to be few. As a result there will often be an amount of 'making do'.

A look at the service divisions in Goldberg-Huxley and in Hardiker et al, supplemented by those in HAS 1993 reveals that, in the general classification of services, several dimensions tend to become prominent:

1. specialist service vs. generalist service, either on needs-led or service-led (especially practitioner training) criteria
2. 'light' vs. 'heavy end' services (community care being light, residential care being heavy – again on user-focused and service focused criteria)
3. type of prevention exercised (see below)
4. whether service is acute (the client-centred term corresponding to the service-centred term 'short-term') or long-term (which largely is replacing the client-centred term 'chronic', which carries a 'labelling' ring)

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5. whether service is carried out by networking independent mono-professional practitioners or by team (see HAS 1993 and 1995)
6. which is the lead profession or agency or level of government (as in the designation of the social-worker led Local Authority Social Services Departments as the lead agency in case management in the UK in the aftermath of the 1989 White Papers).

It is interesting, for example, to see how 'type of prevention exercised' (3, above) has been found by several to be unsuitable as determinant of overall service division (See Newton 1992, p.25, who quotes Newton & Craig, 1991). It is interesting to note that in the Care Program Approach (CPA) within British mental health services, many local services do not find it practical to separate acute from long-term services or teams. However, the NHS and Social Services guidelines oblige them to separate Simple from Complex CPA. Simple CPA means care programs under the care of a single (obviously monoprofessional) worker, possibly networking with others. Complex CPA involves care, and therefore care plans, that involve more than one practitioner, typically in a team and interdisciplinary. The simplicity of care by one person is not considered as a tarnishing of the ideal of interdisciplinary and team care, but rather as often a welcome way to reduce cost to the services in complexity and bureaucracy, over-riding in importance the division between acute and long-term services.

This official backing of using non-specialist as a prior level and gatekeeper to specialist, and networking or sole professionals as a prior level, similar in function, to interdisciplinary teams, is also interestingly developed in the Health Advisory Service's (1995) *Together we stand: the commissioning, role and management of child and adolescent mental health services* (adapted in Table 3. 6: Key Components, Professionals and Functions of Tiered Child and Adolescent Mental Health Services). The four-tier system can in many ways serve as model of a richer, more holistic and user-friendly mapping out of ideal mental health services for adults than one that defines level in terms of medical input. It is here presented as a division by levels that manages to create room for richly holistic and interdisciplinary service. It leaves plenty of space for the social and strengths models, and makes a very wise and practical choice in the way the six levels on page 35 are combined loosely and, in parallel and selectively rather than

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fully and in cross-division, which would create an unmanageable complexity. However, in not separating acute from long-term services, one should be careful that one of them does not become the Cinderella. British services counteracted the danger of neglect falling on long-term care in several ways.

Level:	Professionals:	Functions:
<u>Tier 1: Primary Level (non-specialist)</u>	GPs, Home Visitors, School Nurses, SSD, Voluntary Agencies, Residential Social Workers, Juvenile Justice Workers	Services to: <ul style="list-style-type: none"> - identify mental health problems early in their development - offer early advice and sometimes treatment - pursue opportunities for promotion and prevention
<u>Tier 2: Service by Uniprofessional Groups Networking</u>	Clinical & Educational Psychologists, Paediatricians, Child psychiatrists, Psychiatric Social Workers, CPNs and Nurse Specialists	<ul style="list-style-type: none"> - training and consultation to other professionals - consultations for professionals and families - assessment – may trigger treatment at different tier - outreach
<u>Tier 3: Specialist Service for More Severe, Complex and Persistent Disorders, e.g. interdisciplinary teams</u>	Psychiatrists, social workers, Clinical Psychologists, CPNs, Child Psychotherapists, OTs, Art/Drama/Music Therapists	<ul style="list-style-type: none"> - assessment and treatment - assessment for referral to Tier 4 - contribution to services at Tiers 1 and 2 - participation in research and development projects
<u>Tier 4: Access to Day Units, Highly Specialised Outpatients, Inpatient Units (severe mental illness or suicidal risk)</u>	(In UK considered as feasible on a supra-district level)	<ul style="list-style-type: none"> - adolescent inpatient units, secure forensic adolescent units, specialist teams (sexual abuse, neuro-psychiatric problems.)

Table 3. 6: Key Components, Professionals and Functions of Tiered Child and Adolescent Mental Health Services

The above frameworks are introduced for important reasons. Mainly, they show that, in presenting a holistic service, other classifications are necessary for good planning than ones built on a primary-secondary-hospital model. Secondly, the epidemiological figures in the first model mentioned give a benchmark, though perhaps of limited intercultural value, for

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expected population numbers suffering from mental illness, which will help for comparative purposes.

3.3 Guiding Values

When Audrey Leathard was introducing her early commentary (1990) on the Thatcherite health service reforms at the University of Malta, she commented on the motto on the then recent White Paper, subtitled 'Proposals for a Social Welfare Strategy for the Nineties and Beyond' (Malta, Ministry for Social Policy, 1990). The motto went, 'Where there is love and care, there God is.' Leathard mused that if a British white paper were to have a motto then, it would be a quotation not from a religious source but from an economist, and a right-wing one at that. In fact, strategies require mission statements, professions are built around codes of ethics and reforms must identify and promote their inspirations, their values and visions.

This section proposes key values for good community care in mental health. International associations – and, nowadays, conscious of the differences that keep dividing them, even inter-professional associations – *do* manage to make statements of value consensus that go a long way. However, what is said in this part of the chapter admits that it deliberately has a strong 'local colour'. It was originally formulated in a privately circulated discussion paper (2000, pp. 7,8) circulated among participants in the reform. It explained that,

The present paper sets out to contribute to the discussion needed to make sure we give the users the best possible deal we possibly can. "Small is beautiful", and there are many advantages in being a small country. But one disadvantage we need to overcome is the relative scarcity of platforms and opportunities for the collaborative development of ideas. Countries at a lower level of industrial development than Malta often have more learned journals, white papers, national seminars, practice manuals and reform handbooks than we do, because sheer size favours the greater availability of sufficiently concentrated effort. This paper is presented as one attempt to help bridge that gap. It will serve its purpose if it focuses and aids collaborative exploration and widely supported decision-making.

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Coming from a small country, one looks with some – though not unalloyed - envy at the deluge of literature that accompanied such changes in Britain like the Mental Health Act and the changes in the NHS and Community Care given shape in 1989-90. In a small country little groups working simultaneously on many functions will have to make do with much less, to soldier on with much less material and often with a dearth of feedback. However, a reform cannot take solid shape unless its direction is defined, and that applies to the operational as well as to the inspirational – value, vision, rationale – level. Small countries may need some extra attention to put together and push forward the needed vision

The two proposed core values, clusters of values or generators of values are needs-led service and the commitment to the good of the most vulnerable. Needs-led service is largely translatable into the concept of '*personalizzazzjoni*'. 'Personalised social services' has been a rather sloganised way of referring to the rapid development in personal social services and social care since around the mid-eighties, correcting a tradition of Maltese social services being 'transfer-heavy and service-light' (if we exclude investment in residential care from the latter). 'Personalisation' (as long as it is not allowed to carry a denotation attached to one political party) can be extended to the key concept that clients do not simply get whatever stereotyped services are offered. Their needs are defined, instead, in terms closer to the client, in a way that could lead to more individualised solutions or services.

Along with needs-led service or 'personalisation' come the related values of quality of life, partnership, empowerment, and a strengths approach. A 'strengths' approach corrects the deficit view that sees needs in terms of illness to be healed and deficiencies to be corrected to reach a level of 'functioning' that is considered normal. A 'strengths' approach assesses in terms of strong points and potential first and foremost, and seeks fulfilment at the highest attainable level rather than the reaching of a base-level minimum. Strengths and partnership are extended to family, community and other areas of potential (such as values backed by society or religion) in civil society. It is to be made clear that all the above values can be operationalised in ways that can help one distinguish between one alternative and another that is more congruent with the value of partnership (or another) or less so.

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The above key values lead to other, no less indispensable, instrumental values. These, notably, are effectiveness, efficiency and economy and related values, prevention (minimising cost both in terms of human suffering and in the use of finance and other scarce resources), and congruence with and appropriateness to context or need.

Key service qualities

Key quality goals would be:

- **Quality of life:** we are not out simply to make people enjoy the absence of disease, or good health: all basic and strategic needs have a place in making life in the community not only feasible but also worth while, enjoyable, full of worth.
- **Holism:** we are now challenged not to consign people to the poverty of life associated with institutions, not only by ensuring all needs crucial to survival in the community are basically met, but also by giving a certain amount of richness to their life.
- **Sustainability:** With the present tension in Malta between an increase in the recognition of need on the one hand, and economic problems on the other, we can operate through the quest for greater efficiency, proper targeting and triage and the choice of low-cost alternatives. What is required also is the capacity to keep seeing the long view. This would avoid losing the pounds to save the pennies, 'being kind to be cruel' by short-sightedly misplaced and counter-productive 'generosity', or directing more of our time to some at the cost of depriving of it others who need it more severely.
- **A preventive approach:** As mentioned in above, and in connection with the Hardiker framework.
- **An encouragement to self-reliance:** With a strong community and family, but weak services and resources, combined with a cultural tendency towards dependency, this aspect should be a strategic objective, translated into specific elements in work plans.
- **Dependability:** Overload is more often experienced on the 'social' side of the services, more than the health and the education aspect. This often gives the service an air of 'hit or miss', a resigned feeling of helplessness that many services are given almost on a 'lottery' basis, that it is mostly a matter of pot luck whether one will be served or not. This is, of

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course, fast improving. It must be further improved to the point that at least those who have the biggest needs, and those whose needs, if neglected, will lead to the highest cost, in human and in economic or service terms, can count on being served.

- **Genuine support:** Respect, warmth and recognition should be communicated to the client.

3.4 Underlying foundational concerns: how do post-modern discussions of the validity basis of value and scientific knowledge affect or colour the conclusions?

This section springs from a concern experienced by the writer that was felt to have wider significance than a purely personal concern. As I undertook to write this dissertation I increasingly felt the need to clear the philosophical basis of what I was doing. It had looked as if quantitative research had been regarded as the guarantee of objectivity and scientific method, but now qualitative research was not only growing, but also vying with the quantitative in the estimation of many scholars as itself the best guarantee of validity. Besides, postmodernist literature was throwing doubt on much discourse that had been at the centre of the literature of the scientific establishment. Postmodernist positions were among the few recently influential new schools of thought, yet they attracted charges of being relativist, anti-scientific and anti-objective and incapable of supporting essential ethical positions. Questions arose as to how need can be objectively defined and assessed. The basis of belief in congruence and integration as a basis for policy design also called for a critique.

However, I wanted to keep my thinking about such philosophical issues apart from the main enterprise of the dissertation, which was empirical in nature, supported by forays into the historical method. As a result, my philosophical concerns are being confined, with very few exceptions, to the present section and to Chapter 10.

Early on in the project I formulated my philosophical concerns as a series of issues and questions. Chapter 10 purports to respond to these concerns. That chapter provides some sort of response to practically all the questions and issues then formulated. It does this in the light

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of the completed research project, and does its best to underpin the dissertation in the shape into which it developed in the years that it took to complete. As always happens, the questions and issues became substantially reformulated and regrouped. This reformulation of questions happened, in different ways, in all the aspects of the research project. Normally the reader is spared the burden of seeing the initial formulations and following them through to the final version, because looking into false starts and awkward initial attempts is both much heavier and much more complicated to follow than looking at the streamlined final product. However, my questions have remained substantially the same though, as I said, reformulated and regrouped in Chapter 10. I will list those question and issues here, with no change from their initial wording. This will convey an idea of the exploration that took place in the intervening time, without burdening the reader with the tortuous intervening pathways.

Philosophical concerns, as formulated towards the beginning of the research project

- To theoretically underpin my central concept of integration / congruency , and its relations with ethics
- To comment on the intertwined subjective and objective elements involved in the ‘social construction of reality’
- To present critical realism (see Chapter 10) as a firm basis for distinguishing between the notions of objectivity and subjectivity, making possible and compatible both a critical approach on the one hand, and robust and non-relativist and non-sceptic use of intelligence and reasoning on the other
- To comment on social causality in an interactionist perspective that is not, however, based on an unnecessary relativism or scepticism about the notion of sociological explanation.
- To see cultural and personal pre-perceptions as an initial given, but which should be the object of critical reasoning (plus intelligent understanding and sensitive observation) just as much as the functional world of facts
- To respond to niggling doubts that people might have that the qualitative is not scientific, while the quantitative is.

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- To comment on rating scales and models as constructs, and to see the notion of construct validity as a way of escaping from the unnecessary dilemma involved in seeing constructs as 'unobjective'.
- To underpin some critique of the concept of quality of life, with some reference in relation to Joe Oliver Lancashire Quality of Life Profile (see Oliver et al. 1996, Priebe et al, 1999).
- To underpin some critique of the concept of need, relating it to Max Marshall's Autoneed Scale (see Marshall 1994, Marshall et al 1995), used for measuring need, met and unmet.
- To find the legitimate place in administration and practice for what is other than the 'evidence-based', trying to characterise the source and the criteria for validity, of what is 'before' or 'largely independent of' the evidence
- To see if Bernard Lonergan's (1957, 1958) notion of the 'truth of interpretation' can be a useful way of indicating how the qualitative is also a rigorous method (whether or not it is called 'scientific' - it is scientific in Popper's sense of being falsifiable)
- To draw attention to the usefulness of Lonergan's (1957, 1958) notion of 'higher integration'
- To show that rigorous scholarship is completely and eminently compatible with the implementation of clear values, but to 'keep the levels apart'
- To preserve a common ground for a caring approach that is congenial to the 'post-modern' world without falling into the clutches of (some of?) the proponents of the so-called postmodernist critical theory who take up untenable and self-contradictory positions
- To give an acceptable answer to any charges emanating from an undermining cognitive or ethical relativism
- To offer a basis for a criticism of beliefs, an antidote to interest-determined accounts of reality that are continuously communicated, an awareness of the ways in which genuineness and honest thinking and doing can lead to development, as opposed to the decline that results from dishonest thinking and communication; illustrating this with examples of how the conflicting rationalities of organisations and agencies (including rationalities related to sectional interests) come in the way of development, and sometimes even lead to decline

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- To underpin motivation in ethical concepts that are meaningful to the Maltese mind, which are very rich, in an area where indiscriminate importation can result in a vacuum of values, while also leaving room for contemporary culture change.
- To show value-related analysis as valid, and to show some relevant lines for its use, motivated by humanistic and solidaristic concerns.

3.5 Value Tailpiece: A 'preferential option' in favour of the most vulnerable

One of the most basic chicken-and-egg questions is whether our perception influences our values or our values influence our perception. As with all chicken-and-egg situations we can never remember a beginning where there was only an egg or only a chicken. We get involved in social policy having found ourselves at the deep end, already in the swim, rather than trying to set our terms before we jump in. We look for foundations *after* having indulged in both perceiving and valuing. Some opt for radically questioning values, others embrace the values expressed or implicit in a social ideology or the ethics of one or several helping professions.

However, this writer attempts to adhere to a value choice that is given precedence over specific ideologies and particular codes of ethics, namely a choice in favour of the poor and vulnerable (see Hennelly A T, 1990). This is considered as a pre-ideological stance (see Lakeland 1984, pp. 62 ff.). As such, it is expected to shape systems of expected social organisation, rather than be shaped by them. It provides a deeper criterion whereby one evaluates particular ideologies so as to decide whether, how far and with what provisos or modifications one is ready to embrace them. Its ring is rather more radical than that of many ethical systems that tend to be followed – and for that reason is often more of a powerful attractor to ever-higher ideals than a descriptor of widespread full-blown achievement. Still, this ideal is thrown forward, as an appeal to go rather deeper than many widely acknowledged codes of behaviour, addressed to reader and writer alike. Now, having focussed on foundational issues, and admitted an initial desired value bias, we push these below the surface until we re-visit them in Chapter 10.

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Chapter 4

Country Context and Reform Narrative

This chapter has three important contributions to make to this extended discussion aimed at finding the best service models for Malta's community care, while also developing a method for adaptive policy adoption. First, it gives an overall presentation of the Maltese welfare state in a manner that is descriptive, comparative and explanatory. As far as the present writer knows, no attempt has yet been made to describe and interpret Maltese welfare as a whole, or to locate the Maltese welfare state against the current typologies of welfare states or welfare regimes. An explanatory approach is important for the present essay, in that it seeks to explain what moulded, what maintains and the influences emanating from this welfare state.

Second, in this chapter we describe the Maltese country context, attempting to understand its dynamics. This contributes to the analysis within what we have termed the C- or (Country) Context Level in our Active Remodelling for Congruence. Out of the general discussion of the context we wish to draw out and understand the context's salient characteristics. These we will take up again once we are at the stage of fitting service models to the context, as they characterise it.

Third, in its final part it will present a critical narrative of the Maltese mental health reform, from 1995 till 2001. As we come to the main focus of our interest, we shall have moved from background to foreground, from the context to the subject itself, from the C- or Country-Context Level through the O- or Organisational Level and into the S- or Services level. Preliminary readers have pointed out that it is better, for the sake of a satisfyingly continuous narrative, to so press on with the history and narrative, moving from context to subject, rather than splitting the account into several chapters that keep the levels separate.

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The understanding of the country context should help us to see what services and service adaptations would fit within it. In Britain, the development of community care went hand in hand with very deep and wide-ranging reforms in the organisation and management of both social and health services. It is hoped that a contextual analysis will help one decide how far and how a change in the context and organisation will also be needed to improve the quality of life at the User (U-) level.

The simultaneous use of the explanatory and the comparative gives, one would hope, some protection against both indiscriminate service design importation and, equally, 'home-grown' solutions that also do not fit the tone or the dynamics of the country one is working in. In other words, we are after a congruence that is both functional and 'meaningful' (see Sorokin 1947 and below), taking the latter provisionally to mean all that makes sense to people beyond what we may call the functional, or 'purely functional'.

Malta and its welfare system will be first introduced by a brief presentation of its geography, demography and economy. Then the history of its welfare system's rich but not always steady development will be narrated, hoping to give insight into important aspects of both the functioning and the particular tone or character of the islands' system of social provision.

The comparative analysis will focus first on the indicators of the various welfare regimes, and then on the ways and degrees in which what in Britain is labelled 'new managerialism' and, in a broader perspective, the mixed economy of care and administrative reform, give shape to what happens. After this, the account of the mental health reform will be taken up.

4.1 Introducing the Maltese Welfare State

4.1.1 Geography, economy, demography

Geographically, as we have seen, Malta is small in population (381,000 in 2000; Department of Statistics, 2000) and still 'smaller' in area: 315 sq. km. Such smallness results in a tight-knit and stable community. In a town with the same population in an average-sized or big country, the average member of the population will have friendships and links that form a

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network, much of which spills out of the confines of that town. In other words, they will know and interact with many people living outside the town. The people they know outside town will in turn have many of their acquaintances and associates living even further afield, being therefore joined to networks involving many strands that radiate further out. Not so the average inhabitant of a small island state. A much smaller proportion of the network links will cross the confines of the island. Many of these will 'bounce back' at the coastline and link to people who, again, will throw out links which will make the network within the island still thicker. In big countries the confines that 'bounce the network into itself' are much farther out, involving much less network density.

Maltese, in fact, rarely move house in pursuit of a new job, because all work places are within easy commuting distance (though commuting between the two main islands often leads people to make an exception). Communities are stable across the generations, though, admittedly, this is increasingly coming to mean living within easy commuting, rather than walking, distance. "Malta zghira u n-nies maghrufa" ("Malta is small and reputations are widespread") is a proverb that conveys this. Being often 'known' is part and parcel of living in 'strong' communities. This quality, not always welcome, often sits side by side with the supportive potential in small communities, an aspect to be borne in mind in developing community care.

Malta's geographical position between North and South reflects its economic status. With a GDP per head of \$9525 (The Economist Intelligence Unit and Central Bank of Malta, 2000), it has only a decade or two ago moved from developing status to a newly-developed country, being now accepted as one of the very top economies among the countries applying for EU membership. The growth of the economy and the development of welfare are at present seriously constrained by the struggle to reduce the government's budget deficit, which stood at 11.7% of the GDP in 1998. The government's plan to steadily reduce it to 3% by 2004, mainly by restraining expenditure and clamping down on rampant tax evasion, seems to be on track. A public debt (including parastatal companies') of 60% of the GDP is proving harder to reduce and the squeeze has slowed down economic growth to 4.5%, considered to be modest for an island economy. This too has to be borne in mind in developing community care.

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Malta has, since the 1950s, had a most dramatic increase in both life expectancy and fertility rate (latter being now at par with those of Sweden and US). Dependency ratios will be expected to have dropped from 4.2:1 to 2:1 between 1994 and 2030 if current trends continue, creating a 'pensions time-bomb' that has now become prominent in popular awareness. The debate on an effective and accepted solution is right now steadily picking up momentum.

4.1.2 History of the Maltese Welfare State

Putnam (1993) discovers a much more vigorous civil society in the North than in the South, and attributes this to the difference of regime that started with the Norman Conquest of the South. What better way to start our 'tale of two islands' (that is, a study that has, at core, a comparison between Malta and Britain) than to start with Malta's own '1066'. This history, true to the value and service preoccupations of this dissertation, will focus on developments and expectations regarding institutional and community care social welfare, civil society, power and participation – or, to put it in a nutshell, the intertwined themes of *welfare, cultural identity and empowerment*. The aim is to find aspects of the context of welfare that, like Putnam's empirical results, find their explanation in events and processes that occurred in the past.

Malta underwent a Norman Conquest in 1091, 25 years after Britain's, though this became more definitive in 1127. Malta then became part of the Kingdom of the Two Sicilies, comprising Sicily and the southern half of mainland Italy. It then merged into that kingdom's destiny as its rulers, through rebellion and war, marriage and inheritance, became the Hohenstaufen, then the Angevin and then the Aragonese dynasties. Malta was ruled like a Sicilian commune, with an elected local government called 'Universita' based in the fortified capital, Mdina. Welfare was exercised in the manner characteristic of the Middle Ages centred mostly on hospitals (see Fiorini 1989), that sheltered the frail and the destitute, and brought up

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foundlings and distributed alms and bread to the poor. Remarkably, Santo Spirito Hospital outside Mdina survived from a date before 1372 till 1967. Community health, in the form of a government paid pharmacist and doctor (the latter later called the District Medical Officer), gave their services free of charge to the poor. The first discontinuity in this service occurred in 1977. A traumatic 10-year doctor' strike/lock-out started then, massively affecting both hospital and primary health care. Its underlying cause is seen, at least partly, as a dispute smouldering precisely around the provision of free primary care – a limitation that was to have important repercussions on the mental health reform.

By the 1300s, therefore, a backbone of the overall welfare services was already in place. Maltese welfare was probably very typical of welfare in feudal Europe. Mainly financed through philanthropists' foundations, it featured 'last resort' (see Hardiker 1991b, 1999, 2000, classification of service) total institutions joining the functions of hospital with long-term residential social care, free community medicine for the common people, alms for the poor. This backbone remained constant and received incremental changes until the coming of the post-war modern welfare state.

Putnam (1993) finds that the frontier between the very vigorous civic participation in Northern Italy and its rather stymied existence in the south coincides with the upper border of the Kingdom of Sicily. Between the 12th and 16th century, the North was a collection of the democratically liberal city-states. Meanwhile the south became a successful kingdom, under a monarchy that was to be the forerunner of the model of an absolutist, authoritarian and repressive regime that later on became the rule in Europe. Malta may have been, at least at times, less tightly controlled, at least for noblemen. In fact, the Sicilians' rebellion against Charles of Anjou, which started at the 'Sicilian vespers' in 1282, is said to have been fomented in Malta for that reason. Still, on the political, administrative and civic front, Malta shared the fate of the forceful and authoritarian southern kingdom. By the end of the 12th century, "Sicily, with its control of the Mediterranean sea routes, was the richest, most

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advanced and highly organised state in Europe” (Times Atlas of World History, p. 124, cited by Putnam, 1993, p. 123).

In the turmoil, lawlessness and internal strife of the turn into the sixteenth century, the time of Macchiavelli (Hale, 15 ff.), even the North found it necessary to have a strong prince. Yet, Putnam’s researches find these ex-city states, in spite of such political change, are even to this day, better able to ‘manage collective life and sustain effective institutions’ than the South.

Malta’s destiny parted with that of Sicily as it entered two long dominations that affected its civic life, its openness to the rest of the world, as well as its welfare. In 1530 Charles V of Spain handed Malta to the Knights of St John, making the order’s grand master technically Malta’s feudal lord. While the grand master displayed more and more the trappings of royalty, Malta grew increasingly like a sovereign country. But the Maltese lost whatever autonomy, Sicilies style, they had as a commune, and were subjected to a despotism that was however, marked by generosity in what we would today call welfare provision. The knights had originated as a religious order to take care of the health of pilgrims to the Holy Land. While later they became a crusading and military order, they never relinquished their welfare function.

The knights were a peculiar group of rulers (Luttrell, 1993, p. 257). However, in the opinion of the present writer, the greatest peculiarity of Maltese welfare at the time was that, while in other countries welfare was largely run by Church bodies and philanthropic foundations and institutions, what we today would call NGOs, Malta was, from 1530 till 1798, ruled by a rich, multinational, aristocratic and religious welfare NGO. The Knights of Malta were possibly the only welfare NGO ever to become a government. While they were not forerunners of democracy, they were, as a result of this novel development of role, among the very first major forerunners of substantial state welfare. The Knights of Malta, and groups related to them, exist as NGOs till this day. The biggest welfare NGO to arise in post-communist

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Hungary, for example, is one such association, commonly referred to there as ‘the Maltese’ (see Szeman & Harsanyi, 2000, especially pp.73-83)

During their stay, the knights established the best hospital in Europe as far as its ‘hotel’ aspect, with medical expertise at times attaining international renown. Hospital was open to all, rich and poor, men and women (in separate establishments), free or slave, Catholic or Lutheran. The knights used to come and serve the sick, leaving all signs of rank outside. So did the Grand Master, until he decided one day to turn this obligation to one to visit the Blessed Sacrament in the chapel (Cassar, P, 1983, 1992), this change obviously reflecting the gradual decline of the order’s highest ideals. Still, the knights started other charitable foundations too, besides financially rescuing and taking over pre-existing ones. The two-year French occupation, much of it under the control of the rebellious but impecunious Maltese, disclosed the knights’ munificence, through the contrasting poverty and dereliction that ensued when their charitable works were discontinued. Over these centuries there were important cultural and economic changes (Cassar C 2000). Malta’s harbour area became a cluster of four walled cities with a very distinct and cosmopolitan way of life. Perhaps it was because of Malta’s smallness that the Maltese could not afford the disdainful cultural resistance that Lampedusa (1991, 1999) classically attributed to the Sicilians. But in the wider country context, characterised by a near-feudal economy, and severely limited empowerment and participation rights, continuity much more than change remained well into British rule and into the twentieth century. There was also incremental change overlying a relative continuity in the welfare system.

Early British rule was, in fact, another ‘historical litmus’ or discloser. British 19th century liberalism clashed with Maltese expectations regarding welfare. “There is too much charity in Malta,” remarked Sir Penrose Julyan (1880) commissioned in 1878 to report on administrative organisation and costs in Malta.

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Everybody in Malta who lives by daily labour, that is every working-man, is considered to have a claim to receive medical assistance and medicines gratuitously, when he or any member of his family is ill.

However, Sir Thomas Maitland, the first British governor, had found there was no other option than for the colonial government to assume responsibility for the multiple health and social care services started or assumed by the knights. A government monopoly on the provision of grain, the most staple food for the populace, justified as a way of keeping prices down, duly crowned the welfare responsibilities that had to be assumed - quite a tall order for nineteenth century Britain, where liberalism reigned supreme.

In pursuing our 'tale of two islands', it is very enlightening to do parallel reading of G Pirotta's (1995) and R Pinker's (1971) accounts of this period as it unfolded in Malta and Britain respectively. An interesting period is the governorship of Patrick More O'Ferrall (1847-51). He showed enormous insight by accepting the analysis of a visiting liberal economist, William Senior Nassau, who saw that the great dependence on government that the Maltese got used to during the time of the knights had not only cultural but also deeper economic roots. Back home in Britain he was the most prominent of the originators of the British Poor Law amendment act of 1834 (Pinker pp 53-65) which abolished out-door relief and started the workhouses as the remedy against poverty, which liberalism saw as the result of indolence. However, this same economist saw the confinement of government's role to "the strict duties of protecting its subjects from violence and fraud" to be insufficient in Malta. Government was such a big landowner that this left little opportunity for entrepreneurship. One should add that the key industry through the periods was defence, and this again constrained potential industrialisation. Government was therefore to be more active in improving the infrastructure and in promoting trade. Maltese participation in high civil service roles and entrepreneurship were restored. Incidentally, Senior Nassau gradually turned to relatively more collectivist views, implicit in Bentham (Pinker, p. 66).

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In fact, the British basically left Maltese social care outside big institutions alone for the Maltese to run and develop. The early British protested ineffectually against the protective atmosphere in residential care that contrasted with the deterrent features of their workhouses, but basically concentrated their main effort on poor-house type institutional care and hospitals. The latter 'exception' was in line with the cautiously collectivist view that was gaining ground in Britain. As Dicey put it (p. lxxiv) "A collectivist never holds a stronger position than when he advocates the enforcement of the best ascertained laws of health". The idea that health service is less open to abuse than others even gained the support from JS Mill in the 1860s. Pinker (p. 72) describes 1861-91 as a period of hospital building that was unprecedented in its volume. Remarkably, its beginning and end were marked out in Malta by the inauguration of the Attard 'lunatic asylum' (the present Mt Carmel Hospital) in 1861 and the Mgieret 'poorhouse' in 1890, both large institutions that are still in use today. The visiting Florence Nightingale, an admirer of 'continental' models in more ways than one, praised the second of these as an ideal poorhouse (see also Cassar, 1993).

After the mid-1800s, Britain was gradually won over to the idea of institutional state welfare. But in Malta an impressive array of Maltese became founders of residential 'institutes', staffed by Catholic religious (See, for example, Grasso 1992, 1995, Bonnici 1988, 1999). Beyond that, Britain fast outstripped Malta in the development of the 'social security state', that throughout Europe was precursor to the post-war welfare state. Malta's social security developed more slowly than Britain's, and its post-war welfare state did not have a 'big bang' inauguration, as Britain's did.

This was not for want of a favourable ideology, but due to a combination of low GNP and low taxation. In fact we can say that the three highest determinants of Maltese welfare have been a high expectation of state welfare, cash limits and a resistance to taxation by important sections of the middle class. For long periods during British rule, the main tax was on bread and, as such, paid in higher proportions of income by the poorer sections of the population. The landowners and businessmen not only resisted taxation on land and income, but also mobilised the common people, who were not yet enfranchised, to vigorously protest against attempts to

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introduce such progressive taxation. “This was putting the principle of ‘no taxation without representation put on its head,” remarked Dominic Fenech (1998).

Malta’s start of the welfare state consisted in the introduction of income tax and a successions and donations bill as late as 1947 and 1948 respectively (Pirotta 1987 pp. 100, 116), and the introduction of the National Insurance and National Assistance Acts in 1956. Free secondary schooling and university, as well as free hospitalisation and increased government intervention in housing and employment, took decades to emerge. There are still today features that are integral to social welfare in western industrialised countries that are not covered by the Maltese welfare state. Most notably an NHS GP service (beyond health centres featuring no patient registration and little continuity of care) and free medication irrespective of means for people not staying in hospitals are still lacking. Besides, professional social work only got off the ground around 1980 (Pace 1993), and many aspects of social care still have a lot of catching up to do if they are to be anywhere near average OECD countries.

With this we interrupt our historical account, leaving the most recent developments for the description of the present.

4.2 Situating Malta among the Models of Welfare or Welfare Regimes

4.2.1 Basic structure and amount of expenditure

Esping-Andersen’s (1990) seminal classification of welfare regimes in capitalist countries will be the main framework against which we will attempt to situate Maltese welfare. However, we shall use first two other sources of classification that historically came earlier. The first

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will be in terms of proportion of Gross National Product (GNP) spent on welfare, while the second we shall call the 'basic structure' of social security and health financing.

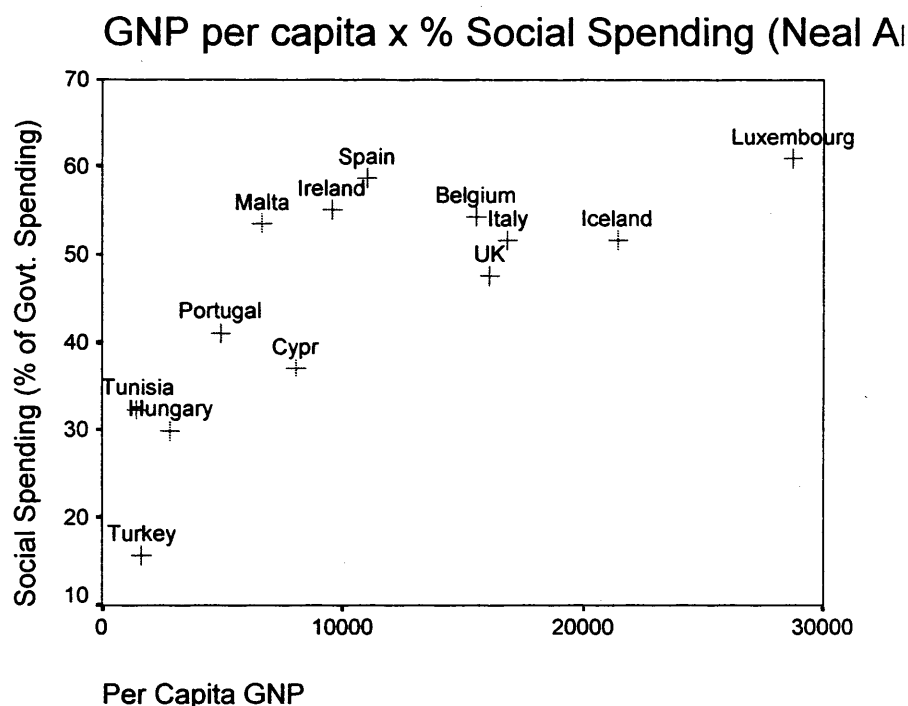


Figure 4. 1: Social Spending as Proportion of Government Spending, against GNP, of selected countries (Anderson, 1992)

Prior to Esping-Andersen's theories, the proportion of the GNP spent on all welfare was considered to be the best summary indicator of model of welfare followed. The higher the proportion the stronger was considered to be its socialism, or the normative character of state welfare within it. The lower the proportion, the stronger was its liberalism, or the residual character of the state's intervention in welfare. With respect to this crucial question, only a tentative answer can be given. Comparative data require the comparison of like with like. Different governments have different definitions of the categories they use. Malta's Statistics Department is at present in the throes of converting to EU definitions, and widening the

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inclusiveness of Maltese GNP figures. As a result, new statistics are beyond our present scope, and only figures from 1992 will be cited.

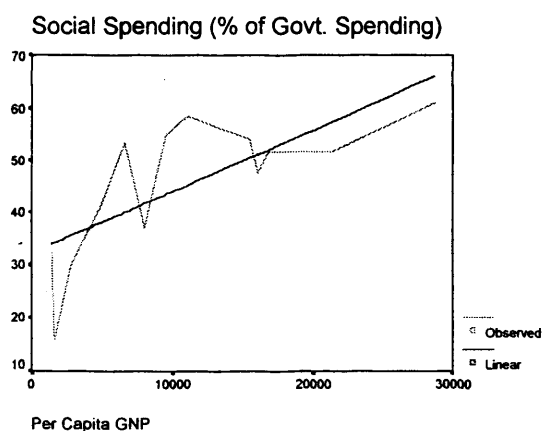


Figure 4. 2: Social Expenditure as Proportion of GNP against GNP for selected countries: Regression Line (Based on data in Anderson 1992, shown in Figure 4.1)

Figure 4. 1: Social Spending as Proportion of Government Spending, against GNP, of selected countries (Anderson, 1992) graphically represents his data, comparing Malta's social expenditure with that of a selection of other countries. The proportion of a country's government expenditure that goes on welfare is plotted against the country's GNP. Three conclusions are clear. Firstly, the richer the country, as a rule, the more its government spends, proportionally, on welfare. Secondly, countries, however, vary, within that tendency. The more generous a country, the more it deviates up from the regression line. The third conclusion is that Malta is among the greatest 'deviants' on the higher-spending side.

Two remarks can be made. First, Malta appears among the highest because the most generous spenders (such the Scandinavian countries) have been omitted. On the other hand, Dean Anderson, ever an advocate of caution in spending, could have made his point more strongly if he brought it to the attention of readers that government spending is much higher than average

SPECIAL NOTE

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as a proportion of the GNP. Malta, therefore, spends more of its state expenditure on welfare, while state expenditure is a quite bigger slice of the GNP than average.

As to basic structure of its welfare state, Malta seems to have had no other model to imitate than the British one. A National Insurance model prevails in social security, while financing of the state health service comes from general taxation. In other words, it was based on 'Beverage', rather than 'Bismarck' or 'Business' (following Zollner's (2000) nomenclature; see also Saltman et al., 1998)

One might object that Malta's state health expenditure is not financed by general taxation, but by National Insurance, if we go by the official annual 'welfare gap' estimate. Government estimates, or the year's national budget figures, always include a balance sheet that places a number of categories of welfare expenditure against National Insurance contributions (Ministry of Economic Affairs, Annual Publication). On the expenditure side are placed not only the National Insurance benefits, but also the recurrent expenses on the divisions (or clusters of department) of Health and of the Elderly and Persons with Special Needs. The resulting deficit is described as the exact yearly sum of what in Malta is called the 'welfare gap'. *Il-welfare gap* has been used to annually impress on people's minds that, though the National Insurance (NI) has been, till very recently, strictly speaking in the black, it carried a balance problem, locating in the more impressive present through 'creative' accounting a problem that will surely catch us up, but later.

Outside the domain of the 'tendentious' categorisations of the 'welfare gap' balance sheet, health expenditure can only be attributed to general taxation. In fact, Malta joined early the big club of countries that have resorted to the 'pay as you go' system that pays today's pensions with today's contributions and keeps no ring-fenced funds either for the future or for the present. The financing of NI by NI contributions is therefore usually an approximate, rather than exact statement and, therefore, the conclusion that Malta's basic financing structure is British and (a 'later model') Beveridge still holds.

4.2.2 Locating Malta among the Welfare Regimes

Esping-Andersen classifies welfare regimes by describing in terms of indicators that are structural and quantitative, and explaining them in terms of the ideological and political history that led to them and to the contexts that tends to maintain them. To ask which such identity Malta carries one has to study which of the three social movements (liberal, socialist, conservative corporatist) were influential, and in what way.

However, we shall look first at Esping Andersen's descriptive and comparative indicators. He applies quantitative indicators to 18 of the 25 OECD countries (excluding, most notably, the 3 poorest and the few smallest ones). Liberalism, he hypothesises on the basis of his historic-political analysis, would be expected to score highly on means-tested poor relief, private pensions, private health spending and high benefit differentials (between those who get the highest and the lowest). Socialism would score highly on Universalism, while high Corporatism, Etatism, Benefit Differentials and Support of the Traditional Family would mark Conservative Corporatism's welfare system. He tests and confirms the hypotheses. But the countries are not divided into three neat groups of members each 'getting full marks' for exhibiting a model in its pure state. In fact, all countries manifest mixes of different doses garnered from each model. But the tabulated ratings confirm quite strongly the divisions hypothesised on the basis of a historical-political and intuitive analysis. In each group, one model strongly dominates, empirically justifying the threefold classification.

The present writer has worked out most of the indicators for Malta for 1989, which is conveniently more or less half way between Esping-Andersen's date and the present (**Table 4.2: Esping Andersen's** indicators applied to Malta for 1989.) The results are, at first sight, surprising. Malta is among the top three or bottom three for all but one of the indicators that could be worked out! More surprisingly, it scores highest on the Liberal indicators (means-tested poor relief and private health spending), lowest on Corporatism and is ranked only

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seventh for socialism in terms of ‘average benefit equality’. This contradicts the expectation of socialism based on percentage of GDP dedicated to social spending.

	Liberal	Socialist	Conservative Corporatist
Corporatism			x
Etatism			x
Means-tested poor relief	x		
Private pensions	x		
Private health	x		
High benefit differentials	x		x
Universalism		x	
Welfare supports traditional family			x

Table 4. 1: Esping-Andersen's (1990: 47-54) indicators of socialism, liberalism and conservative corporatism

One possible clue is that the OECD list omits, out of that ‘richer nations’ club’, four Mediterranean countries with an average GDP (among them) close to Malta’s (Spain, Portugal, Greece and Turkey) and two with population sizes similar to Malta’s (Iceland and Luxembourg). But, in fact, some reflection on each indicator in its context will show how the Maltese context is so different from the listed countries as to alter the meaning (though possibly not the relevance) of the indicators

Malta turns out to have the lowest score possible in corporatism. Corporatists conserve income differentials through the multiplicity of their pension schemes. Different professions or occupations have different pension schemes, and benefits are in proportion to salary. Malta has only one pension scheme, the National Insurance one.

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Since 1979 this has changed in being income-related, in both contributions and benefits. Thus, Malta retained a British or Beveridge type structure, but departed from the British liberal flat-rated mould and gave it a 'conservative' significance. But it scored the lowest

Item	Definition	Figures for some countries, means and standard deviation + at top of scale -at bottom of scale	Malta's place in list	How Liberal is Malta ?	How Socialist is Malta ?	How Conservative. Corp. is M.?
Corporatism	How many distinct occupational pension schemes?	+ Italy 12, France 10 - Australia, Ireland, New Zealand 1; UK = 2 mean = 4.1, sd = 3.2 Malta: 1	Last (with three others)			---
Etatism	Expenditure on Govt. pensions as % of GDP	+Austria 3.8, Belgium 3 UK 2 US 1.5 Sweden 1.0 Malta: ambiguous	?			?
Means-tested poor relief	(as % of total social expenditure)	+ US = 18.2 Canada = 15.6 Italy 9.3 France 11.2 -Sweden 1.1 Denmark 1 Finland 1.9 mean = 5.9, sd = 5.1 Malta: 14	3rd	+++		
Private Health Spending	% of total	+US 57, Canada 38, Australia 30% - Norway 1, Ireland 6, UK 10, Italy 12 mean = 22, sd = 14 Malta: 43%	2nd	+++		
Average benefit equality	ratio, maximum/minimum benefit	+ Australia, New Zealand 1, Canada = .99 - US .22, Japan .32 mean = .65, sd = .22 Malta = .73	7th		+	

Table 4. 2: Esping Andersen's indicators applied to Malta for 1989.

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possible in 'corporatism' because it drove out of service all other existing pension schemes. The pension, for full contributors, was to total a generous two thirds of salary. However, the NI pension would be reduced by any amount received in pension from another source. This rendered all other pensions, barring ones that massively exceeded the two-thirds' entitlement, useless and 'money down the drain', so that they were all quickly liquidated. Only now, in view of the increasingly publicised 'pensions time-bomb', is there a significant and growing call to create room for private pensions.

The 1979 'two-thirds' pension' reform, by introducing an income-related pension, signalled the end of almost a decade of the most egalitarian income maintenance policy in Malta's known history, probably among the most effective exercises in equalisation ever, anywhere (see Kaim-Caudill 1981; Malta Labour Party c. 1982). The Nationalists returned to power in 1987, further increasing social security, re-liberalising trade and increasing wage differentials, as the economy vigorously pursued a dramatic upturn.

Beneficiaries of the two-thirds pension have a ceiling which, if not raised in response to inflation, will soon mean that pensions will start amounting to less and less than two thirds for more and more pensioners. However, this does not apply to ex-MPs and ex-presidents, and does not apply in the same way to ex-soldiers and ex-police officers, civil servants recruited before 1979 and (anomalously) ex-British army pensioners . This could perhaps be classified as 'etatism', privileging those who work directly for the state. In practice this is a similarity to conservative corporatism, but what remains of it after 1979 is really very weak.

Having been reluctant collectivists, by now the Nationalists became strong left-of-centre, in a Christian Democratic mould (see Schiavone, 1991). At times, though it turned out to look for more leftist solutions than the Labour Party, which assumed New Labour ideas about the

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economy by the time it returned briefly to power between 1996 and 1998. The question arises whether the indicator means that Malta has had nothing to do with the conservative corporatist tradition. In fact, the conservative corporatist social insurance structure was never present. Occupational pensions, in fact, have disappeared from the scene since 1979, though pension reform proposals are expected to favour their reintroduction. What we have perhaps is what could be called 'conservative corporatism by osmosis'. Catholic social teaching has had its moderating influence on right and left in Malta, at least after 1919 (see Agius 1991), the same way that it influenced the type of redistribution advocated by conservative corporatism. The near-amalgamation of conservatives and Christian democrats on the continent also furthered this 'osmosis' through the Nationalist Party. However, the pensions system is both universalistic and income-related. Esping Andersen would certainly place it under the Social Democratic model, with its extension of universalist benefits to a middle class that does not shop around for private pensions. The latter, however, is not an option as yet, so that middle class preference is as yet a coerced one.

Added to Esping-Andersen's list, Malta would be second most liberal for proportion of means-tested benefits, and third most liberal on the criterion of highest percentage private spending on health. This seems to contradict all claimed expectations of welfare generosity. One thing that is certain is that these are not driven by any expressed right-wing motivation. A Maltese is surprised to find out that many American or British, and lately Italian, politicians expect to catch more votes by saying that they want to reduce welfare. At home, such a claim would be politically suicidal, though lately the need to temper generosity with caution has become increasingly accepted.

But receiving a means-tested benefit is rarely seen as humiliating in the Catholic, interdependent Mediterranean and ex-colonially dependent Maltese mentality. What is and what is not means tested more or less follows British definitions, which may be a liberal legacy. However, national assistance is on a national level and has a much firmer coverage

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than in many Mediterranean countries. Its ring is more one of generosity than exclusion. Long years with little or no control of abuse, again, do not smack of liberalism.

Observers were surprised in 1999 to hear two authoritative descriptions of the Maltese health services. One was that Malta's private spending on health, at 40%, is Europe's fifth highest (European Observatory in Health Care Systems, 1999, p. 33). Church hospitals disappeared from the scene in reaction to an effective nationalisation threat during the socialist seventies. Hospital care takes place in state hospitals, except in the case of a very small minority who can afford and opt for private care. But free state GP and medical specialist services as well as pharmaceutical service in the community are accessible to or preferred by only a minority, and that is where most of the 40% expenditure goes.

The second was that Malta's health system is the fifth best in the world (WHO, 2000). A good look at WHO indicators will attribute such a good placing to the following items: (i) Malta's hospital and medical care in general, as well as its health status, is of a standard that is very near to that of the most developed countries; (ii) the system is described as very equably distributed; (iii) the expenditure it entails is much lower than that of such countries.

One wonders whether the report underestimates differences in standards between paid and free services in the community. But Malta's highest distinction was that it ranked second lowest in the world in terms of cost of the service. Malta's medical association warmed to the honour to the service but this gave further ammunition to its insistence that this is not sustainable, claiming that its members were actually subsidising the system heavily by being paid less than par for state service.

The interrelation, if not symbiosis, between public and private health, is an interesting case of a somewhat uneasy but long-lasting Maltese settlement between left and right, state service and the market. Doctors' state pay is incredibly low, and flat rated. Their private practice is

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highly lucrative, in proportion to service and marked by very low tax compliance, State hospital care becomes a patient attractor to private practice. In private practice patients tend to get more attention if they can pay more. When teachers give private lessons in the evening to children they teach during the day, schools consider this to be unethical. But state hospitals allow patients to choose their consultants by the simple and exclusive expedient of attending their private practice. This creates no problem in case of self-disciplined doctors. However, protection from abuse becomes very difficult to enforce. Many doctors will retort that exercising more control on this, short of blatant abuse, is unthinkable, given their 'subsidising' the system. What would in a richer country – or in a more northerly one – have resulted in a clearer and more 'over the counter' settlement, seems to be more than the Maltese system can afford.

Still, it is interesting to see, in this WHO report, small and Mediterranean countries, often described in welfare literature as struggling hard to catch up with the 'established' countries, rated on top. The desirability of the Mediterranean art of making do or *arrangiarsi* is a deep issue of governance, with fierce pros and cons. But the added tendency in small countries for matters to be unregulated, and for conflict of interest to be tolerated, probably calls for proportionately greater initiative and more decisive collective effort for greater equity and for a more level ground. Genuine empowerment and system sustainability seem to call for it.

For, though there are vociferous calls for left-wing and left-of-centre generosity in Maltese welfare, the right speaks less but has many cards to play. While tax evasion by the self-employed has long been known, its extent has only started to be revealed through published statistics since around 1997 (see Pace 1997). Perhaps with more accomplished high-level entrepreneurs, Malta would have been better prepared for globalisation. But the same middle class tradition that resisted the introduction of taxation minimises their effects once introduced till this day. Perhaps the most serious problem of social exclusion in Malta is this middle class's largely excluding itself from paying its full share for social policy, while still in many ways directly remaining its beneficiary. Data even suggest that, for many self employed,

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National Insurance has been regressively redistributive, that is, using the contributions of the poorer to pay for the pensions of the richer.

Such evasion also shackles sustainability. Some services – like a generously ‘full’ spectrum of health care – should never become means-tested. Like Scandinavian services or the British NHS, continued coverage of the middle classes guarantees their continued support and protects from slipping standards and a migration of quality from the public to a rival paying sector. But if the richest declare themselves to be of more modest means, the brunt of greater contributions or exclusion from service will be borne by the higher-salaried people, who earn much less. The doctors’ recent clamour for a special hypothecated health tax (February 2000 conference, see below) can only result in the middle brackets paying for the service of their richer counterparts. It is in the interests of doctors to support all efforts to curb tax evasion effectively, because only this can make possible the allocation of greater funding for health coming from those who can afford it, without undermining the service to the majority.

An equally uneasy settlement between right and left occurs in housing. Malta’s population was second only to Russia’s in the percentage of persons killed during World War II. An emergency law that froze rents at 1939 levels still applies, 62 years after the post-war emergency, with a security of tenure that passes to the tenants’ relatives too. But new houses can only be bought at prices that rose seven-fold in about 10 years, often necessitating a lifetime of double jobs to afford one (see Pace 2001b). Yet, neither of the two main political parties actively favours any limit, either to the extreme socialism that reins in old rented housing, or to laissez-faire in the market for new houses. The most potent law about expectations seems to be that, while people express themselves in the culture’s current rhetoric, their expectations often coincide with what the system in fact provides! ‘Much will have to change if things are to remain the same’, to quote Lampedusa, hoping that what will be conserved will be the generous, the efficient and self-reliant, rather than the opposite. This will test and stretch Malta’s capacity to understand, communicate and change

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One of the most important factors in a welfare system's country context is, according to Esping Andersen (1996), its capacity to and mode of achieving consensus. Malta's elections are fiercely fought, with voting percentage being the highest in the world for non-compulsory voting. Parties run neck-and-neck while an alienated floating vote can easily tip the balance. As a result, both parties are sorely tempted to seek solutions that least rock the boats. While a sober attitude has increased the areas where a mature discussion and a calm consensus is sought, anything that touches established welfare practice tends to be seen as an opportunity to demonise the other party, grabbing the chance for a tit-for-tat. The star of the show will probably be the settlement about the pensions time bomb, which will severely test Maltese society's readiness to find solutions that are maximally win-win and consensual.

4.3 Mixed Economy, Public Management and Community Care: Old Moulds and New Transformations

Reform in management was at the heart of the transformation of British community care. In fact, for more than a decade, the reform in management and financial management was so all-enveloping that it could be said, as far as the goals of central government was concerned, to practically constitute the change that was introduced. One of the main criticisms at this time, in fact, was that the values of efficiency and responsiveness to consumer demand relegated the caring values of the helping professions to a secondary role.

'The problems are the same everywhere, but different countries have to come up with different solutions,' David Challis aptly put it (in a personal communication). Active Remodelling for Congruence will be used in an attempt to identify responses that better fit the local context in response to the problems that prompted many to focus attention on community care.

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In order to schematically represent sets of solutions that have been widely tried, two sets of disaggregated model components, in ARC 'unpacked' fashion, are presented in Tables 4.3 and 4.4, listing components of new management belonging to ARC Organisation and Context levels respectively. Using more recent language, they largely refer to components of New Public Management and New Public Policy respectively. Some items in Table 4.4 are singled out by means of an asterisk to indicate that they tend to be 'right wing' solutions. This refers to policy components that manifest a dominant belief in the market and that tend to be stronger in the more neo-liberal welfare states like the US, UK and New Zealand.

It is not the intention of the present enquiry to review the evidence evaluating the desirability of the components of new public management and new public policy. Sceptics say savings accruing from the former have been found to be quite modest even in such profoundly adept countries as New Zealand. Regarding the latter, the introduction of markets has been described as creating more problems than it solves (Saltman et al. 1998).

The sets of items are therefore largely presented as menus. Much synthetic intuition and creativity will help in any action-oriented exercise in congruence analysis. The inventories in Tables 4.3 and 4.4 have been constructed over the British experience. British 'new managerialism' and community care reform have been a leader, guinea pig and influential model to others. Its reform involved a change from a model of provision that was initially among the most integrated, which was rapidly decentralised, using both novel concepts of quasi-markets and a strong component of marketisation and privatisation. The rapidity of the change and the centralisation of its control also contributed to making the UK a very good choice for a benchmark or 'ideal type' against which to comparatively describe other welfare states.

We shall, therefore, use the menus or sets of items first to be able to describe the local context as compared with others, and secondly to help in finding out what would be the service

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models that would best fit the context largely as discovered. Light will also be thrown on cases here and there where the context itself can beneficially be altered.

4.3.1 The Public Service Management Reform

A public service reform was initiated in Malta in 1989. Very soon after the start, the government dropped the word 'new' in describing the reformed management it was promoting, in order to lessen resistance. Many civil servants defined the required goal as 'to return to what the civil service was before the 16-year rule of the socialists'. During the latter there had been very substantial benefits in equality and welfare, but the downside was a drop in civil liberties and the old disciplines of a good civil service. Twelve years on, Prime Minister Fenech Adami reminded (Sunday Times 2001) that the reform was deliberately gradualist, to gently win compliance and to allow its principles to be absorbed. Gradualism is in many places the mark of Maltese reform, though sometimes this is because faster plans failed to work out. Both the British welfare state, and the British combined new management-new community care reform were, by contrast, largely 'big bang' events. They reflected a managerial capacity and a government authority that probably can be found nowhere in the Mediterranean (on the issue of 'weak government and strong society' see Turner & Hume, 1997, pp. 48-50).

The reform (see Commonwealth Secretariat, 1995) has yielded many sure signs of improvement, ranging from tone on the 'phone, through to an evidently more professional approach to tasks at all levels, though not all round. All the items listed in , more or less, appeared on the reform scene, each in its own big or small way. Perhaps among the slowest have been the use of audit and evaluation. Unions resisted the direct recruitment of managers from the private sector to higher departmental grades, but this happened in non-departmental state bodies, poised probably to multiply.

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1a. Hands-on professional management in the public sector
1b. Explicit standards and measures of performance
1c. Private sector styles of management
1d. Human relations management
1e. Greater emphasis on output control
1f. Greater discipline and parsimony in resource use
1g. Increased accountability and discipline
1h. Strategic management strategy-operational planning-implementation (well-linked evaluation and policy)
1i. Recruitment of persons trained in management
1j. Empowering of the Generic Manager vis-à-vis the Professionals
1k. Recruitment of persons with managerial experience from private industry
1l. Recruitment of or consultation with persons with knowledge of social policy and welfare management
1m. In-service training in management
1n. Local training in Health services management and social administration
1o. Audit
1p. Quality management
1q. Evaluation in contracts
1r. Greater customer orientation and customer choice
1s. A tight approach to costing and budgeting
1t. Value-for-money budgeting

Table 4. 3: Components of 'new management' belonging largely to the Organisation ('O-') Level

The Maltese public service now sustains a mix of actors and activities that range from a very high to a very low calibre. Over-regulation and the consequent systematic cultivation of loopholes often conspire with under-regulation, and the turning of a blind eye, to widen the room for abuse. Big areas persist where good practice is only motivated by personal integrity, and hardly promoted, if not even perversely shackled, by the prevailing system of reward and punishment. Overall, however, the system's managerial capacity is steadily growing. While

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not viewing new public management or the reform as having risen up to expectation, it is difficult to see how good community care can be organised without the management good practice that has been incorporated in the ideals of both. When we look at how the mental health reform actually unfolded in Chapter 9, we shall obtain a few snapshots of capacity as in fact achieved.

4.3.2 Structural Reform in the Public Sector, especially Social Policy

But the quest for improved managerial efficiency and responsiveness, for the promotion of a customer-oriented managerial role, required changes also on a wider scale, located in our Context level. These are listed in Table 4. 4: Components of 'new management' belonging largely to the Country Context ('C-') Level, whose items probably merit more attention than the ones in Table 4.3, through having a direct bearing on the structure that community care can take. Decentralisations have in the last decade affected both the social services and the health sector. True to gradualism, both former provider departments are only in 2001 on the verge of becoming non-providing regulators. Hospitals (and, presumably, community-based health care, often styled 'primary care' in Malta health division parlance) will become financially and administratively autonomous. They will still draw their funds and their policy from their respective Ministries, through the mediation of a non-departmental 'foundation'. The latter nearest thing to a trust in Maltese law, spells the end of departmental status for all hospitals and provider agencies, and probably some or all their employees, something that the doctors have been clamouring for as a way to revise and liberalise their working conditions.

But there has been no mention of internal markets or privatisation in this announced reform. It is quite probable that some minor mutual purchasing of service will take place. But each hospital will have a different client group to care for, beside the fact that such competition seems alien to the envisaged policy. The only 'level ground for competition that was mentioned in the launching was that with private hospitals. 'Presently the Health division regulates private hospitals. But the regulation of its own hospitals is weak, creating anything but a level playing field. There has to be a radical reorientation,' stated Health Minister Deguara (2001). Social services provision will also be divided into independent parastatal bodies, one providing most areas of social work, another all substance abuse services, and still

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another the key community social resources for home care, day care, hostels and social care in large institutions.

2a. Decentralisation, disaggregation of units in the public sector
2b. Corporatisation (department or part of it becoming 'parastatal', or non-departmental while still under Government)
2c. Regulator Role
2d. Autonomously administered hospitals & agencies
2e. Contractual culture
2f. Purchaser/provider split
2g. Greater competition in the public sector*
2h. Compulsory competitive tendering*
2i. Internal markets*
2j. Downsizing*
2k. Contractual job tenure & casualisation of jobs*
2l. Devolved budgets
2m. Fundholding GPs
2n. Fundholding case management teams
2o. Privatisation
2p. Effectively competitive markets, managed markets
2q. Arm's length relationship with providers*
2r. Partnership relationship with providers

Table 4. 4: Components of 'new management' belonging largely to the Country Context ('C-') Level

4.3.3 New Directions in Community Care

Current UK preoccupations in health and social care with contracting out and purchaser-provider splits cause puzzlement among colleagues in other parts of Europe. Discussions with a large group of Belgian social work students revealed that they had never heard of case or care management and elsewhere in Europe the emphasis is still on direct provision by social care practitioners (Munday, 1996, p.61).

The above reflects a striking difference of context, springing as much from age-old practices as from recent policy changes or their absence. Giddens (1998, pp. 111 ff.) performs a similar 'cross-context interpretation' as he points out that private provision in welfare is not the

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opposite of solidarity, and that Christian democracy had long developed a system of generous welfare provision in which the provider was not the state. We can add that, whereas in Britain there was room for a purchaser-provider split, in much of central and southern Europe the provider, most often in the form of a non-profit (frequently Church) organisation, provided long before the state thought of purchasing or financing the service. There was, then, no question of split, but of more tightly regulated financing, often enabling such non-government service to expand and improve.

In Malta, social care of the residential type, for children, the elderly and the destitute, was long run, or at least staffed, by religious orders or other Church bodies. However, when community care became prominent in the policy agenda, traditional Church bodies were hardly in a position to expand and contribute. Church care had long been of the traditional 'last resort residential' type (see Hardiker 1991b, 1999, 2000). St Vincent de Paule is acknowledged not only as the first originator of a casework method, but also as the first Churchman who was wily and resourceful enough to escape the combined pull of authority and tradition and to succeed in founding an order that worked in the community. But the appearance of the need for community care support has come after both the potential and the expectation has very largely moved away from the religious orders that pioneered dedicated care.

However, consistent NGO involvement in community care is now very much a matter of undeveloped potential, mostly in the form of many 'lay' groups and individuals, religiously-inspired or otherwise, who already do voluntary support work or who would very likely participate if encouraged, and given the training and opportunity. Caritas, and its linked parish-level 'Diakonia' groups, already show commitment and interest that can be developed and professionally and managerially supported. 9% of women do voluntary work with organisation, including 5% with persons in need (Camilleri, 2001, p. 83). A recent seminar brought together vigorous grass-root groups and local councils, with strong central government support for the venture.

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The above background will enable us to address the level and type of readiness for community care that can be found now in Malta's society and services. Table 4. 5: How and how far do the 1989 White Paper's Six Goals Apply to Malta?' The answers lay a somewhat greater emphasis on services for the elderly.

<u>Six goals of 1989 UK White Paper on Community Care (not in same order as White Paper)</u>	<u>Development in Malta, 1990-2001, with special reference to the community care of the elderly</u>
• Promotion of domiciliary, day and respite care to permit independent living at home	➤ Good growth of 'community resources' especially for the elderly: home care, later day care
• Promoting the development of a flourishing independent provider sector	➤ Nothing like the dramatic 'purchaser-provider split'. But much (especially residential) provision was traditionally private/NGO/Church anyway. ➤ Funding of NGO projects and government-private partnerships set to grow in volume and
• Clarifying the responsibility of agencies to increase accountability	➤ Steady improvement in the last decade, soon to become much firmer through social services inspectorate
• Securing better value for money by introducing a new funding structures	➤ Budgeting stricter and more devolved internally. ➤ Very little purchasing of community resources, but growing in specific areas, with a rate that probably will gain more momentum. ➤ Scope given to competition very limited.
• Making the good assessment of need and good case management the cornerstone of high-quality care	➤ Casework with very limited personnel takes place - idea of case management only being very tentatively mentioned
• Making support for informal carers a priority	➤ Acknowledged, growing at a slowly increasing rate

Table 4. 5: How and how far do the 1989 White Paper's Six Goals Apply to Malta?

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Efforts to train and deploy social workers for the care of the elderly dated from the 1950s. But these materialised slowly, and only as part of the first solid promotion of community care initiated in 1987 by Rizzo Naudi, Nationalist Junior (and first ever) Minister for the Care of the Elderly. The previous Labour government had transformed the life of the elderly through generous social security, and remarkably upgraded the living conditions of the 1000-bed institution at Mgieret (the one praised by Florence Nightingale). Home care services grew steadily since then. By 1996 5% of over-65s received home help services in the island of Malta, placing its service at the cut-off point between the Walker's (1993) minimal level, characteristic of Latin rim countries and Ireland, and the residual level, of which France and Germany are examples. The level in the smaller island of Gozo, at 14%, belonged to the top or institutional bracket, far surpassing Britain's 9%, nearly reaching the Scandinavian countries' 15-20%. Locality rates ranged from more than twice the latter amount to 0%. The high level in Gozo can be partly explained by lower residential provision, more supportive and more spatially concentrated extended families and a stigma locally attached to the existing limited state provision which is really in the nature of a geriatric hospital (see Xerri J, 2000). Home care attains a highly satisfactory, if unevenly and inequitably targeted, average level of support.

Through all this, social workers have long hovered at numbers in single digits. Their work has been emphatically short-term and narrowly targeted, and often been restricted to organising and supervising the home care and day care services. This is probably another case of 'reluctant residualism', if not even 'reluctant managerialism'. Through the British reform, the helping professions, social workers in particular, have observed that the managerial approach was often at loggerheads with their caring approach.

Much has been written to protest against the impoverishment of the social work role into one of 'just social care' and administrative resource allocation, whereby checklists and alternative service brochures pushed aside essential elements of professional casework (Mackintosh

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1997). The latter including an empathic and facilitative, professionally assessing and counselling approach, often necessary in the face of puzzling and distressing personal crises.

- Much spent on elderly care, but mostly on social security and residential care
- There has been a recent increase in home support (mainly through home care and day care)
- Casework remains weak, while there is no unified philosophy and system of management of community care
- Improving but comparatively weak resources and management capability
- Comparatively strong family and community support potential
- Public sector administrative reform improving capability but still shows many weaknesses.

Malta is

- more like Britain than like central Europe in that reform started off with very heavy direct government involvement in provision of care, especially residential care, and rising assumption of govt. responsibility in community care.
- rather like central Europe in having traditionally strong NGOs (especially Church involvement in residential care); NGO and Church involvement in community care is initial and more of a potential than a reality.
- rather like Southern Europe (see Rhodes 1997) in that NGO community support tends to be patchy, mostly in the form of scattered and small-scale voluntary initiatives.
- Place of for-profit provision in social care (except for residential care and some private hospitals) weak.
- Private health strong on primary care and specialist clinic care (though both mono-disciplinary, while latter often expensive): private hospitals affordable only by very small minority, covering only selective needs while claiming shorter waiting lists and better 'hotel' standards.

Table 4. 6: How is Malta different? Important characteristics of the context of Maltese community care

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Now that the number of Maltese social workers is bound to increase, it is important not to give way to a continuation of the same minimalism. Nor should one lurch into a reactive generosity that can only be sustained through arbitrary neglect of others in need.

4.3.4: Reviewing financing and looking at right-wing recipes: markets, competition, downsizing

Wide and extensive discussion of social policy matters is limited in Malta, largely due to small size and capability, but also to a tendency of professions to hold their cards to their chest, partly in fear of superficial or politically polarised and exploited discussion. It was a sign that such vicious circles are being partially overcome when, in February 2000, a 'Consensus Conference on the future of Health Care in Malta' was organised, under the title, 'A National Agenda for *sustainable* Health Care'. Crucial on the agenda was the future of financing. The present situation featured doctors feeling so underpaid in the government system as to be effectively 'subsidising' it. There had also been tensions with private insurers because of exorbitant prices asked by some doctors for private practice. Providers explained at the conference that in Malta only a very small minority found private hospital care affordable and that their own capability fell far short of a full alternative health care service to clients.

Persons who approached the conference in the fear that this would be taken as an opportunity to usher the beginning of the end of generously comprehensive care, free at the point of use, were relieved to hear a general consensus in favour of its continuation. The organisers - the Foundation for Medical Services (to emerge, in 2001, as we saw, as the 'super-trust' to co-ordinate the newly autonomised hospitals) and the unions/associations of doctors, nurses and pharmacists - put it over to representatives of other stakeholders that the best solution was a hypothecated tax dedicated to health. The proposal was heard but there were objections. More has to be done first to ensure the removal of waste and the promotion of efficiency. Secondly, with rampant tax evasion by the self-employed and a flourishing black economy, any attempt

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to tax in proportion to income would in effect bear most heavily, instead, on the lower-middle group formed by the higher-salaried dual-career employed.

Any fears of a call for privatisation or for the reduction of the level of free health care did not materialise either. Some participants echoed denigrations of the NHS model, while a suggestion to imitate the German structure was aired in the press in the preceding weeks. However, no well-thought-out alternative to the hypothecated tax concept was put forward. Though the organisers claimed higher spending was necessary, it was unclear whether anybody thought that any new services should become free, such as the independent GP service and specialists' clinics. Thought of an expansion of free service must have been excluded, in spite of equity problems, by the *sustainability* accent of the conference.

No policy pronouncements were made after this conference. A consensus about the hypothecated tax was not reached, but a general consensus in favour of having free health coverage at levels similar to the present, though not limitless, was there throughout. Around June 2001 papers from the same quarters were communicated to the Minister, but not to the public. The call to dedicate more of the GNP to health has joined its voice to the need for more reliable community care, partly to save on expensive and institutional care. But equally pressing is the call for sustainable pensions and the clamour by representatives of business and the International Monetary Fund to reduce taxes and welfare in order to reduce national deficits and debts more ambitiously, especially in expectation of international recession. But the decision about health financing, at least as far as the public is informed, stands adjourned.

Will community care in Malta take the road of marketisation and privatisation? It helps to view the issue first within the picture of general social and health care, including institutional care. As regards health, the autonomisation of hospitals will probably uncouple doctors from public service departmental grade levels. One big question is how far they will go on accepting the limitation of public service pay on the consolation that this can be compensated by private practice. This can be extremely lucrative, but not for all, and not in proportion to contribution given in their morning job, that is state service. If discontent with what Malta's

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GNP can be judged to afford destabilises the present general equilibrium, the strain might be expressed in more service or better service being diverted to the private hospitals, which would undermine the levels of what is available free of charge for those who cannot afford. It would be socially very harmful if Malta's free health ceases to be like the British NHS, that is, used and preferred by the vast majority of the population.

What are the applicable lessons to be learnt from the introduction of market competition in other countries? Malta's health division has already made it known that the Maltese way of controlling expenses in health is not through micro-costing and market competition, which is considered 'top-heavy', creating greater transaction costs and taking more managerial time than can be afforded. Dr Ray Xerri (1999), Director of Policy and Planning, explained that spending standards and limits would be agreed through discussion and negotiation with each specialty in turn. Details of a 'Malta model' for the running of the service had been discussed with WHO but, as usual, this model was not made public.

Evaluators of the British and other experiences found out that true competition requires markets above a certain size. Big towns like London and Birmingham had enough hospitals that were close enough for a patient's admission, that true choice and competition existed. Not so in small towns and rural Britain, where there were too few hospitals within an acceptable distance. In Malta's case there are two private hospitals and a private in-patient clinic. Recently an attempt to merge fell through. No doubt, they do generate a certain amount of competition.

However, in community care, private provision - and hence possibly competition - could be, basically, on two levels: the provision of services, therapies and resources, and their brokerage, co-ordination or purchasing. Let us first consider the latter set. The Blair government has weakened competition in internal markets among hospitals in the UK. But brokerage, co-ordination and purchasing, devolved to a level close to the client, have been confirmed as a cornerstone not only of community care through case management, but also of

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primary care through the extremely influential role given to general practitioners in the commissioning of services. The big question here is, 'Who should do the purchasing?' In case management, the British government assumed – a possibly unparalleled - responsibility of assigning a care manager, in state employ, to every person with continuing community care need. Care managers control budgets accruing from government. Individual care managers do not have their own budgets, but these are devolved at team level, while being subject to priorities and guidelines as set by their employing authority.

In primary care, the purchasing is carried out, not by state employees but by self-employed persons, the GPs. Under New Labour they departed from right-wing dogma that wants purchasers to be as 'atomised' or fragmented as possible, in order to create greater market competition. Large groups of GPs now form primary care consortia, which are led by councils with a place for Social Services and for representative of the user and other stakeholders. It was felt that joint commissioning would result in better 'market intelligence' and the ability to make and sustain better deals with providers. Persons familiar with the Maltese scene will be reminded of the local Insurances that make joint policies and issue joint statements. They have decided they can get better deals if they present a common front to panel beaters and other 'service providers' alike, whom they wish, by contrast, to be fragmented and to make individual bids, in orthodox competitive market fashion. But our conclusion at this point is that brokering, purchasing and commissioning, even if government financed, and accountable to government and society, need not necessarily be by government personnel. Let us note, however, that purchasing by GPs and by case managers in Malta is not on any known policy agenda.

Several reflections about market and quasi-markets can be made before we concentrate on private providers of services, therapies and resources for primary care. First, the smaller the market, the greater the drift towards cartels and monopolies, price fixing and anti-competitive covert deals among bidders. Second, social welfare markets will have to be managed markets, rather than largely unregulated ones. Third, non-profit organisations are often only weakly moved by the profit motive, though stringent environments might re-balance – some would

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say even pervert – their priorities. Fourth, a relationship of partnership is often much more appropriate and effective than an “arm’s length” approach characteristic of unsentimental, for profit, business transactions. A contract for meals-on-wheels may be a short-term one, to be succeeded without any qualms next time round by one with a provider with a better offer. But one cannot switch a contract for the provision of residential care for the elderly or the rehabilitation of persons with physical disability to a new provider with such ease. Residents cannot be suddenly transplanted, nor personal relations severed. An organisation committed to a mission and to its clients cannot switch mission and competence to a new area, and be replaced so easily by one new to the field.

Which types of private providers for community care services does, and can, Malta have? Where would be a good place for ‘arm’s length competition’, and where would partnership be more appropriate? How far has purchasing and contractual agreements gone to date, and which direction can and should they take? How can service quality be assured? What is the place for for-profit, non-profit and unpaid providers? How should they relate with each other?

At present, the only purchasing of a professional health service that takes place in the health sector is for the provision of all generic community nursing by MMDNA (the non-profit Malta Memorial District Nursing Association) making Malta one of the last countries to change from an integrated to a contractual model (European Observatory on Health Care Systems (1999). Contractual relationship with providers in social care is, on the other hand, very well established. Often, nevertheless, the contract could be described more as one of subsidy than purchasing, since such contracts were mostly with religious bodies who both raised their own funds and subsidised the services heavily through their largely unpaid personal service. A new type of contract is emerging, where government may pay higher proportions, and where evaluation – a capability now in demand and increasing - is part of the conditions. However, the initiative has, to date, been almost always on the side of the providers. Competitive bidding has in fact been limited to material resources or services like the running of canteens and provision of cleaning services.

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Malta is one of the most enthusiastic members of the Commonwealth Association of Public Administration and Management (CAPAM), whose patron is Dr Fenech Adami, Malta's Prime Minister. British and Canadian influence put forward a very liberal model, in which competition and downsizing is a central ingredient. Malta in fact subscribes to most of the items in the paradigms of new public management and new public policy. The exceptions are the ones identified as particularly right-wing by Table 4. 4: Components of 'new management' belonging largely to the Country Context ('C-') Level, that is, the ones in listed in Table 4. 7: Components in the New Public Policy paradigm associated particularly with the New Right .

The lack of right-wing tradition, the smallness of the market, the limits to capability that promise that the transaction costs and running costs will offset any gains made, the low capability the government system has for micro-costing, all conspire to make market competition in the provision of service low in volume and mild in tone. Downsizing goes counter to the strong expectation of state jobs to be of sure tenure, and will be very stoutly resisted by the unions. Malta's workers are highly unionised and the right to strike has been described by a recent court decision as more or less equal to what it was in pre-Thatcherite Britain. It is however limited by a Tribunal that both sides find often too unpredictable to lightly appeal to. Job losses by state bodies create also very deep popular opposition. This, in a roundabout way, motivates government to rely more on NGOs and private provision, since such a flexibility is allowed them which is not allowed regarding state employees. However, the experience of welfare states that rely on a partnership relationship with providers is that there often is over-capacity and insufficient search for efficiency, while private firms pressed by competition are more successful.

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- | |
|---|
| <ul style="list-style-type: none">• Greater competition in the public sector• Compulsory competitive tendering• Internal markets• Downsizing• Contractual job tenure & casualisation of jobs• Arm's length relationship with providers |
|---|

Table 4. 7: Components in the New Public Policy paradigm associated particularly with the New Right

With the several commissioning teams that now form part of the newly autonomised hospital system, with both the welfare and the health divisions acting as regulators featuring an inspectorate, contractual relationships are bound to increase rapidly, evaluation, audit and inspection of service to upgrade and assure quality. Scope for arm's length competition will probably, but not necessarily, increase only slowly and in a quite limited range of, probably non-professional, services.

4.4 Looking at the Maltese Mental Health Reform

A look at history is of value in itself for the planner. Many things can be understood only with reference to how they happened, one after the other, one because of the other, keeping in view how they were justified, 'motivated on' or pushed through. Past sequences of events, past causations and past motivations leave their imprint in the dynamics of the present. At times, forces and rationales from the past can become so foreign to the present that the legacy of the past is as alienating and obstructive as the adopted legacy of models that took shape in foreign country contexts.

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A look at history is also useful as a discloser of the systemic, the dynamics in the operative local system that lie largely undetected in periods of undisturbed routine, yet are drawn out by the process of change. Especially revealing are aspects where planned change, such as service reform, refuses to unfold according to plan. Frustrated expectations are everyday stuff in planned change, the more so the newer the planned change. Well-planned change looks up and takes note, adapting the change plan.

Frustrated plans betray the limits of rationality. Insofar as planning can be corrected and the fit between the expected and the actual improves, planning is rational. If the planners are not intelligent and informed enough, this does not mean that reality is less rational and less intelligible, but that the planners' capability has not been up to it. On the other hand, it is difficult to exclude that some planned change may be beyond possible human rationality – but it is equally difficult and perhaps impossible to point to a particular area that one knows beforehand to be outside the bounds of possible rational knowing and rational planning.

In this sense, frustrated plans confirm the validity of planning. Popper describes scientific statements as ones that are falsifiable. That planning can go wrong or deliver confirms that versions of reality enshrined in plans are not just lumps of subjectivity in which any version is as good as another. An ideal of objectivity is being sought, although we can never do the equivalent of a CT scan or methodological computerised tomography that will reveal, layer by layer, the details of where we succeeded and where we did not.

4.4.1 Important aspects of the British reform as it turned out

The aim of this look at the British reform is to highlight some important developments that emerged when the reforms in mental health and in community care were facing 'the test of time'. At this time, the reform of long-term care was exercising the provision systems of many countries. Mangen (1994) finds that, for most European countries, community services for the support of the long-term mentally ill were almost non-existent until well into the 1980s. He discusses the challenges to planning and evaluation, and to provision of services amid Remodelling Services for New Contexts

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decentralisation and the need to provide for daily living needs. In UK 75% of psychiatric reprovion costs were attributed to accommodation and living expense, and only 10% to day care. (Ramon, 1992). In the descriptions given, the US and Britain are the most prominent examples of both case management and the related concepts of managed care and new managerialism. (Rothbard 1999). Italy is an interesting case in being the strongest in acknowledging the political nature of the reforms, and in putting the renegotiation of the relationship with the client at the centre of the reform, yet among the weakest and the most uneven in implementation (di Palma 1977).

Probably the controversies that it aroused and the major changes in policy that took place as it unfolded and as it turned out, disclosed the most prominent features of the British reform. The most prominent controversies had a 'right vs. left' flavour about them. In Britain, community care reform, new management and case management were saddled together, and it is often difficult to separate out the barbs aimed at one from those aimed at the other two. Community care seemed to pit the economies expected from deinstitutionalisation against the improvement in living conditions and empowerment that were expected from it. New management seemed to pit 'hollow' managerial values (see Cutler and Waine, 1994) against the substantive and humanistic values of caring. Case management was often justified in terms of a right-wing ideology emphasising the customer's freedom of choice, being seen by the opposing camp as glorifying a supposed freedom when good choice required deep guidance by the experts in the field in the form of members of the helping professions.

But these controversies cannot be dismissed as the idiosyncrasies of a reform that was dominated by a neo-liberal government that has no parallel in the rest of Europe. Significantly, these reforms very substantially survived the change from the Thatcherite New Right to Blair's New Left, though many supporters of the left see more right than left in Blair's prescriptions. As we look at the eight issues we shall often refer to the British experience, seeing it as typifying inevitable organisational issues calling for a balance between caring and organising, professional and managerial values, central planning and market forces, government and non-government involvement, directing and empowering the client, formal and informal.

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4.4.2 An evaluative narrative of the Maltese reform

In Chapter 2 ('2.4 Malta's mental health reform: changes in primary and secondary care in the pilot area') we have already recounted how the reform in fact unfolded, at the service level, particularly in the pilot area. Several things went according to expectation. Services in the pilot area were enhanced on the input level through the more frequent presence of two psychiatric firms holding mental outpatients once a week each, the full-time deployment in the pilot area of three social workers, an occupational therapist and two OT aides. Specialist personnel, in the form of psychiatric social workers and mental health nurses worked on a visiting basis, largely during MOP, while a psychologist held regular sessions at other times.

However, several factors conspired to make a rather different model of service to emerge from the one that had been planned. These included the failure to recruit the expected specialist social workers, to secure the retention of key personnel promoting primary care and the failure to agree on a basis to provide continuity of care in the traumatically delicate national issue of general practice. To these were added the onset of budget economies around 1996 and the progressive discontent and depletion of health centre GPs nationally, that ground to a worrying climax in 2001.

The social workers originally intended for the planned 'primary team' in fact embraced roles on four levels (all of them divisions within ARC's third or 'service' level). Firstly, at primary care level, they took up health-related referrals, mostly from the health centre GPs. Regarding specialist care, they stood in for the largely unavailable visiting psychiatric social workers, both at the acute level (their second) and on the long-term (their third) level. Fourthly, they also promoted a generic local social work team role, encouraging referrals from families, individuals and schools. In the absence of such a service locally, this found a ready demand, and was promoted by the idea that the best setting for treating a psychiatric patient was in a generic environment that reduced stigma. To speak of a primary 'team' where all three social

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workers collaborated with all the GPs in the large health centre already was a stretching of the term. Once the target clientele itself was stretched, teamworking in point of fact had given way to networking.

The hub of the 'specialist teams' was, in fact, two highly vigorous mental outpatients' clinics. The patients enjoyed the benefit of much improved personal attention, more time availability and much more detailed note taking. The welcoming nurse showed greater acquaintance with the patient and her or his needs. The failure to deploy them on home visits was a disappointment, and their enhanced 'welcoming nurse' duties in fact reduced their participation in the firm's discussions.

Primary care by private GPs remained in fact mono-disciplinary. The health centre GP service remained deprived of reliable continuity of care, indispensable for credible psychiatric work. Clients that should normally have been passed on to primary care, as a result, had to be retained by MOP. The fact that one MOP clinic was established before another resulted in a difference of emergent role, the older emphasising long-term care, the latter acute.

One may coin the term 'model drift', an interesting happening that challenges model adopting services. Faced with models not developing 'as per plan', one can ask how far to re-assert the original model, how far to change the environment to make this possible, and how far to take the adaptation as a lesson in what really works and how things should be done. The latter reaction would be taking a leaf out of the book called *How Buildings Learn – What happens after they are built* (Brand 1997). This book features sets of pairs of pictures of buildings, when new and when, having been lived in for a few decades, architectural alterations had been made to their original design. Most of the modifications were presented as eye-opening improvements that showed how the experienced user who tested out the product could improve upon the work of the original planner. Model 'adaptive adopters' should examine emergent variations from original plans with an open and discerning mind. Such an evaluation will take place later in this chapter, but now we must return to our reflective account of the reform.

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The Mental Health (originally 'Reform') Commission soon became the prime mover in the reform. Its amendments to the original plan by the scientific committee (soon to bow out) were accepted in toto by the Ministry and published as the official policy document. In this way, the widening of perspective from a largely health to a broader social point of view, and of emphasis on primary care extending to secondary care and deinstitutionalisation, was given official blessing.

Having got the policy approved, the Commission became the meeting point of planning and service developing subcommittees. These had the advantage of bringing together the managers and senior practitioners of the involved services, the ones who had to carry the can, and persons from outside, who could bring in particular expertise. Unlike the Commission for Persons with Disability, this Commission was never given legal personality or direct authority over any of the direct services, which meant any approval of policies or employment of persons or funds had to be done on the authority of Ministry, department or NGO. Its strength was as good as the goodwill of its members and its good work generated with the authorities. One notable strength was that its first chairman was the parliamentary speaker, Dr L Gonzi, present Minister for Social Policy and deputy prime minister.

The Commission soon became a hub of activity, organising and monitoring the growth of the services in the pilot area, following up the developments in hospital, and taking a prominent role in health education and in the encouragement of mental health NGOs. Its attempts to organise research and evaluation proved less successful, mainly because the expected funding did not materialise, plus the usual Maltese and 'small country' problem of people dropping out from basically volunteered interest because of mounting commitments. The pilot area service use evaluation described in the third part of Chapter 8 was started under the auspices of the commission, but the efforts to put together a capability and resources to sustain the project under its auspices was a saga of consistently disappointed hopes. Around 2000, a Qormi health centre employee who personally kept service records was awarded a prize, this going

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was beyond the call of her duty, and typifying the slender foothold of the existent research capability. However, a number of highly committed evaluation seminars were held, and these combined to give a very vigorous start to the pilot area services, with mixed feelings of satisfaction and frustration, both of which seemed to have clear justifications.

At the initial stages, both a Belgian and a British consultant congratulated the reformers at the speed they were progressing, at a time when every other country was applying the brakes. Soon their successors found out that this was an environment in which limits of capability soon started doing the braking. Prominent shortages were of social workers and nurses, of essential transport facilities, of strategic planning and of systematic evaluation. Then there was the role overload of many of the highly committed contributors. In 2000 Malta's health services have again been rated second most efficient in the world, the definition meaning 'who gets most out of the least' (WHO, 2000). But this is an environment of high promise and not-so-firm goalposts, where most things take longer than planned to happen, and where many commitments end up coming out of the goodwill of busy people. In it, the temptation to hang on to roles one cannot sustain and to retain duties when it should be clear that one cannot deliver are great indeed. Equally, it is the ones who have to officially carry the can who have, in the end, to step into the breach and do a quick job when the 'experts' could not make it. Equally too, letting projects take longer than they 'reasonably' should often turns out to be the only mature reaction of a person who has sized up the local system.

It took five years to turn the Mount Carmel Hospital laundry to turn into a co-operative system – what has been called, 'Privatisation, Malta style'. The aim in such arrangement is to motivate workers to pull their weight by improving their income as they improved their efficiency. A participant from a managerially more efficient system, who witnessed the big bang transformation in the management of the NHS and Community Care, would have given up long before.

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Still, like buildings, defective systems improve only if they 'learn'. Learning involves a consensus about what is desirable and what is realistically feasible, turning hit-or-miss projects to ones that substantially deliver what they promise. After some experience as Minister for Social Policy, Louis Galea took to often quoting Don Bosco's saying that 'l'ottimo e' il nemico del bene' – 'the best is the enemy of the good'. But this is a social policy system, which is in close contact with better ones in other countries, as well as the medical side of the health system, which is pretty comprehensive and has, despite a lack of frills, all the essentials. Amid such 'obvious' comparisons, to aim at a system compatible with actual capability lays one open to the accusation of being ungenerous and pessimistic.

Perhaps this is no different from the protestation of social workers in the UK when budgeting was devolved. As case managers, like their counterparts in health, they were the ones who were charged with doing the rationing. Much of the literature protests against this doubling of 'carer-advocate' with 'rationer'. In other words, the 'big bang change', though it took hold very quickly, did not do so without inherent pain and dissent. Some British observers have retorted in conversation that that it would do them good to have some Malta-style gentle and gradualist introduction of change instead of the typical Anglo-Saxon 'bulldozing' manner. Still, for the sake of the client, maturation is surely needed by way of a more internally coherent, better self-knowing, system. Only then will it respond as swiftly, as predictably and as faithfully as good service requires.

The times of greatest insecurity were the two times in which there was a change of government (1996, 1998). The switch to Labour Party resulted in a hiatus in which all decisions, all achievement and all personalities seemed to be in question, because it was a new government, and it took time to find its feet and pronounce itself. Most vulnerable could be items like pilot projects implying, as they do a, negative discrimination against competing needs, which now see their chance to re-assert themselves. A balance between the health and the social that was not institutionally robust also looked open to questioning. Shortly after the second commission was chosen, with the secretary and director of psychiatry as the main links with the first one, a new election soon resulted in new insecurities. However, a third Remodelling Services for New Contexts

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commission, less changed in composition, was told to retain the same policy as before. The short Labour Party legislature was valuable in many sectors as a test of the degree of true agreement and disagreement between the two Maltese political parties represented in parliament.

One piece of unfinished business had been the translating of the policy into a strategic plan. The first commission had the will but could not muster the capability or help to get this done. The 'third' commission managed to get this going. Feedback all round was taken, and a consultation exercise resulted in a strategy document that represented a breakthrough in capability, comparable to the original achievement of the policy document. Since only few details have been published, there is little that can be said beyond that it comes up with a very good assessment and some very good and realistic solutions. It requires approval and resources, and these are still pending. One hopes that, while a key member of the responsible team has now left Malta, the Commission and system will retain its capability of strategic planning and extend it to an implementation and monitoring, free from the model drift and with less shortfall between planned and done than its predecessors.

If the strategic plan is taken up, the Commission will have retained, even strengthened, its consultative but still very robust role in service planning and evaluation. It has also dedicated much of its time and budget to mental health education, the promotion of NGO activities and the financing of projects, often in the same areas, not covered in existing provision. It has particularly sustained a vigorous federation of NGOs, financed training and facilitated the provision of housing for deinstitutionalised patients.

The 'third' commission strengthened its role as the main organ of continuing intersectoral collaboration through the appointment on it of persons higher up than previously in the official hierarchy of the departments and bodies involved in relevant state social policy. As such, members are there in a mixture of personal and official capacities. The strengthening of the latter seems to be a good learning point that may be worth strengthening further, though the

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presence of other persons on their personal capacities should not be weakened. Malta will inevitably have many more people than big countries who have multi-hatted roles, which has its plusses and minuses.

The weakness of the Commission as an intersectoral organ is its natural reluctance to take up a position collectively about the division of roles among its various represented sectors. Ministers emphasise an increase in reliance on NGOs and private provision, and the commission is often involved in the implementation of such decisions. But the allotment of highly desired roles and resources to 'the other side' is always painful, and there is always the contrary argument that state services carry the can anyway and have proved they have a definite capacity to grow out of past inefficiencies. In view of the controversy, one would not expect the commission to venture out and take strong positions on the repartition of roles among its member sectors.

In the second half of 1999, many reform leaders gave presentations to parliament's Committee on Social Affairs. This augured well in two ways. The Committee is part of a concerted effort to reduce the kind of insecurities and loss of direction that were feared as the two parties alternated. Secondly, during these presentations, the desire of the official authorities for case management became for the first time public. The discussion showed that there is still a lot to be clarified about the notion and its critical success factors, both on the side of its advocates and on the side of the authorities being requested to sanction it. But the presentations reflected that local knowledge was fast growing and that the Health Division was strongly behind the proposal to introduce case management.

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Chapter 5

Which Service Delivery Framework? - Matters of Evidence

5.1 Introducing Chapters 5 till 9: Four more steps to the Redesigned Model

Till now we have presented the international issue, a framework for its understanding and one local context. In chapters 5 till 9 we shall attempt to arrive at a model that fits that context. On our way to finding out what would be a good model for service delivery, Chapters 5, 6 and 9 represent steps one, two and four. Each of these three steps is introduced by the chapter's respective name: 'Chapter 5: Which Service Delivery Framework? – Matters of Evidence', 'Chapter 6: Which Framework Components? – Matters of Congruence' and 'Chapter 9: Which Further Framework Specifications for the Maltese Context? – Matters of Synthesis.' But before tackling Chapter 9, the fourth step, the model building exercise will stop and await Step 3, namely Chapters 7 and 8, through which an assessment of local need will be first carried out.

In the present chapter, we shall look at what was declared by the UK as the 'cornerstone of community care', that is, case management. Our question in Chapter 5 will be whether this bold and far-reaching decision has the *evidence* behind it. But we do not claim to make an exhaustive review of the reviews of case management. We shall rather look at a set of reviews, similar in approach, that compare case management with alternative service frameworks, that is, arrangements for the delivery of the service that serve as the

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‘container’ or ‘envelope’ (a deliberately figurative expression, at this point) in which the service is tendered.

In Chapter 6 we carry out a *congruence-based* analysis. We shall use the Active Remodelling for Congruence, trying to find what service model would fit the Maltese context, having portrayed that context in Chapter 4.

It would help here to highlight the differences between Chapters 5 and 6. Chapter 5 tries to *find out what is the best service delivery framework*, comparing case management with other alternatives that could be used instead of it. The analysis focuses on components that the alternative frameworks partly share, so that a comparison of components becomes a comparison of models (here SDFs, or Service Delivery Frameworks). In Chapter 6 we focus on the selected SDF and *compare the relative merits of its best known variants*, in search for a mix of components that we would want to put into our composite or syncretic model.

Secondly, Chapter 5 centres its analysis on *evidence of outcome*, while Chapter 6 revolves on criteria of *congruence*. Of course, congruence has to be bolstered by evidence of the correctness of what is largely intuitively perceived, while evidence of outcome on the functional or causality level will also have to come to terms with questions of congruence of both meaning and functioning.

The discussion of the conclusions at the end of this chapter exemplifies interpreting quantitative evidence drifts into ‘qualitative’. Explanation of fits and misfits, and still more recommendations for action, require interpretation, causal path analyses, checking for fitting on meanings and value levels, and jumps of creativity. New meanings and thrusts are introduced. In fact, it is the ‘introducing’, ‘creating’ aspect of thinking, called *active thinking* by Edward de Bono (1985, pp 15 ff)), which is behind the use that adjective in the name, *Active Remodelling for Congruence*.

It would also help to show the difference between Chapters 6 and 9. Chapter 6 goes half-way through the process of finding model components that fit the target context, while

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Chapter 9 completes the exercise. Chapter 9 is a synthetic exercise that brings in all the data available to this enquiry, including the need assessment in Chapter 8. However, there is an advantage in the ‘halfway’ product given in Chapter 6. Its model recommendations are not narrowed down to one country context, but deliberately left broad and flexible, offering broad guidance about how different model components can fit different context characteristics. To the international reader, this chapter could offer welcome broad guidance, though Chapter 9 affords the advantage of a fully ‘worked example’.

5.1.1 Introducing Chapter 5

While Chapter 5 is not centrally about congruence, it still conforms to ARC. Part of Active Remodelling for Congruence is that it looks beyond the model and to its components. “Don’t ask for the model, ask for the component,” we could say, borrowing a turn of phrase from Wittgenstein (1953). Incidentally, in warning us, regarding words, “Don’t ask for the meaning, ask for the use,” Wittgenstein was saying something relevant to congruence analysis. How is ‘congruence as to meaning’, we can ask, related to ‘congruence as to use (or functioning)’, when speaking not of words but of components of service in relation to components of context?

But, true to our resolve to postpone all philosophical discussion to Chapter 10 whenever possible, we shall here return to ‘use’ questions and go back to the question of which service framework is most useful and best delivers. And, true to ARC, we shall compare frameworks by unpacking them into their components, and *comparing components rather than the frameworks* as such. In this way, by ‘asking for the component, rather than the model (or framework)’ we can remodel frameworks by being selective as to which components to use, re-combining together components originating from different frameworks if these fit better, with each other or with the environment.

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In fact we can say that the search for the best model must focus on three aspects of the service itself:

1. The therapies and interventions
2. The resources
3. The service delivery framework.

This triple classification has emerged as a neat and streamlined division after much trial and error. Admittedly, some frameworks are inseparable from intervention. Assertive Community Treatment (see Table 5.6 for characteristics), particularly, though a framework, requires direct rehabilitative, therapeutic and supportive interventions by the ACT team. But we still can conceptually distinguish the two for analysis.

5.2 Case management compared with five alternative frameworks – simply variations on the same themes?

Persons with mental health problems are being supported through therapies and social resources of various types. These, in turn, come through various ‘service delivery frameworks’, the main ones being shown in Table 5. 1.

- | |
|---|
| <ol style="list-style-type: none">1. Hospital-based rehabilitation2. Mental outpatients clinics3. Single practitioners working in networks4. Interdisciplinary community mental health teams<u>5.</u> Case managers and case management teams<u>6.</u> Assertive Community Treatment |
|---|

Table 5. 1: The six alternative Service Delivery Frameworks (SDFs)

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Case management itself, moreover, comes in a number of model variants (see Chapter 6), but it is identified (S Onyett 1992, p 3) in terms of one definition that all true variants meet:

Case management is a way of tailoring help to meet individual need through placing the responsibility for assessment and service co-ordination with one individual worker or team.

The core tasks of case management are: ...Assessment... Planning... Implementation... Monitoring... Reviewing.

The core tasks mentioned are common to all properly done intervention, but it is the continuity of care and the single point of co-ordination, vested in the case manager (or the case management team), that are the core characteristic of case management. Case management was introduced as the corner-stone of community care most notably in Britain, where it is a government-sponsored service to cover all persons needing long-term community care. It is used very widely in the US, and also in Germany, Holland and a number of English-speaking developed countries. It can act as the cornerstone of community care since the case manager becomes the person who brings it all together, making sure the service is co-ordinated 'at the point of use', tailored to the user's needs, and reliably continuous for as long as the need is experienced.

Countries or care systems which do not have case management would be expected to lack this reliable continuity. Three variants are interesting:

1. State-sponsored and state-organised case management, as with British 'care management' and 'Care Programme Approach'.
2. Case management organised by non-governmental (non-profit or for profit) providers, insurers or hybrid organisations (such as US Health Maintenance Organisations). Though it falls short of a countrywide system, its aim is still to overcome fragmentation and introduce co-ordination, aiming at 'a seamless web of service'.
3. Co-ordination through casework or similar systems (or absence of system), weaker than case management in their co-ordinating span, authority and tools, as prevails in most countries in the world, including the majority of European countries.

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What we wish to find out about the six Service Delivery Frameworks is which one, or which combination, is best for long-term care in Malta, in which mixes and with which adaptations, if any. Home-based care, being a purely acute service is omitted. (3), (4) and (5) are long-term services, while the rest are mixed. We shall therefore be looking at all the frameworks in the list.

As we look at the evidence, it is good to remember that one starts research with a hypothesis. The most attractive hypothesis would be a simple one that *the lower you get down the above list (Table 5. 1), the better it gets: the better the mental state, and the social functioning, satisfaction and quality of life of the users, and the cheaper the service.* We shall see if things are so plain and simple.

5.2.1 A 'Staircase-Model' Review of Reviews

The research about all the above frameworks is rather vast, but we shall concentrate on a small number of highly selective reviews that summarise and compare the best enquiries. Particular use has been made of the Cochrane Library (particularly Marshall M, Gray A, Lockwood A, Green R 1997; Marshall M, Lockwood A 1998; Tyrer P, Coid J, Simmonds S, Joseph P, Marriot S 1997). The Library focuses only on enquiries that have high scientific validity and reliability. Most studies compare the outcomes of two or more adjacent service delivery frameworks, from the above list. The present essay puts together the (mostly two-way) comparisons into a series. This follows the logic that if A is better than B, and B is better than C, then we can say that A is better than B, which is better than C; and so on. Of course, 'one must compare like with like'. Not only must we watch for the jump from 'like to unlike', as that from 'mixed acute and long-term' to 'purely long term' which occurs as we jump from (4) to (5). We must also make sure that 'better' is defined on unchanged criteria. Only then can we make generalisations of the type whereby one can conclude a chaining that leads to "A>B>C" from the two statements that "A>B" and "B>C".

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One way of describing the present enquiry is as a quest for the 'active ingredients' in long-term care, to borrow an expression from Dr Max Marshall (in a personal communication). The Cochrane Library, to which Dr Marshall has deeply contributed, presents reviews of research in the form of meta-analyses. It accepts only research that meets very stringent methodological criteria, such as being an RCT (a Randomised Controlled Trial). Besides, its reviewers only endorse the results that are valid on the 95% significance level or higher. Results are most often presented in the form of Peto Odds Ratios, together with the confidence intervals that are valid at the specified significance level.

Hospital Rehabilitati on =	basic therapies & interven- tions +	basic resources					
Mental Outpatients =	basic therapies & interven- tions +	basic resources +	community -based care				
Networking =	basic therapies & interven- tions +	basic resources +	community -based care +	interdisci- plinary care			
Community Mental Health Team =	basic therapies & interven- tions +	basic resources +	community -based care +	interdiscipli- nary care +	team- working		
Case Manage- ment =	basic therapies & interven- tions +	basic resources +	community -based care +	interdiscipli- nary care +	team- working +	case- management responsi- bility	
Assertive Community Treatment =	basic therapies & interven- tions +	basic resources +	community -based care +	interdiscipli- nary care +	team- working +	case- management responsi- bility +	ACT charac- tersitics

Table 5. 2: The 'Staircase Diagram': every comparison between one framework and the one above it in fact tests the 'difference' between them, that is, the shaded ingredient.

ARC is based on the belief that practice models can be profitably analysed into components. A morphological or component analysis is, then, made of the six Service Delivery Frameworks. Such an analysis is shown by Table 5. 2: The 'Staircase Diagram': every comparison between one framework and the one above it in fact tests the 'difference' between them, that is, the shaded ingredient.

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If we want to discover the active ingredient, we should not speak in terms of Service Delivery Frameworks as wholes. Suppose that our task is to make a three-point comparison between network-basis, community team and case management practice in the community. The ingredients common to all, shown in white in the table, are not in question. What is being tested is the components in the grey cells: ‘team-working’ and ‘case management responsibility’.

	<u>Hos</u> <u>pital</u> <u>Reh</u> <u>ab</u> ↓	<u>MO</u> <u>P</u> ↓	<u>Net</u> <u>wor</u> <u>king</u> ↓	<u>CM</u> <u>HT</u> ↓	<u>Case</u> <u>-</u> <u>Man</u> <u>age</u> <u>ment</u> ↓	<u>ACT</u> ↓
<u>Comparison 6:</u> (Case Management + CPA) vs. ACT ⁵					c	e
<u>Comparison 5:</u> (Networking + CMHT) vs. ACT ⁵			c			e
<u>Comparison 4:</u> Hospital Rehab vs. ACT ⁵	c					e
<u>Comparison 2:</u> (Hosp. Rehab. + MOP + Networking + CMHT) vs. (Case Management & CPA) ⁵		c			e	
<u>Comparison 1:</u> (Hospital Rehab + MOP + Network) vs. CMHT ⁶		c		e		

Reference: c = Control Group, e = Experimental Group

Table 5. 3: The Six Comparisons, each showing the Service Delivery Frameworks that are compared between Experimental (indicated by ‘e’) and Control Group (indicated by ‘c’). NB: Comparison 3, Hospital Rehab (‘e’) vs. (MOP + Networking + CMHT) (‘c’) is omitted, since no research making this comparison was cited in the reviews.

The presence and absence of key components is in fact described in Table 5. 5: Presence or Absence of Key Components in the Six Service Delivery Frameworks (SDFs). Please

⁵ Marshall et al., 1997.

⁶ Tyrer et al. (1997).

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note that Case Management is taken to include the British 'Care Programme Approach' which is, using our definition, a form of case management. The available comparisons of SDFs are represented in Table 5. 3: The Six Comparisons, each showing the Service Delivery Frameworks that are compared between Experimental (indicated by 'e') and Control Group.' Comparisons have been numbered from 1 to 6 for ease of reference.

5.3 What are the Active Ingredients within the Six Alternative Service Delivery Frameworks? Four Key Ingredients examined

A look at the six comparisons reveals that in each case we have one Service Delivery Framework (either a Community Mental Health Team, or Case Management or Assertive Community Treatment (see Table 5.6 for characteristics)) compared with 'standard treatment' in the same place at the same time, serving as control group. Standard treatment varies in the SDF or set of SDFs that it represents, as Table 5. 3 shows.

The purpose of the present discussion is to pore through the evidence to decide what would be a good model in the Maltese context. Maltese standard treatment varies between what happens in the 27,000-population Pilot Area and the rest of Malta and Gozo. In both, standard treatment is of the Mental Outpatient type, featuring an amount of home visits by specialist social workers who are involved in only a small minority of the MOP cases. There are also private psychiatrists' clinics, which are on a paying basis and which are uniprofessional, and feature no paramedical, social or counselling personnel. In the pilot area there are much smaller MOP caseloads, plus additional work by a social work team combining primary/generic health care, generic social work and specialist community mental health team type duties, together resulting in solidly greater attention to the client.

Rather than making conclusions about the gains expected by introducing any of the three focal SDFs (CMHTs, case management, ACT) this chapter will try to take the line of trying to discern which are the 'active ingredients', to use Dr Marshall's expression, that

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lie in them. The five empirically-based comparisons⁸ gain not only in simplicity but also in force if they are massed or integrated as in Table 5. 3: The Six Comparisons, each showing the Service Delivery Frameworks that are compared between Experimental (indicated by 'e') and Control Group (indicated by 'c'). Integration is helpful because a morphological or component analysis of the six compared models reveals them to be 'variations on a limited number of themes', or key ingredients.

a: Community-based living & care (rather than hospital rehab) Client resides at home. Other, formal & informal, community-based helpers involved. Client is seen and treated at office/clinic, & other rehab centres
a1: Client seen & treated also at home
b: Teamworking (rather than networking) among core workers
c: Case Management: Case Manager-type Responsibility (rather than none, or Assertive Community Treatment) Single person responsibility for continuity & co-ordination + quasi statutory responsibility
d: Assertive Community Treatment Characteristics
<i>NB: See Table 5. 6: Assertive Community Treatment Characteristics - components of a model designed for the community support of the most vulnerable</i>

Table 5. 4: The Four Key Ingredients representing essential similarities and differences among the Service Delivery Frameworks

In fact, Table 5. 4: The Four Key Ingredients representing essential similarities and differences among the Service Delivery Frameworks', spells out such variant themes. Meanwhile Table 5. 5: Presence or Absence of Key Components in the Six Service Delivery Frameworks', shows how the six Service Delivery Frameworks represent so many sets of variations on the four 'Key Ingredient' themes. Given this analysis, rather than tracing the implications of six comparisons, some of which may apply to the country in question, while others not, the effect is, instead, traced regarding the four key ingredients. In other words, the evidence is 'massed' or combined, to tackle the question of 'What is the outcome' about each of the four ingredients (listed in Table 5. 4).

⁸ Omitting, therefore, the derived Comparison 3.

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Case management responsibility in the UK carries with it a quasi-statutory responsibility (similar to Highway Code: failing to provide as agreed in service contracts with clients does not directly break the law, but "may be seen as contributing to negligence in legal proceedings."⁹) Through specific and voluminous legislation¹⁰, the British government has undertaken very clear responsibilities to support people in need in the community. Any lack of clarity in delineation of obligations is removed through clear service contracts which, under the influence of the Griffiths report (1988), lend reliability to the service and a measure of empowerment to the service user.

How the 4 Ingredients are 'active' in all SERVICE DELIVERY FRAMEWORKS

<u>The 6 SDFs (Service Delivery Frameworks) →</u> <u>The 4 Key Ingredients↓</u>	Hospital Rehabilitation	Mental Out-Patient	Net- work- ing	Com- muni- ty Ment Hlth Team	Case man- age- ment & CPA	Assert ive Com- muni- ty Treat- ment
a: Community-based living & care (not hospital rehab)	(absent)	<u>Present</u>	<u>Present</u>	<u>Present</u>	<u>Present</u>	<u>Present</u>
a1: Client seen & treated also at home	(absent)	(absent)	<u>Present</u>	<u>Present</u>	<u>Present</u>	<u>Present</u>
b: Teamworking (not networking)	<u>Present</u> ?	<u>Present</u> ?	(absent)	<u>Present</u>	<u>Present</u>	<u>Present</u>
c: Case Management: Case Manager- type Responsibility	(absent)	(absent)	(absent)	(absent)	<u>Present</u>	(absent)
d: Assertive Community Treatment Characteristics	(absent)	(absent)	(absent)	(absent)	(absent)	<u>Present</u>

Table 5. 5: Presence or Absence of Key Components in the Six Service Delivery Frameworks¹¹

9 Wessex Regional Health Authority (c. 1998). Care Programme Approach - A Guidance Document, p.1.

10 See the 600-odd page Mandelstram (1999).

11 A fuller version can be found on accompanying CD-ROM.

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Assertive Community Treatment Characteristics

- **More than just brokerage offered**
This excludes the model in which the case manager is broker and advocate, but not a counsellor, nor a provider of services or close personal support
- **Personal support and skills teaching in vivo**
In vivo: in client's home or places of work or daily living.
- **An 'assertive outreach' approach**
Refers to the style of interacting with the client, expecting strong, decisive and energetic leadership and initiative from the worker directed especially to reluctant and unco-operative clients.
- **Round the clock support availability**
After hours availability can be either in the form of person on duty or on call, as appropriate.
- **Same person (or team colleagues) offers the direct/personal services**
- **Same team/agency provides the resources**
Day care and home care, skills teaching, vocational training and all services provided by the case management team or agency.
- **Individual care is given on a teamwork basis.**
All team members know all the team's clients. This enables them to react with the safety and appropriateness that comes from this knowledge outside the key worker's normal hours. Several team members also often share the care of individual members.
- **Low staff to clients ratios** (usually 10 to 15 clients per worker).

Table 5. 6: Assertive Community Treatment Characteristics - components of a model designed for the community support of the most vulnerable

A fuller tabulation of varying components, on more themes than four, is given in at the end of this chapter in 'Table 5. 16: A Fuller Analysis of the Varying Components in the Six Service Delivery Frameworks'. It conveys the complexity that emerged towards the beginning of the analysis. This was later replaced by the framework behind Table 5. 2 and Table 5. 3, which was more streamlined and in itself incorporated or anticipated some of the important focuses of the research without, it is here maintained, prejudicing the answer to the question addressed.

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Further back we opined that the '*obvious hypothesis*' would be that each Service Delivery Framework further down the list would spell an improvement in outcome. Translated into our 'Key Ingredient' perspective, *we would be expecting community-based care, teamwork, case-management-type responsibility and the Assertive Community Treatment characteristics each to bring about an improvement in mental state, social status, quality of life, survival out of hospital and all the outcome figures.*

5.4 Reviewing the Findings about the Four Key Ingredients

Having re-aligned the research comparisons in terms no longer of Service Delivery Frameworks but, instead, in terms of key ingredients, we can now discuss the findings about each key ingredient and see what seem to be advisable ways of putting into practice the lessons that we learn. Our aim is to design a framework for service delivery that gives the best rook for play to the active ingredients, given the context and level of capacity. But there are some crucial lessons about all the Key Ingredients that must be discussed first. The 'Review of Reviews of Research' is summarised in Table 5. 7: The Key Ingredients and their effect on Hospitalisation, Remaining in Contact, Cost, and Table 5. 8: The Key Ingredients and their effect on Social and Clinical Outcome. The method used in creating this summary on the level of Key Ingredients had to go, in ARC fashion, beyond the models to the components that were missing in the controls and present in the experimental group. This required an improvised method that, however, can claim an acceptable – and not overstated - level of both validity and reliability. The conclusions made about each key ingredient in Table 5. 7: The Key Ingredients and their effect on Hospitalisation, Remaining in Contact, Cost and Table 5. 8: The Key Ingredients and their effect on Social and Clinical Outcome were the result of an 'adding' up or 'massing' of the evidence of all the cited controlled trials about that ingredient. The adding up was not of a strict mathematical type, but included an adding of an intuitive but rigorously applied kind. Table 5. 17: Which of the comparisons studied feature a neat comparison between a present and an absent key ingredient so as to warrant conclusions about outcome' indicates the careful work that was required to make inferences only where a key ingredient happened to be the valid object of a control experiment.

The Key Ingredients and their effect on Hospitalisation, Remaining in Contact, Cost

	Reduction of number of admissions	Reduction of duration of admissions	(c) Remaining in contact	Reduction of likelihood to leave study early	Reduced cost of hospital care	Reduced cost of care as a whole
a: Community-based living & care (rather than hospital rehab)	Yes: Strongly *	Yes: Strongly *	-Very unclear-	Yes-But not clear		
b: Teamworking (rather than networking)	-Very unclear-	-Very unclear-	-Very unclear-	Yes-But not clear		
c: Case Management: Case Manager-type Responsibility (rather than none, or Assertive Community Treatment)	No-Contrary effect! : Strongly so	No-Contrary effect! : Strongly so	Yes: Strongly			
d: Assertive Community Treatment Characteristics	Yes: Strongly	Yes: Strongly	Yes: Strongly		Yes	No

Table 5. 7: The Key Ingredients and their effect on Hospitalisation, Remaining in Contact, Cost (empty cells = no findings to note)

How do they improve social and clinical outcome?

	Quality of life	(Known) death reduction	Self-harm reduction	Compliance	Patient satisfaction	Accommodation	Employment	Mental state
a: Community-based living & care		Yes-But not clear	Yes		Yes: Strongly			
b: Teamwork		Yes-But not clear	Yes-Very unclear-		Yes-Very unclear-	Yes-But not clear	Yes-But not clear	
c: Case Manager-type Responsibility		Yes		Yes: Strongly-But not clear				
d: Assertive Community Treatment items					Yes	Yes: Strongly		

Table 5. 8: The Key Ingredients and their effect on Social and Clinical Outcome (empty cells = no findings to note)

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5.5.1 General lessons about Frameworks

The most disconcerting of the findings (Table 5. 7, Table 5. 8) was that, as we move up the staircase to 'more 'intensive' or advanced frameworks, no significant improvement in clinical state or social status is observed, barring some exceptions here and there. These exceptions are mostly linked with Assertive Community Treatment. Since, in all comparisons, frameworks were compared in which 'all other things were equal', it can be inferred that what really affects mental state and social outcome (job, accommodation, etc.) is more linked to improved therapies, staffing, resources and staff skills.

GENERALLY ABOUT SERVICE DELIVERY FRAMEWORKS

What is observed:	What we should do:
<ul style="list-style-type: none"> As regards social and clinical outcome, Service Delivery Frameworks are generally neutral. Mental state and social situation are improved not by improving Service Delivery Frameworks but more by improving <ul style="list-style-type: none"> therapies social resources staff levels and staff training. 	<ul style="list-style-type: none"> Providing case management without good <i>resources, therapies, staffing and staff skills</i> will only serve for better support and follow up - which, of course, have their value. Keep good balance between investment in (i) Improving the Service Delivery Framework and (ii) Improving the Therapies, Interventions and Resources.

Table 5. 9: Inferences from the Findings about Service Delivery Frameworks in General

The main lesson (see Table 5. 9) is that *providing case management alone will largely be, as far as mental and social outcome are concerned, like improving delivery without improving the product*. To ignore this is to expect case managers to 'take care' without having resources or specific therapies to deliver. This, in at least one instance, was the picture given to some practitioners of what it would be like when they changed over to case management. It is basically a matter of balanced resourcing. Case managers and

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resources and therapies are all essential and need to be provided in the relative quantities that most enhance their joint action.

5.5.2 How important is it for clients to be cared for in the Community?

Improved mental state or social status was not, then, a consistent 'plus' when comparing community-based rehabilitation with hospital-based rehabilitation. However, client and carer satisfaction was higher. Again, the more intensive end of community care, in the shape of Assertive Community Treatment, did bring about social status improvements, but it seems safe to attribute this to specific Assertive Community Treatment characteristics. One of the latter, however, is a necessarily community-based characteristic, namely in vivo treatment, additionally potentiated by assertive outreach.

RE KEY INGREDIENT A: COMMUNITY-BASED LIVING & CARE

What is observed:	What we should do:
<ul style="list-style-type: none">• Improves quality of life, client satisfaction and empowerment (latter concluded not on basis of research but on basis of values). *	<ul style="list-style-type: none">• Where feasible do rehabilitation in community rather than hospital.• Use of Day Hospital rehabilitation can be both cost-effective and possibly more acceptable to users.

Table 5. 11: Inferences for Practice from the Findings about Community-Based Care

Probably the best argument in favour of community care is one of ethics and quality of life, in line with our social models and empowering values. These should be given great priority, as far as we can afford. What could be a sensible policy reaction to the above finding? One could be 'Where we cannot afford, let us provide at least the cheaper and more affordable hospital- or office-based care.' Particularly, less vulnerable clients might not fare so far worse if office contact instead of home visits is resorted to when there are no clear indications for home visits, given Maltese levels of provision. Besides, this finding should bring home the message that the improved quality of life expected of community living and care often is possible only if therapies are available that more

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directly improve mental state. Simply living in the community is not a substitute for such therapies.

5.5.3 Just how essential and advantageous is teamworking?

No clear conclusions can be garnered from the findings about teamworking (working in a team, as opposed to 'teamwork' broadly meaning 'being co-operative'). This is far from implying that teamworking is not effective. Rather, in none of the comparisons considered did we have a clear contrast between an experimental group with teamwork over against a control group without it (the latter involving co-operation through networking, presumably, rather than non-co-operation).

RE KEY INGREDIENT B: TEAMWORKING

<u>What is observed:</u>	<u>What we should do:</u>
<ul style="list-style-type: none">• Unclear effect on outcome, (partly because research design did not clearly compare between team and non-team intervention¹²).	<ul style="list-style-type: none">• Team-working not to be everywhere. Networking, especially where the problems are relatively simple and can be largely dealt with by one or two individual workers, networking can save on bureaucracy and time use on meetings and inter-communication.• Allocate simpler cases to networking, more complex ones to teamwork.• Enhance co-ordination both in teams and in networks.¹³

Table 5. 12: Tentative Inferences for Practice from the Findings about Teamwork or Networking

Given that collaboration and co-ordination are central in our initial basic values, and rightly so in view of the plurality of providers in holistic community care, one would be tempted to advocate team-working 'for value reasons' in the same way that community-based care has been advocated. In Malta co-ordination is an ideal that is the more prized the more it locally turns out to be often, though not always, elusive. Exhorting in favour

¹² See discussion, in Chapter 9, re specialisation, bureaucracy and catchment area.

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of it is as strong as the pervasive private complaints about its frequent absence, though there are signs that in various quarters co-operativeness is improving. In this atmosphere, networking may sound like the opposite of good practice.

However, it is instructive to take note of the complaints of evaluators of British case management that care management and the care programme approach tend to be excessively bureaucratic and time-consuming. It is also worth noting that networking has been given official blessing as a first-line level of service, that should prevent the more costly teamwork where there are no clear indicating of the latter¹⁴. The most common practice is for 'Simple CPA', or one-team-member service, to be provided, wherever 'Complex-CPA' (team working among several) does not seem to be indicated.

The recommendation here is therefore *to approve of single-practitioner work on simpler cases*, be it by nurse, social worker, psychologist or doctor, exercising collaboration through 'cover' (medical or social or psychological as necessary), or through the intermittent involvement from members of other professions as necessary. Probably this would have to be done oftener in Malta than in better-resourced places. Realistic consensus is a better promoter of effective collaboration than the blaming, suppressed recrimination and severed lines of communication that can result from the frustration and dissatisfaction that comes when the expected 'good' practice is impracticable.

5.5.4 Implementing the inferences about Case Management-type responsibility: can the responsibility backfire?

Perhaps the most challenging finding is the effect of service delivery frameworks on admissions. The data show that, moving from hospital rehabilitation to standard community practice before case management (which is largely where we are at in Malta) one registers a decrease. But with case management, admissions are almost doubled;

¹³ See later re. co-ordination.

¹⁴ (See NHS Executive, 1996, Monitoring the Care Programme Approach and HAS 1995).

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only to be then drastically reduced with the introduction of Assertive Community Treatment.

Such findings gave rise to lively debate about interpretation and implications for practice, remembering that case management being the cornerstone of British community care and much US managed care. One important reaction was that of Max Marshall, himself a co-author of the Cochrane Library reviews on Case Management and the one on Assertive Community Treatment. In a British Medical Journal Editorial he (1996a) called the introduction of case management 'a disastrous mistake'. If it was introduced partly to reduce admissions and improve outcome, how can one claim to pursue evidence-based practice and retain case management if it did the opposite?

The short polemic that followed on the British Medical Journal put forward two interpretations. Dr Marshall saw these increased admissions as unacceptable, insisting that it was wrong to see case management as 'doing no harm'. It is taking up so much of the available energy and resources, that it is in fact obstructing improvement. He has favoured (in personal communications) family intervention or other short-term interventions promising a long-lasting effect; and, more lately, the use of day hospital as an alternative to full hospitalisation. Another participant (Phelan, 1996) in the BMJ polemic saw increased admissions as a proof of 'case management doing its job'. He saw it as the effective answer- finally! - to the 'neglect in the community' that had earlier in commentaries fallen on deinstitutionalised mental patients. Still another letter complained about the time-consuming nature of case management, in terms of paperwork, and meetings, with their travel and waiting.

Specific research could quantify cost and benefit, especially since these vary with local circumstances. One could also envisage a piece of research in which the sub-population missed by Community Mental Health Teams but admitted by care managers is identified, to find the proportions of false and true positives. But, though that could be generalisable to much of Britain, the Malta context is different in several ways.

RE KEY INGREDIENT C: CASE MANAGER RESPONSIBILITY

<u>What is observed:</u>	<u>What we should do:</u>
<ul style="list-style-type: none"> • Two interpretations have been proposed of increased admissions: <ul style="list-style-type: none"> ➤ "Many of those admitted did not need it, but were admitted because case manager wanted to 'play safe'. Best to scrap case management." ➤ Those admitted needed it. This is a sign of success and shows case management 'doing its job' - ending the gross 'neglect in the community' that existed before. 	<ul style="list-style-type: none"> • Introduce case management with narrow targeting of responsibility (only those most in need and/or expected to be most responsive) • But avoid <ul style="list-style-type: none"> ➤ dependency or vulnerability trap (since help stops once you improve a little, then you can improve no more) ➤ missing those who need admission out of fearing to admit those who do not need.
<ul style="list-style-type: none"> • Taking on a quasi-statutory responsibility for clients while having a large caseload increases admissions. • But we in Malta should be warned of the dangers of giving case managers more responsibility than they can take, which would encourage more hospitalisation than is necessary. 	<ul style="list-style-type: none"> • Narrow targeting needs <ul style="list-style-type: none"> ➤ tight management, tight implementation, ➤ ability to assess 'finely' on the critical features that make admission necessary, ➤ ability to prioritise ➤ freedom from (& safeguards against) extrinsic influence (relatives, powerful friends or patrons.)

Table 5. 13: Inferences for Practice from the Findings about Case Management Responsibility

The most important lesson is probably *the danger of 'taking too much responsibility'*. While not claiming that there is certain evidence that this happens widely, one plausible explanation is that case managers with big caseloads improve monitoring but not treatment. In contrast with Assertive Community Treatment practitioners, who improve both monitoring and community treatment, they resort to admission. This could amount to 'defensive practice', meaning admitting more than strictly need it, 'just in case'. This would prefer bloated admission figures to the risk of being held responsible for the

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neglect or danger faced by an exceptional 'false negative'. But the lesson for a country with a low level of provision is clear. Taking more responsibility than one can honour could overburden the service more than can be afforded.

The challenge, therefore, is to work with narrow targeting. Managerial and practice procedures should be found to narrowly target any case-management type responsibility that is taken. This would involve the safeguards listed in the last quadrant of Table 5. 13: Inferences for Practice from the Findings about Case Management Responsibility.

5.5.5 Inferences for Practice about Assertive Community Treatment: If it is so effective, should we afford it?

ACT (Assertive Community Treatment) is the choice method for reducing admissions. It also improves social outcome, e.g. employment and accommodation, and probably any social outcome that is provided for by the programmes, therapies and resources that it is the vehicle for. It is obviously too expensive and too ambitious for a country that has not yet afforded even consistent specialist community teams, and it is, even in the best resourced countries, reserved for the most vulnerable, often referred for Assertive Community Treatment specifically because their admissions were particularly frequent or long.

Where full-blown Assertive Community Treatment cannot be afforded, it is suggested that teams could give service similar to ACT to a small part, or 'stream', within their caseload (see Table 5. 14: Inferences for Practice from the Findings about ACT ingredients), to the more vulnerable clients. There is no reason why assertive outreach, in vivo skills teaching and other characteristics should not be practised on part of the caseload. Other ACT characteristics will turn out to be unfeasible without 'going the whole way'. Full 24-hour team availability would probably be difficult to resource. But keeping it on an on-call basis, or even having a member on call who could brief a

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general-purpose after-hours crisis intervention team, could turn out to be a good substitute, good enough for most clients, though not for the most vulnerable.

RE KEY INGREDIENT D: ASSERTIVE COMMUNITY TREATMENT COMPONENTS

<u>What is observed:</u>	<u>What we should do:</u>
<ul style="list-style-type: none"> • Very effective in reducing admissions. • Also often improves social outcome and clinical state. • Very costly care. Does not save money in US, probably even less so in Malta. • Shows that the most vulnerable need very intensive care to keep them stably in the community (but most of these in Malta are either in hospital; or, if at home, kept there at very high human cost to carers). 	<ul style="list-style-type: none"> • Do not look on ACT as money saving, but as a reliable way of keeping in community. • We cannot afford such teams (or, at most, just one for the whole island). • We should be slow in discharging the most vulnerable before we can provide services that are adequate to their needs. • But should consider it as a possible stream (that is <i>part of</i> caseload can be dedicated to a service that has <i>several but not all</i> ACT characteristics.)

Table 5. 14: Inferences for Practice from the Findings about ACT ingredients

5.6 Interpreting and Applying the Findings: the case for 'Flexible Case Management'

It is easy now to summarise what is being recommended by way of a hybrid Service Delivery Framework, which we can call *flexible case management*. This would feature *a judicious mix of (or ability to 'change gear' between) community-based and hospital-based care, networking and teamwork, narrow-targeted statutory responsibility and streaming according to vulnerability is introduced, in congruence with our basic aims and awareness of the relatively low level of our resources*. 'Mix' is not to be mistaken with lack of structure. In fact, the tight service design, demarcating criteria and procedures and skills that ensure effective implementation are essential to delivering that balance that gets the best service out of the resources that we are in a position to marshal.

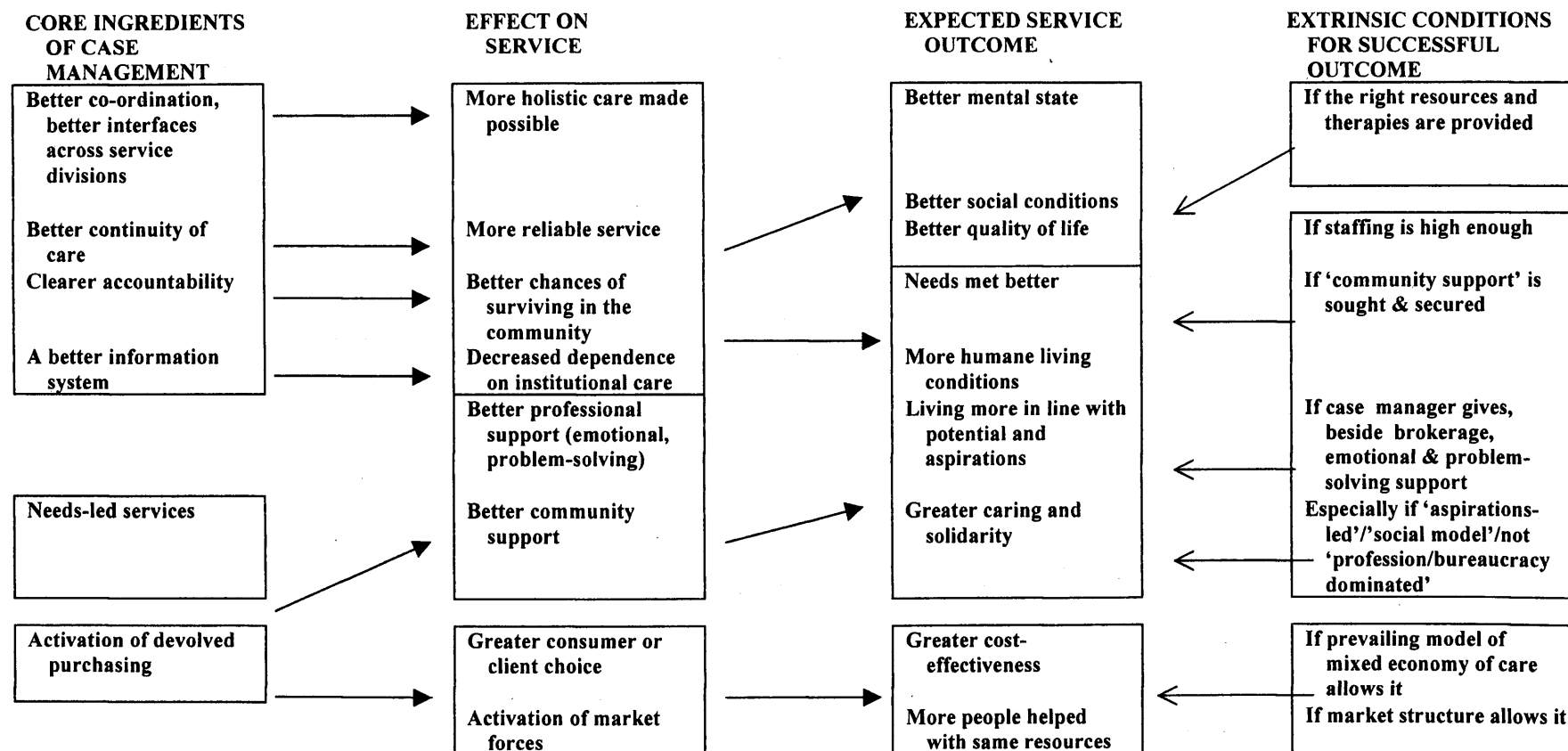


Figure 1: A Functional Analysis of Case Management - by giving a dynamic or 'inner' understanding of a policy or model, such an analysis highlights its 'line of force' and serves as guide to maximising effectiveness in its adoption.

Hospital Rehabilitation	Mental Outpatients	Networking	CMHT	Case Management	CPA with Case/Care Management	Assertive Community Treatment
Where client resides 1. Hospital 2. Home	Where client resides 1. Hospital 2. Home					
Where client is seen and treated 1. Hospital 2. Office/clinic 3. Other rehab centres 4. Home & in vivo	Where client is seen and treated 1. Hospital 2. Office/clinic 3. Other rehab centres? 4. Home & in vivo		Where client is seen and treated 1. Hospital 2. Office/clinic 3. Other rehab centres? 4. Home+ & in vivo-			Where client is seen and treated 1. Hospital 2. Office/clinic 3. Other rehab centres++ 4. Home & in vivo++
Who helps 1. Dr & Nurse. 2. Core 'wider' disciplines? 3. Other, formal & informal	Who helps 1. Dr & Nurse. 2. Core 'wider' disciplines? 3. Other, formal & informal?	Who helps 1. Dr & Nurse? 2. Core 'wider' disciplines? 3. Other, formal & informal?	Who helps 1. Dr & Nurse. 2. Core 'wider' disciplines 3. Other, formal & informal?	Who helps 1. Dr & Nurse. 2. Core 'wider' disciplines 3. Other, formal & informal		
What type of core worker collaboration & responsibility? 1. Networking 2. Teamwork+ 3. Joint care program+ 4. Key working ? 5. Quasi-statutory responsibility 6. Single case manager responsible for continuity & co-ordination 7. Team so responsible	What type of core worker collaboration & responsibility? 1. Networking 2. Teamwork+ 3. Joint care program+ 4. Key working 5. Quasi-statutory responsibility 6. Single case manager responsible for continuity & co-ordination 7. Team so responsible	What type of core worker collaboration & responsibility? 1. Networking 2. Teamwork 3. Joint care program 4. Key working 5. Quasi-statutory responsibility 6. Single case manager responsible for continuity & co-ordination 7. Team so responsible	What type of core worker collaboration & responsibility? 1. Networking 2. Teamwork 3. Joint care program 4. Key working? 5. Quasi-statutory responsibility 6. Single case manager responsible for continuity & co-ordination 7. Team so responsible	What type of core worker collaboration & responsibility? 1. Networking 2. Teamwork 3. Joint care program 4. Key working 5. Quasi-statutory responsibility? 6. Single case manager responsible for continuity & co-ordination 7. Team so responsible	What type of core worker collaboration & responsibility? 1. Networking 2. Teamwork 3. Joint care program 4. Key working 5. Quasi-statutory responsibility 6. Single case manager responsible for continuity & co-ordination 7. Team so responsible	What type of core worker collaboration & responsibility? 1. Networking 2. Teamwork 3. Joint care program 4. Key working 5. Quasi-statutory responsibility 6. Single case manager responsible for continuity & co-ordination 7. Team so responsible
			What therapies? 1. Low/less 2 Indifferent 3 High/better			
What resources? What staffing levels? 1. Low/less 2 Indifferent 3 High/better						What resources, staffing? 1. Low/less 2 Indifferent 3 High/better

Table 5. 16: A Fuller Analysis of the Varying Components in the Six Service Delivery Frameworks

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Meanwhile, it is worth looking at Figure 1:A Functional Analysis of Case Management - by giving a dynamic or 'inner' understanding of a policy or model, such an analysis highlights its 'line of force' and serves as guide to maximising effectiveness in its . It is offered in an attempt to picture the way case management, in spite of being in itself neutral with respect to some aspects of care, is still, in view of other aspects that are no less real, a solid contributor to effectiveness. It is hoped that this representation of the dynamics it carries helps in the process of adapting it in a bold yet balanced way.

Key Ingredient→ Comparison, - see 'Reference', below↓	Community- based living & care (Not hospital rehab) is 'added on' in...	Teamwork- ing (not net- working) is 'added on' in...	Case Manager- type Responsibil- ity is 'added on' in...	Assertive Communi- ty Treatment Character- istics are 'added on' in...
Comparison 6: (Case Management + CPA, i.e. 2 control subgroups)# vs. ACT*				All of 2 control subgroups
Comparison 5: (Networking + CMHT, , i.e. 2 control subgroups)# vs. ACT*		1 out of 2 control subgroups		All of 2 control subgroups
Comparison 4: Hospital Rehab (i.e. 1 control subgroup)# vs. ACT *	All control subgroups	0 or all of 1 control subgroup?		All of 1 control subgroup
Comparison 2: (Hosp. Rehab. + MOP + Networking + CMHT, i.e. 4 control subgroups)# vs. (Case Management & CPA)*	1 out of 4 control subgroups	2? out of 4 control subgroups	All of 4 control subgroups	
Comparison 1: (Hospital Rehab + MOP + Network, , i.e. 3 control subgroups)# vs. CMHT*	All 3 control subgroups	>1? out of 3 control subgroups		

Reference: * indicates the experimental group, # indicates the control group, ? indicates uncertainty

Table 5. 17: Which of the comparisons studied feature a neat comparison between a present and an absent key ingredient so as to warrant conclusions about outcome

Research articles often read as very abstract, but often they are followed by letters and counter-articles that explore significance, implications and the validity of their internal logic by viewing the studied causalities in the context of other causalities. The abstract skeleton of the original research article is thus 'fleshed up' through this contextualisation and discussion. As we said in the beginning of this chapter, this ventures without apologies into the qualitative, seeking fits and congruences in meaning and function.

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To conclude on the level of service applications, the following overall recommendations about service delivery frameworks can be used as broad summary:

Recommendation 1 (related to community-based service): Where possible treat in the community for the sake of better quality of life and client satisfaction and empowerment, even though improved clinical state does not seem to depend directly on this factor. After all clinical state is for the sake of quality of life.

Recommendation 2 (related to teamwork): Develop structures and climate, by means of specific actions and exercises that promote both teamwork and networking. Networking should be considered as official good practice when used as the first port of call and where the service to be given is relatively simple. Discussion, exercises and negotiation should be made so that interdisciplinary boundaries are consensually agreed and practice is realistic and sustainable, compatible with local levels of staffing.

Recommendation 3 (related to case management responsibility): Case management responsibility should be introduced for the cases that most need it, but realistically restricted through narrow targeting, support rather than replacement of existing caring networks and through short-term psycho-educational and support-building intervention. However, care should be taken so that targeting is not so narrow that clients are caught in a dependency or neglect trap.

Recommendation 4 (re. Assertive Community Treatment component characteristics; targeting, streaming): Do not introduce Assertive Community Treatment, but create streaming within the service that is as similar to Assertive Community Treatment as is feasible for the more vulnerable clients. Rather than a dedicated team, an Assertive Community Treatment-like stream should be part of the work of every mental health case manager. Clients could be classified by vulnerability into two or three streams by level of required case management intensity, the most intensive being most like ACT and being allotted on a 1:10 to

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1:15 staff/client ratio. Alternatively, create just one Assertive Community Treatment team for a large area such as all Malta, possibly without full after-hours cover.

Recommendation 5 (re Balance in investment between case management and other items): Flexible case management as proposed in these recommendations should be introduced but not alone. Since it is a mechanism for co-ordination and service delivery that results in a clinical outcome that is only about as good as the therapies it delivers, it should be provided along with good resources and therapies. The right balance should be struck in investment between the levels of case management, and the set resources and therapies provided.

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Chapter 6

Which Framework Components? - Matters of Congruence

As we said in introducing Chapter 5, Chapter 6 is the second among three chapters, along with Chapter 9, in which we progressively derive and specify the model that seems to fit the Maltese context. Active Remodelling for Congruence was introduced in Chapter 3 as a way of actively adapting a policy or service or administrative model to a new context. Table 6. 1 recalls the five steps that have been proposed in order to apply it. The purpose of this chapter is precisely to apply – and test out – the method. Within this chapter, special attention will be given to the *process of application* of ARC. The model recommended for Malta will be finalised in Chapter 9. Here the application is generic enough to serve as a general guide for, more or less, any country.

One basic aim of this enquiry is to propose a model for the delivery of mental health services in the Maltese community. Another, just as important, is to clarify the use of ARC, testing it out on the Maltese case in order to ‘pilot’ it, check if it works and improve it. From this point of view, ARC is a method that interests service designers and providers in whichever country. Any policy or service model would be expected to be amenable to the use of ARC, to guide the process of its adaptation to a new context.

Chapter 2 suggested that the five steps could be used to produce a ‘buyer’s manual’. This would give an analysis of a policy or service model in a way that can be applied to many possible contexts. Its challenge would be to guide would-be ‘adapting adopters’ of

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whichever kind of country context or, at least, a broad range of them. This would not only require the 'manual' to examine and selectively fit together each aspect of the model with the particular attributes of one country or district. It would also give a typology of the variations that each aspect could take, and go on to say what service characteristics would fit with each hypothetical variant that each context characteristic could manifest.

Actively Remodelling for Congruence, Step by Step

- 1. Identify the policy, programme or service model being considered for adaptive adoption and explain its rationale as seen within its native context.**
- 2. Compile background information, such as by analysing the characteristics of all the levels (Values, User World, Service. Organisation), and evidence-based data and by building up functional analyses.**
- 3. Analyse the policy model as well as other competing or variant models into components.**
- 4. Identify the issues expected to affect the choice of model components to adopt. With the help of a two-way diagram, identify the design features which each issue is expected to affect.**
- 5. Reflect on each issue, proposing adaptation to it in the affected model components. Build these up into a coherent design that is up to the desired level of specificity**

Table 6. 1: Active Remodelling for Congruence in Five Steps

Thus, it would be expected to give a whole spectrum of variant forms that could be taken by the mixed economy of care, the potential for division of responsibility between state and civil society, the state of progress of deinstitutionalisation or the managerial or resource capacity of the system. Beyond that, it would give guidelines as to which service forms would best fit with each contextual variant. This would be a tall order

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indeed, especially given that interacting typologies would generate permutations and combinations that would become too many to cope with. Besides, items in typologies tend to give 'ideal types', and these are notorious for their own internal variability, when one applies the ideal to the actual and concrete. Therefore no such manual can be expected to become a 'universal ready reckoner', giving a ready answer for all the possible contextual variation.

At the other end of the scale, an exercise in Active Remodelling for Congruence could aim to simply produce a specific service design, destined for adoption in a known setting. In its most concrete and finished form, this would be a detailed strategic and operational plan, a 'turnkey' project, ready-made for the adopters to follow in detail. But even the dissertation as a whole will not go as far as giving such a detailed service design for Malta. It will, rather, make concrete suggestions that, rightly and sensibly, still leave elbow room for wide variation, choice and adaptation by the actual policy makers, in line with their own know-how and responsibilities. This chapter will therefore carry out the second step in this process, further identifying, mainly on criteria of congruence with the context, the desirable components recommended for the desired model.

Because the enquiry will not yet have turned its full circle, many of the chapter's recommendations will retain an open-ended nature. They will as a rule keep some distance from the Maltese context. In the process they will be relevant to a wider range of contexts, though with a bias to those that bear some similarities with Malta. It is therefore hoped that this chapter will serve as guide for would-be introducers or adapters of mental health community services in a wide range of country contexts.

6.1 Do we focus on case management or an alternative service delivery framework?

Step 1. Identify the policy, programme or service model being considered for adaptive adoption and explain its rationale as seen within its native context.

As we tackle step 1, let us recall what we have said in Chapter 5. Case management ‘comes in many shapes and sizes’, but amid the several model variants, we have (in section 5.2) defined and identified it in terms of one definition (S Onyett 1992, p 3) that all widely acknowledged variants conform to: ‘Case management is a way of tailoring help ... through placing the responsibility for assessment and service co-ordination with one individual worker or team...’ It is the continuity of care and the single point of co-ordination, vested in the case manager (or the case management team) that are the core characteristic of case management.

For the purpose of Step 1, therefore, we identify the policy or model we are seeking as first a service for people living in the community that need long-term care because of problems of mental health. Secondly, it consists of a choice among the following six delivery frameworks, or their variants or inter-combinations:

1. Hospital-based care
2. Mental outpatients clinics
3. Single practitioners working in networks
4. Interdisciplinary community mental health teams
5. Case managers and case management teams
6. Assertive Community Treatment.

Thirdly, we have adopted *‘Flexible Case Management’* as our service delivery framework which, as described in the conclusions to Chapter 5 and recalled below, largely employs the general case management model, but does so parsimoniously, economising on its most resource-intensive features. This implies, among other things, that it is quite ready to ‘change gear’ into any of the other five Service Delivery Frameworks in its attempt to reserve its most potent and expensive levels of action to the clients and situations that need them most.

6.2 Conclusions from other Chapters

Step 2. Compile background information, such as by analysing the characteristics of all the levels (Values, User World, Service, Organisation, Country Context), gathering related evidence-based data and building up functional analyses.

Chapters 4, 5 and 8 contribute to this. The reason why the circle will only be closed in Chapter 9 is to give room for the contribution of the Findings, both from the empirical enquiries and the participant-observation role.

6.3 Analysing case management as a service related to context

Step 3. Analyse the policy model as well as its competing or variant models into components

<u>Variant Model of Case Management</u>	<u>Major source used</u>
Expanded brokerage	Solomon (1992)
Assertive Community Treatment	
Full Support Model	
Strengths model	
Rehabilitation model	
Care Programme Approach	Department of Health (1990)
Falloon & Fadden	Falloon & Fadden (1993)
Supported Living Model	Kinsella (1993)
Neighbourhood Model	Baldwin (1993)

Table 6. 2: Nine variant models of case management used as sources of model components

Nine variant models of case management are used in the analysis that is here undertaken. The characteristics of five of them are mainly derived from an excellent review of them by Solomon (1992), but most of them are subject of a relatively wide literature of their own. In line with the third step of ARC (Active Remodelling for Congruence), they will be analysed into their main components, pooling them into one 'menu', from which to choose the ones that best fit the context. Of course, they must fit together too. One cannot simultaneously fit together the rehabilitation model and the strengths model, for

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instance, at least as regards the central components or 'traits' (re 'trait' see Eysenck et al. 1972) of the latter have been introduced precisely to react against and correct the 'deficit' view of treatment and care.

The 'pool of traits' or components garnered from the nine models is displayed in Table 6.

3: A Glossary of Components of Case Management Models. This table tries to briefly convey the meaning of each 'trait' or component listed, which will help us in advancing in our analysis seeking to maximise congruence with the target environment. Table 6. 4: Important Components Present in Selected Models of Case Management (Y = present. y = demanded by good practice). The first three items, however, marked '0' and A, derived from Onyett (1992) and Huxley (1991) are not, however, identified with any model in particular. But they are included because they are key components that should belong to all models, the first on the ground of being the basic definition, the others on the basis of being good practice.

A Glossary of Traits or Components found in Case Management Models

Minimal definition (as per Onyett)

Case management came to mean widely differing things to different people, but we can follow S Onyett's (1992, p 3) minimalist definition applicable to all case management, namely,

Case management is a way of tailoring help to meet individual need through placing the responsibility for assessment and service co-ordination with one individual worker or team. The core tasks of case management are: ...Assessment... Planning... Implementation... Monitoring... Reviewing.

Service targeted clearly and specifically (Huxley)

Reviewing recent US studies, P Huxley finds evidence that effectiveness is associated with specificity in the groups targeted, that is, with services that are congruent with the needs of a specific, rather than diffuse or mixed group. Adding case management, in itself a long-term care model, to the duties of an acute care team is seen as an example of widespread inferior effectiveness.

All members of team are accountable to a single authority (see Onyett)

While quoting no particular empirical studies, Onyett singles out for criticism case management teams where members of different professions recognise no single authority to which all are directly accountable.

This is seen as resulting in much uncoordinated effort and weak responsiveness to policy decisions.

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Skills deficits targeted

Teaching skills necessary for survival and well being are seen to be essential services in rehabilitation.

More than just brokerage offered

This excludes the model in which the case manager is broker and advocate, but not a counsellor, nor a provider of services or close personal support

Personal support and skills teaching in vivo

In vivo: in client's home or places of work or daily living.

Aggressive/assertive/directive approach

Refers to the style of interacting with the client, expecting strong, decisive and energetic leadership and initiative from the worker.

Round the clock support availability

Same person (or team colleagues) offers the direct/personal services

Same team/agency provides the resources

Day care and home care, skills teaching, vocational training and all services provided by the case management team or agency.

Team has clear and specific case responsibility

The workers within the Care Programme Approach are given a quasi-legal responsibility for the good care and safety of their cases, all characterised by a notable amount of vulnerability to danger.

Needs recognised and targeted are defined 'generously' on a strengths and personalised need model

Particular stress on client self-determination and continuing personal growth

Models centring on empowerment and client self determination have produced a veritable revolution in status and expectations, originally for the person with disability, but later extended to practice with other potentially dependent groups.

Stress on tapping and developing community resources - 'community as resource, not obstacle'

This is especially developed in Baldwin.

Placement at 'neighbourhood of choice'

Baldwin sets great store on (i) knowing each neighbourhood's peculiarities, (ii) informing the clients about it, and give them choice, so that client can reliably and freely decide which neighbourhood is most suitable for him/her to live in.

Integration with primary team

Case management in the Falloon and Fadden model is co-ordinated by the GP, who enjoys rich and immediately available specialist back up. This practice was discontinued in Buckinghamshire, where it originated.

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Temporary intensive training of carers + network-building for subsequent better coping, more self reliance, lower long-term load on services

Several authors describe intensive and effective training given to carers and neighbours. This reduces subsequent dependency on the service, since the carers will have been empowered to cope much more independently.

Emphasis on supporting and teaching the family to cope

This practice has prospered and become a method of intervention in its own way, called Family Intervention, the subject of a vigorous growth movement and robustly supportive empirical literature.

Table 6. 3: A Glossary of Components of Case Management Models

Step 4. Identify the issues expected to affect the choice of model components to adopt. With the help of a two-way diagram, identify the design features which each issue is expected to affect.

One thing that soon became apparent in developing and trying out ARC was that the fitting process is not really a two-way 'confrontation' between model components and context components. A third element intervenes, and this is the *issues* that we want or need to take into account. This makes it more of a three-way process. Which issues are important will depend on various factors, including both subjective and objective elements. What will be the criteria of a good fit for one person might not be a good fit for another, because there are values and visions, perceptions and policies involved. What counts here is 'what there is or should be put on the policy agenda'. Any planner will bring in issues that emanate from operative values and visions, from declared or implicit policy goals, and from the instrumental and operational items that would be necessary for the policy aims to be attained.

Case management model in which the component or trait is found→		Expan ded broker age	Asser- tive Com- muni- ty Treat- ment	Fully Sup- ported Model	Stren- gths model	Reh- abilit- ation model	Care Prog- ram App- roach	Falloo n & Fadde n	Sup- ported Liv- ing	Neigh bourh ood Model
↓Case management model component or trait										
0	Minimal definition (as per Onyett)(see also Sledge et al.)	Y	Y	Y	Y	Y	Y	Y	Y	Y
A	Service targeted clearly and specifically (Huxley)	y	y	y	y	y	y	y	y	y
A	All members of team are accountable to a single authority (see Onyett)	y	y	y	y	y	y	y	y	y
B	Skills deficits targeted		Y	Y		Y			Y	
B	More than just brokerage offered	Y	Y	Y	Y		Y	Y	Y	Y
B	Personal support in vivo and by case management team personally		Y	Y						
B	Aggressive/assertive/directive approach		Y	Y	Y					
B	Round the clock support availability		Y	Y						
B	Same team offers the direct/personal services		Y	Y						
B	Same team/agency provides the resources			Y						
B	Team has clear and specific responsibility			Y			Y			
B	Needs recognised and targeted are defined 'generously' on a strengths and personalised need model				Y				Y	
B	Particular stress on client self-determination and continuing personal growth				Y				Y	
B	Stress on tapping and developing community resources - 'community as resource, not obstacle'				Y				Y	Y
C	Placement at 'neighbourhood of choice'								Y	Y
C	Integration with primary team							Y		
C	Temporary intensive training of carers + network-building for subsequent better coping, more self reliance, lower load on services					Y		Y		
C	Stress On Supporting And Teaching The Family To Cope							Y		

REFERENCE: 0: Essential definitional characteristic of Case Management. A: Taken as a characteristic indicated by good practice for all intervention, independent t of model B: Items prominent in the five models described by Solomon C: New items prominent in additional models (Care Programme Approach, Neighbourhood Model, Falloon and Fadden model and the Supported Living Model).

Table 6. 4: Important Components Present in Selected Models of Case Management (Y = present. y = demanded by good practice)

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Like all planning exercises, and any activity involving creativity, these issues raise ‘chicken and egg’ questions. Did the issues ‘draw out’ the affected model components, or did the model components, or even the context components, stimulate the identification of the issues, that is, the questions to pose in the search for congruence? The answer is that they elicit and stimulate each other. ARC discovers and exercises creativity through morphological analyses (See Melchior T M, 1996). Morphological analyses divide items into known aspects and components and cross these with components or aspects of related items. They help one move over the terrain systematically, discovering unnoticed gaps, new interactions and new issues

Service Design Issues

1. Preliminary Issues, mostly related to Framework and Cost

- Issue 1. What service delivery framework is to be used?
- Issue 2. What does good practice require?
- Issue 3. What has particular resource implications?
- Issue 4. What has mostly process and people implications?

2. Issues mostly related Level U-1, the Inner User World : Responding to user need in openness to user-centred values

- Issue 5. How will the service be centred on the client’s needs?
- Issue 6. What would a social or empowerment model require?

3. Issues mostly related to Level U-2, the Wider User World – Family, Community and Civil Society: Sharing responsibility among state, family, civil society, neighbourhood

- Issue 7. What responsibility is to be undertaken and how shared?

4. Issues mostly related to Level C, the Country-Context Level

- Issue 8. How will the service be located within the service’s centralisation/ decentralisation and mixed economy structure?

5. Issues mostly related to Level S, the Services Level

- Issue 9. How cater for different levels of vulnerability?
- Issue 10. At what times will the service be available?
- Issue 11. How is the service to be streamed?
- Issue 12. What span of clients will be targeted by the service?

Table 6. 5: Key Model Design Issues or ‘Questions of Congruence’: a provisional list of the issues or questions for which the congruence analysis seeks a response (this table is completed in Chapter 9, Table 9.1)

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Sometimes one uses what Strauss and Corbin (1990) call the 'flip-flop technique', applying the 'what's sauce for the goose is sauce for the gander' logic, such as where an issue that is naturally raised about men is raised about women, often with surprising results. Thus, one might discover that a service model attribute is desirable, noticing that this is because it is expected by good practice. Then one extends the analysis by applying to all the components the criterion of 'being required by good practice', arguing that its usefulness is worth testing more widely.

The issues in Table 6. 5 are tabulated over the five ARC levels, represented by the acronym 'V-USOC' (with Level O issues postponed till Chapter 9, being too broad to be component-related). The meaning of some of the issues will be clarified as the analysis progresses. The issues are considered to be relevant to a wide range of contexts into which one is 'fitting' a model for community mental health service delivery.

		Values-Level related		'Main Cost'	
		Issue 2	Issue 6	Issue 3	Issue 4
		What good practice requires	What belongs to the 'social model'	Particular resource implications	Mostly process and people implications
01	Minimal definition : case manager exercises continuity and co-ordination	x			x
02	Service targeted clearly and specifically (Huxley)	x			x
03	All members of team are accountable to a single authority	x			x
04	Skills deficits targeted	x		(x)	x
05	Needs-led services	x		(x)	x
18	Integration with Acute team	-ve		-ve	
13	Needs recognised and targeted are defined 'generously' on a strengths and personalised need model		x	(x)	x
14	Particular stress on client self-determination and continuing personal growth		x		x
15	Stress on tapping and developing community resources - 'community as resource, not obstacle'		x	(x)	x
16	Placement at 'neighbourhood of choice'		x	(x)	x

Table 6. 6: How to compile a 'list of model features related to the Design Issue': Focus on the V-Level: Value and Good Practice Implications. (Columns indicating implications on resource, process and people aspects are best always included.) Reference: x = affected, (x) probably or mildly affected, -ve = this factor has a negative influence.

Most related ARC Level→		Framework & Cost issues			User Level 1 (U1)		U2, C-Levels	Service Level (S)	
Service Design Issues→ Service Design Features: Characteristic or Component found in one or more Case Management Models ↓		2. What does good practice require ?	3. What has particular resource implications?	4. What has mostly process and people implications?	5. How centre on the client's needs?	6. Social or empowerment model requirements?	7,8 What has particular contextual implications	9,10. How cater for different vulnerability levels?	11. How is the service to be streamlined?
01	Minimal definition : case manager exercises continuity and co-ordination	x		x			(x)		
02	Service targeted clearly and specifically (Huxley)	x		x	x				x
03	All members of team are accountable to a single authority	x		x					
04	Skills deficits targeted	x	(x)	x	x				
05	Needs-led services	x	(x)	x	x				
06	More than just brokerage offered		x		x		x	x	x
07	Personal support and skills teaching in vivo (In vivo = in client's home or places of work or daily living.)		x		x		x	x	x
08	Assertive outreach		x		x		x	x	x
09	Round the clock support availability		x		x		x	x	x
10	Same person (or team colleagues) offers the direct/personal services		x		x		x	x	x
11	Same team/agency provides the resources		x	x	x		x	x	x
12	Team has clear and specific case responsibility		x	x	x		x	x (1)	x
13	Needs recognised and targeted are defined 'generously' on a strengths and personalised need model		(x)	x		x			
14	Particular stress on client self-determination and continuing personal growth			x		x			
15	Stress on tapping and developing community resources - 'community as resource, not obstacle'		(x)	x		x			
16	Placement at 'neighbourhood of choice'		(x)	x		x			
17	Integration with primary team		x	x			x		
18	Integration with Acute team	-ve	-ve						
19	Temporary intensive training of carers + network-building -- subsequent better coping, more self reliance, lower long-term load on services		x	x			x		
20	Emphasis on supporting and teaching the family to cope		x	x			x		
21	Improved Information system		x	x					x
22	Activation of devolved budgets and purchasing		x	x			x		x?
23	Is case manager to be part of -purchaser? -regulator? -provider? -rep of client? -client?		x	x			x		x?

Table 6. 7: Synoptic Table of Case Management Model Design Features related to particular Service Design Issues located on the User, Organisation and Country-Context Level (Values level is pervasive and implicit; Issues 7,8 and 9,10 have been joined to reduce complexity.

6.4 Carrying out the inter-level analysis to help find a better fit

Step 5. Reflect on each issue, proposing adaptation to it in the affected model components. Build these up into a coherent design that is up to the desired level of specificity

Synoptic Table 6.7 gives a wide-angle or synoptic view of the two-way diagram created to spot interactions between Issues and possible Model Components. Moving about over a large table may help at the exploratory stage, but it helps to focus attention if a smaller table is prepared which only brings in the components that are affected by the issue being considered.

Such a table is Table 6. 6: How to compile a 'list of model features related to the Design Issue': Focus on the V-Level: Value and Good Practice Implications. (Columns indicating implications on resource, process and people aspects are best always included.) Reference: x = affected, (x) probably or mildly affected, -ve = this factor has a negative influence. The figure highlights the model components or traits that have particular resource implications. This is done so that, while considering particular model features, their 'cost' is also taken into account. Model attributes that would mainly or substantially require more resources are shown separately from those that mainly or substantially require a change in people's attitudes and behaviours, or service processes. Contexts with weak resources but a strong willingness in its employees and a high process-changing capacity and, indeed, anybody who wants to stretch capability, would find it helpful to keep these in mind, and apart, in the exploration process. Others might, of course, have different ways of usefully tabulating the capability aspect within the process.

We can now focus on each issue in turn, specify which model components seem to be affected by it, reflect and formulate service model recommendations. The issues, out of respect for their thought-nudging point of origin, are generally classified by ARC Level. But since levels are a springboard to issues, which in turn are often not reserved to the ambit of that level, the link to the level is seen as a loose one.

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Viewing First the Recommended Basic Framework

Issue 1. What service delivery framework is to be used?

Issue 1, 'What service delivery framework is to be used?' is related with component 01, as shown in the related box below. Recommendations 6.1a and 6.1b reflect the conclusions of Chapter 5, as summarised above, within this chapter. This issue is the odd one out: it is not derived from a congruence analysis aimed at specifying model components coming from variants of case management. Instead, it is based on an analysis of the evidence (of course, over a largely implicit background of expected congruence with prevailing cultural and functional aspects) aimed at selecting a service delivery framework. Each issue is here concluded with relevant recommendations, in the accompanying box related to the issue. The boxes in this section give the recommendations made, in relation to the issue in question and the models design features that can be varied or adapted or mobilised in response to that issue.

<u>Service Design Issue:</u>
<u>1. What service delivery framework is to be used?</u>
<u>Relevant Design Features:</u>
01 Minimal definition : case manager exercises continuity and co-ordination
<u>Recommendation/s:</u>
Recommendation 6.1a : Use flexible case management, that is, case management that takes on characteristics of other service delivery frameworks according to need, as recommended in Chapter 5, mainly to stretch the capability of available resources in a way that goes a long way in respecting client needs.
Recommendation 6.1b: Though this is essential to the definition, do not apply continuing care more widely than you can afford. Use characteristics 19 & 20 as recommended.

Issue 2. What does good practice require?

Our second and third issue have to do with value considerations, focusing the analysis on the V- or Value Level. We have undertaken a basic commitment in favour of the vulnerable, which very often, as now, can warrant options that would also be called for by the expressed mainstream values of the helping professions. A look at the components or design features showed that many of them are not optional, since they are required by professional good practice. For example, it does not seem that good practice can tolerate members of a case management team who are not somehow accountable to one authority

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(though this should leave room for definable areas of autonomy for, profession, practitioner and service unit). An empowerment or 'social' model is also required by our basic option, even though unfortunately it is not universally embraced and practised by the helping professions.

Here we can use Table 6. 6, 'How to compile a 'list of model features related to the Design Issue': Focus on the V-Level: Value and Good Practice Implications. (Columns indicating implications on resource, process and people aspects are best always included.) Reference: x = affected, (x) probably or mildly affected, -ve = this factor has a negative influence. As we have said, its purpose is to show in detail what Table 6. 1 displays on a wide canvas. Only the relevant components and issues are shown (with capacity issues included for the reason mentioned above), in order to concentrate attention. It is suggested that such detail tables be used for every issue, though they have not been here reproduced in order to save space.

Needs-led service, the targeting of skills deficits, the designing of programs of therapies and interventions to reach specific aims and safeguarding accountability to a single authority are all characteristics that should be part of the model, for value reasons, whichever the context. However, in their own way they are context specific too, because they all beg such context questions as, "What are the local needs?", 'What rehabilitation or growth goals are here a priority?' or 'How are the diverse accountabilities regarding care program, professional conduct, resources, work discipline etc. to be woven into a harmonious whole compatible with local realities?' Specific rehabilitation aims, be they promoting job, pushing for deinstitutionalisation, cooking 'in situ' or reducing admissions, may vary not only by case but also by local priority. More generally, it is precisely because of such frequent 'begging of local context questions' that recommendations here remain partly open-ended. It is hoped that this does not reduce their value.

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<u>Service Design Issue:</u> 2. What does good practice require?
<u>Relevant Design Features:</u> (01 Minimal definition : case manager exercises continuity and co-ordination) 02 Service targeted clearly and specifically (Huxley) 03 All members of team are accountable to a single authority 04 Skills deficits targeted 05 Needs-led services
<u>Recommendation/s:</u> Recommendation 6.2: All these are required by good practice. Introduce them all, but be careful not to 'overuse' the ones with particular resource implications.

Issue 3. What has particular resource implications?

Issue 4. What has mostly process and people implications?

These issues have been raised all through this analysis. Where there are resource limitations but willing and able staff, plus a modicum of training, communication and growth capability, components with high people and process needs but low resource needs could be targeted as valuable growth points.

<u>Service Design Issue:</u> 3. What has particular resource implications? 4. What has mostly process and people implications?
<u>Relevant Design Features:</u> See tables
<u>Recommendation/s:</u> All the recommendations in this chapter take into consideration resource and capacity aspects.

Viewing from User Level 1: User World and User-centred Values

Issue 5. How will the service be centred on the client's needs?

While research shows that specifically targeted services do better there will, of course, always be a broad range of needs that will have to be catered for by services that will take as their province 'the rest' of the needs, when one surpasses the point where specific services can be introduced without reducing efficiency. This dissertation invests in need studies. A challenge for systems in the middle level of provision is to decide which needs

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to be included in assessments. If critical needs are left out of assessment and intervention, placements will fail. The temptation will be to make less than comprehensive assessments and care plans, applying an arbitrary rationing system, seeing this as inevitable because 'we can't do everything'. It takes very clear planning and implementation to target all the critical needs of those in most critical states, and to identify the type of information system about needs that is affordable, reliable and sufficiently prioritised.

The components here affected are those involved in Issues 2 ('What does good practice require?' and 11 ('How stream service?') plus components 06 and 21. The former reminds that brokerage of service separated from the facilitating, supporting and therapeutic skills of social workers and other helping professions leaves crucial personal needs unmet. Here again, important value and practice recommendations are made, but they still – appropriately, it is hoped - beg the question of what is the local need. That is why we give specific answers regarding Malta only after the findings about local need have been described in Chapter 8. But needs cannot be met in an ongoing and consistent way unless an efficient information system, probably featuring more simple computerised forms than heavy paperwork, is part of it.

Service Design Issue:

5. How will the service be centred on the client's needs?

Relevant Design Features:

- 02 Service targeted clearly and specifically (Huxley)
- 04 Skills deficits targeted
- 05 Needs-led services
- 06 More than just brokerage offered
- 07 Personal support and skills teaching in vivo
- In vivo: in client's home or places of work or daily living.
- 08 Assertive outreach
- 09 Round the clock support availability
- 10 Same person (or team colleagues) offers the direct/personal services
- 11 Same team/agency provides the resources
- 12 Team has clear and specific case responsibility
- 21 Improved Information system

Recommendation/s:

Recommendation 6.5: Since client groups vary, there is little one can say generally beyond the need to study client need in line with the above service modes, to improve the fit between service and need.

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Issue 6. What would a social or empowerment model require?

Service Design Issue:

6. What would a social or empowerment model require?

Relevant Design Features:

- 13 Needs recognised and targeted are defined 'generously' on a strengths and personalised need model
- 14 Particular stress on client self-determination and continuing personal growth
- 15 Stress on tapping and developing community resources - 'community as resource, not obstacle'
- 16 Placement at 'neighbourhood of choice'

Recommendation/s:

Recommendation 6.6a: Stretch your process capacity to make these possible: they need tight management and good leadership to implement.

Recommendation 6.6b: Apply leadership, training and process refinement to promote commitment to these high ideals. Often it is more a matter of commitment and imagination than resources: more a matter of imagination than money. It also requires particular types of resource and service developments. With the resources in hand then find out, case by case, how you can go in pursuing the 'social model'.

In view of our value option in favour of the vulnerable, we see the characteristics of social and empowerment models not to be optional but a requirement. Mobilising staff and management imagination and commitment even where resources are limited is a central challenge. To fail to motivate, liberate and support an 'empowering imagination' on grounds of poor material resources is based on an incorrect and over-generalised line of reasoning.

Viewing from User Level 2: Family, Community and Civil Society

Issue 7. What responsibility is to be undertaken and how shared?

The issue is what case responsibility the team or case manager is to undertake, and how this is to be shared with family, community and neighbourhood, whether this responsibility should be time-limited or permanent, and whether it should include the responsibility to maintain an information system, of what type and with regard to what level and type of need. This is a crucial matter of policy. A more detailed discussion of this in relation particularly with Malta will be found in Chapter 9.

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<u>Service Design Issue:</u>
<u>7. What responsibility is to be undertaken and how shared?</u>
<u>Relevant Design Features:</u>
19 Temporary intensive training of carers + network-building -- subsequent better coping, more self reliance, lower long-term load on services
20 Emphasis on supporting and teaching the family to cope
12 Team has clear and specific case responsibility
21 Improved Information system
<u>Recommendation/s:</u>
Recommendation 7: Design the Service to Reflect the status of the division of labour and relative strengths of the formal services on the one hand and the family and community on the other. Where family and community are strong and the formal services are weak, invest more in the former.

Viewing from the Country Context Level: Mobilising the Mixed Economy of Care and administrative Decentralisation

Issue 8. How will the service be located within the service's centralisation/ decentralisation and mixed economy structure?

Again, more detailed discussion of this as applied to Malta and similar places will be found in Chapter 9.

<u>Service Design Issue:</u>
<u>8. How will the service be located within the service's centralisation/ decentralisation and mixed economy structure?</u>
<u>Relevant Design Features:</u>
12 Team has clear and specific case responsibility
21 Improved Information system
22 Activation of devolved budgets and purchasing
23 Is case manager to be part of
-purchaser?
-regulator?
-provider?
-client world, or client system?
<u>Recommendation/s:</u>
Recommendation 8: Design the system in congruence with the prevailing and desirable system of decentralisation and mixed economy of care.

Viewing from the Services Level

Issue 9. How cater for different levels of vulnerability?

Assertive Community Treatment (see Table 5.6 for characteristics) is very resource-intensive, and difficult to afford. Ways of limiting its use would be to have it in small

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numbers (such as 1 team for the whole island in the case of Malta) or to have it only as part of a team's workload. Alternatively one could have its after-hours work done by the 24-hour crisis intervention service, if available. However, the latter could limit the level of vulnerability of users that could be discharged into the community. Temporary admission in an existing unit could also be a feasible way of supporting highly vulnerable clients in the community without having after-hours ACT service.

<u>Service Design Issue:</u>
<u>9. How cater for different levels of vulnerability?</u>
<u>Relevant Design Features:</u>
07 Personal support and skills teaching in vivo (in client's home or places of work or daily living).
08 Assertive outreach
09 Round the clock support availability
10 Same person (or team colleagues) offers the direct/personal services
11 Same team/agency provides the resources
<u>Recommendation/s:</u>
Recommendation 9: These are resource-intensive. But they are the only way you can keep highly vulnerable clients consistently out of hospital. - Ideally, it is best to have a dedicated team on this. If you cannot afford, consider streaming clients by level of vulnerability, giving most intensive service to those who need it most.

Issue 10. At what times will the service be available?

This is discussed under Issue 9, above.

<u>Service Design Issue:</u>
<u>10. At what times will the service be available?</u>
<u>Relevant Design Features:</u>
09 Round the clock support availability
<u>Recommendation/s:</u>
Recommendation 6.10: If you cannot afford this on a full presence basis, consider its being kept on an on-call basis.

Issue 11. How is the service to be streamed?

This can be done in various ways. However, it is suggested that features belonging to ACT be used as one of the main bases, as a streamed response to users streamed by level of vulnerability. Where a full ACT team cannot be afforded, ACT characteristics can be exercised to a substantial extent to the more vulnerable part of the caseload.

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<u>Service Design Issue:</u>
<u>11. How is the service to be streamed?</u>
<u>Relevant Design Features:</u>
06 More than just brokerage offered
07 Personal support and skills teaching in vivo (in client's home or places of work or daily living).
08 Assertive outreach
09 Round the clock support availability
10 Same person (or team colleagues) offers the direct/personal services
11 Same team/agency provides the resources
<u>Recommendation/s:</u>
Recommendation 11 : Design service in terms of: (i) level of users' need and vulnerability, (ii) stage of local progress in deinstitutionalisation (iii) the existent supportive and protective services (formal or informal) and resources that are already in place.

Issue 12. What span of clients will be targeted by the service?

This will have to be seen according to the context. Generally, the broader services make for lower effectiveness, partly because practitioners who deal with a narrow band of problems can gain from more practice and better refinement of the methods used. See Chapter 9.

<u>Service Design Issue:</u>
<u>12. What span of clients will be targeted by the service?</u>
<u>Relevant Design Features:</u>
17 Integration with Primary team
18 Integration with Acute team
<u>Recommendation/s:</u>
Note that both integration and specialisation have a cost that has to be measured and balanced in the light of local realities and possibilities.

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Chapter 7

Research Design of the Need Assessment and its Rationale within the Multi-Level Enquiry

The aim of the present chapter is to explain the research design of the needs assessment whose findings are set out mainly in Chapter 8. Designing the right model of service requires a look at the needs to which the service is expected to respond. In the present enquiry, this has occasioned a substantial amount of fieldwork among the users and their carers. However, it is emphasised that this fieldwork is only a part of the overall enquiry.

7.1 The interwoven levels of this enquiry

In fact, the present research project can be said to have five levels:

- a) the conceptual level, which mostly focuses on a conceptual study of various models of service delivery;
- b) the service effectiveness level, based on outcome studies in the literature;
- c) the contextual level, which studies the welfare state and the social and living situation of the service beneficiaries;
- d) the needs-assessment level, which is what Chapters 8 and 9 focus on;
- e) a study of congruence, leading to service recommendations which bring into agreement on the service practice level services as conceptualised, effectiveness as learnt, needs as discovered in the context where they are found to occur.

SPECIAL NOTE

**This item is tightly bound
and while every effort has
been made to reproduce the
centres force would result
in damage.**

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Interwoven with the enquiry are the deeper, 'more philosophical' questions of *cognitive validity* and *value congruence*. In other words, this thesis addresses itself to the two basic questions. One is how and how far we can consider our knowledge as objective and, in the end, correct. The other is how our view of what there is and what should be done is, and can legitimately be, coloured by values in general, and by a system of values that we have embraced. Such values, basically an accepted solidarity with those who suffer and a commitment for good quality of life for all, with special attention to the poor and vulnerable, were communicated to the reader from the very beginning. Attention to the 'twin deeper questions' is especially important if we want to promote human quality of life at a time when consensus about basic views cannot be taken for granted. Whether we discuss differing models and differing views, or look upon society as in transition, within what has been termed a post-modernism, post-modernity phase or late modernity phase, we would ignore such issues to our peril. This is especially interesting in places, like the country we are focusing on, where, arguably, modernity and post- or late modernity are not really two distinct phases historically, and both seem to be happening together. Understanding what is happening can ideally save us from first repeating and then laboriously unlearning, the mistakes of others, and also from 'throwing away the baby with the bath water'. From the viewpoint of a commitment to human good, however elusive this may sound, the issue is important.

7.2 Rationale of the Needs Assessment

The need assessment aims at obtaining knowledge that is at once objective and personal. Without making any impossible claims for 'unlimited' objectivity, it pays special attention to using scientific rigour in its search. Yet, an attempt is made to bring out in Chapter 8 some of the interpersonal encounter that the exercise is in fact. The lengthy interviews that took place yield a rich harvest of detail. Reading them, it is hoped, we get better acquainted with aspects, here and there, of 'the world of the user'. This is in line with our commitment, made clear early in this dissertation, both to the good and the quality of life of the service user, and to 'getting to the facts' and 'improving our understanding' as best we can.

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Previous chapters sought primarily to find out which are the models that exist, and that best fit. What we learn here will probably help us rather to decide which services and therapies to emphasise, where the accent and priority should be. By learning what are the needs, and how they are experienced, we can decide in what relative doses and mixes we need to administer our services.

The needs we want to study are those of persons considered as needing long-term care and support by reason of problem in mental health. We therefore are interested in the people who still have therapy and support needs after the acute phase of their illness has passed, and who would be expected to have such needs in a continuing fashion.

We can say that the study of needs presents to us three particular challenges. The first is *conceptual and value-linked*. Not everybody will agree what the needs are. Listing and assessing need is not a straightforward exercise about which all agree. Needs are relative and contested (Fraser 1989). Because needs are experienced, formulated and interpreted differently by different people, decisions have to be made about where to draw the line, what to acknowledge and recognise, to what extent to accept wants as (recognised) needs, by what process and with what justification to draw the line.

To a person who has embraced no over-riding value stance, the relativity of need will remain the only absolute. For a person that has embraced a primary and pre-ideological stance to favour the quality of life of people, especially those who are weak, one has only to open one's eyes and look around, for the inventory of hardly-to-be-doubted needs to become a veritable bombardment. Anybody who decides in favour of working for a better life for people will encounter ample examples of needs that they experience, regarding which no doubt as to their validity seems reasonable.

Discussion on the relativity of need often moves like a pendulum, which will betake itself to the right when it has gone too far to the left, and to the left when it has gone too far to the right. People will speak in favour of greater relativity or smaller relativity according to what

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they think will re-establish the balance in the situation, or in the mind of the person they are debating with. There will never be a formulation that says it all and has the last word. Yet, in practice decisions have to be made. Standards and benchmarks are like constructs that give a certain definitiveness to need, being tools that attempt to draw a line that is rooted both in needs that are definitely and inescapably there, and in decisions to draw lines that are based on an arbitrary element that is equally definite.

In our case, drawing the line will be guided not only by the basic stance embraced, but also on a model of care that goes beyond the simply medical, or rehabilitational, to wider social, empowering, holistic and growth- and aspiration-driven vistas. Empowerment requires partnership, and the voice of the service user becomes paramount. Here clients' view is given prominence.

Client opinion, however, is not without its limitation. "Clients tend to be highly satisfied, citizens highly dissatisfied," is the conclusion from wide research. Asked about their level of satisfaction in the largely face-to-face setting of service delivery, clients tend to be appreciative, thankful and complimenting. When questioned away from this setting, they are more apt to complain.

In the context of community care in Britain, 'needs-led service' has become one very central and highly sought criterion of good service. Services should be designed in terms of the beneficiary's need. The opposite, 'service-led help', is rightfully seen as a very common pitfall. This dissertation attempts to support the creation of needs-led service by doing its best to have a good look at client's needs.

But the criterion of 'needs-led service', every time it is invoked begs the question: 'which are the needs?' We have already discussed the conceptual and value-centred challenge that this presents. This discussion is taken up again in section 7.4. Being in the nature of reflection that supports the main argument but is not essential to it, it is left for the end of the chapter so

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that it can be skipped at first reading or by those who wish to move on to the essential part of the argument.

A second challenge is, we can say, *managerial and related to resource constraints*. However big objective need is, and however needs-led we aspire to be, all provision must be limited to the constraints of the resources. Though governments and providers often need to increase their capacity and resources, they must also draw a line as to the extent of need they will recognise or acknowledge.

The third challenge is that of *ensuring the validity of the instrumentation* used in research to assess need. Having addressed the conceptual issue we can hopefully start making up our minds about what weight and what interpretations we give to the bombardment of need statement that we will, willy-nilly, receive (though what we do about it largely depends on our value stance more than anything else).

7.3 The Research Design of the Needs Assessment

In the very beginning of this chapter we have spoken of the needs assessment as one of five converging and triangulating enquiries. These we called (i) the conceptual (focused on service delivery models), (ii) the literature synthesis about outcome, (iii) the contextual study, (iv) the needs assessment itself and (v) a study of congruence that puts all together and makes recommendations.

The aim of the needs assessment is to quantify the prevalence and, secondarily, the incidence, of needs that are usually the target of good community mental health care in a way that helps the planning and organisation of services that give the best possible response to need, given the available resources and potential.

The study was carried out in three phases, as explained below.

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Phase 1: Quality of Life and Family Impact Interviews

A Quality of Life and Family Burden study of mental health service with long-term care needs all over Malta and Gozo¹ took place in the second half of 1996. Inclusion criteria were as set out in Table 7. 1: The Inclusion Criteria for Phase 1 and Phase 3 of the enquiry. Sampling frames were patient lists in mental outpatients and mental hospital admissions. Numbers interviewed originally planned to be 100 for Quality of Life and 100 for Family Burden Questionnaire. Difficulties were encountered around the availability and state of sampling frames, constraints on time and state of knowledge of caring psychiatrists who were to select clients needing long-term care. There were problems in finding addresses and a minor incidence of refusals. All these resulted in lower numbers of actual interviews done: 43 for Quality of Life and 26 for Family Burden. However, sampling was very rigorous.

INCLUSION CRITERIA

- Age (15 & over): if so elderly as to be very physically frail or bedridden, exclude (psychiatric being no longer the predominant mode of management)
- Dementias and organic illness: if so low IQ or confused as to be unable to do interview: exclude.
- If suffers from chronic psychotic illness. Include except if high level of functioning (> 40 as per GAS) between episodes in social functioning (job, family role, relationships, self-care). If other mental disorder, include if social functioning (job, family role, relationships, self-care) is seriously impaired between episodes (= \leq 40 as per GAS).

Table 7. 1: The Inclusion Criteria for Phase 1 and Phase 3 of the enquiry (GAS = Global Assessment Scale, Endicott et al., 1976)

¹ Gozo is the smaller of two main islands in the Maltese archipelago, where live about a twelfth of an overall population of about 375,000.

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Phase 2: Study of Utilisation and some aspects of Process in the Pilot Area

A Utilisation Study was conducted of the services at the mental health reform Pilot Area (population 30,000), ranging from the beginning of 1997 till mid-1999. This was based on forms: (i) contact sheet, designed by the author in consultation with local health professionals; it recorded each visit by each patient to the Health Centre for mental health service, specifying mainly date and time duration, type of service, type of service given; (ii) information given by treating psychiatrists and from notes about diagnosis and whether or not the client required long-term care. This gave a picture of the profile of persons using the service, time trends in utilisation, and something about the pattern of division of labour that emerged among the two specialist teams and the rudimentary and patchy primary care services that were offered. Study of actual use was especially important since keeping to plan proved in many ways difficult.

Phase 3: Study of Met and Unmet Need using the Autoneed Scale

The administration of the Autoneed Scale to a small number of users from the Pilot Area took place during the year 2000. This is a very important part of the enquiry, since it is the only outcome study in a strict sense. The Autoneed scale came last and had to compete with other uncompleted analyses for attention, as a result of which, this highly valuable scale could only be administered to a sample of thirteen. Its value was largely in giving some important qualitative indications, and in showing the scale's useful potential.

Enquiries 1 and 3 were assessment of need on the strength of the three rating scales used, which will be explained below. Enquiry 2, though basically a service utilisation study, made an irreplaceable contribution to the Needs Assessment. In Enquiry 1, sampling frames and screening processes for 'need for long-term care' turned out to be relatively weak as tools for the reliable assessment of prevalence of need. But in the Pilot Area this process proved quite robust, being based on reliably retrievable patient list, and knowledgeable screening by

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psychiatrists for 'need for long-term care' and diagnosis. Enquiry 2, the utilisation study, therefore yielded a figure of crucial importance: that of the proportion of the general adult population needing long-term psychiatric care. This could serve as corrective of the figures for Malta and Gozo as a whole. Figures for outside the pilot area gave reasonably good percentages of prevalence, relative to each other, but the Pilot Area figures served as a corrective by having a much smaller number of missed service users. The mode of carrying out and the expected reliability of this generalisation will be discussed below.

Each of the three 'main' scales, that is, Quality of Life, Family Burden and Autoneed, was accompanied by a further questionnaire. Quality of life was followed by brief consumer satisfaction questions. Family Burden was followed by questions to help fill a form that described the family's social support network. Autoneed was accompanied by a description by client and carer of the care program being received, as they perceived it, plus a 'proposed ideal plan' to be formulated by the interviewer. In view of the mass of information to be processed, these additional will only be partially analysed and presented at this stage.

7.4 Instruments and Domains of Need Assessment

Here follows a description and discussion of the various rating scales used. All look upon the client's life as a number of domains, and questions are made to effect assessments under each domain. In order to reap the benefits of triangulation, the account given will be in a form that synthesises the three scales by taking them up together where more than one of them speaks about the same domain. Results can be described as giving a rather rich picture of the world of the user and the needs as experienced.

Lancashire Quality of Life Profile (LQOLP) - Life's Quality: parts clearer than the whole

LQOLP assesses the main domains of life that seem to largely determine how good respondent's living conditions are, over a number of life domains. Joe Oliver, its author, stoutly resisted the clamour for one overall rating which purports to represent a person's global quality of life as of too dubious validity. He considered (in a personal communication) the

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conceptual challenge as, at that level, a philosophical one, ranging from Aristotle's 'the good life', related to virtue, to the convictions of the 'me generation'. He used it with demonstrated validity on particular life domain levels both as assessor of quantity of need and as discloser of what affects quality of life negatively and positively. Some interesting discoveries were made through it related to what affects the quality of life of the mentally ill.

The Family Burden Questionnaire: Family Impact

The questions of this elaborate questionnaire can be found in the tables compiled in Chapter 8 and its Appendices. They are a series of questions to the main caring relative about the various ways in which the taking care of the client can or does create a 'burden' to the family. The terms 'Family Impact' or 'Impact on Family Life' have been introduced in the present enquiry, responding to the increased reluctance of Dr Fadden, the originator of the scale, to use the word 'burden', which was formerly in common use.

The great strength of this questionnaire is the richness of the information that it obtains. Though lately its originator has moved to collaborative research that looks for the correlates of domains of burden, FBQ is an excellent tool to give us a very close look at the life of such families.

Family burden research has now become part of the more active and interventive subject of 'family intervention'. Outcome research will be cited. While an important research review assessed family intervention as having low outcome with respect to input, especially professional time input, more recent studies have been much more encouraging. What is most interesting for middle-income countries like Malta is that the benefits of good outcome spring not only from the sophisticated family-therapy type interventions, but also from simpler ones. I will also discuss modifications I discussed with Dr Fadden about how family intervention could be effected with less cost in professional input.

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The Autoneed Scale: Met and Unmet Need

This rating scale greatly enhances the value of the research. Its great value is that it assesses need, met and unmet. It is very mental-health service oriented. That is, it manages to concentrate on the basic needs that are the stock-in-trade of long-term community mental health care. T Pelosi (see Murray et al., 1996) a researcher who applied it, sees it as healthily down-to-earth, in contrast with 'services that social workers offer that promise the earth'.

This issue will be discussed. While seemingly conforming to the down-to-earth budget constraints we set ourselves, does it violate our concerns for 'social' and 'empowering' models? The answer is mixed, and the discussion is interesting.

Questions are asked to client and carer about needs. A need is registered if one of these results: (i) client sees it as a need, (ii) it causes carer stress, (iii) it endangers the client's present or aspired-for placement or, (iv) leads to danger to self or others. The Autoneed computer program inventorises discovered needs according to a fixed criteria, involving decision making that is partly automatic, on fixed thresholds, and partly through the application of expertly judgement by persons experienced in rehabilitation. The latter judgement is applied at the stage where the software suggests interventions to its operator. The professional operating them will contribute answers. The net result is a short and simple list of needs that are still unmet.

In our context, the value of Autoneed would be that, while the need assessment was basically 'pre-intervention', or, at least, before the pilot area reform was activated, Autoneed looks at results afterwards. This is one further reason why it was decided, in the end, to administer Autoneed only to pilot area clients.

For better or for worse, Autoneed greatly contrast with FBQ's richness of detail. Autoneed software does not readily yield the detailed answers that would quantify the incidence of

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depression, carer stress for Problem A or Problem B, etc. But, combined with the record taken during the Autoneed interview of the care program as perceived by the client, one paves the way to an Audit of Unmet Need. These detected unmet needs will be connected with an Audit of Readiness in a subsequent chapter. Key teams in community care services in Malta will be briefly interviewed to find out, according to a prepared schedule based on the literature, how far they and their context is prepared to develop community care according to the criteria seen as important in the dissertation.

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Chapter 8 (I)

Types and Extent of Mental Health Long-term Care Needs in Malta's Community: the Findings

PART 1- Users, Carers, Support

8.1 Populations and Sampling; the Presentation of the Tables

8.1.1: Which Populations studied, and by which Sampling Process?

A sample was drawn through a separate process for each of the three phases of the Needs Assessment. Table 8. 1: Populations & Samples in each of the three phases, tabulates the various samples, and can serve as a guide to the present description. The first sample was for the Quality of Life (QOL) and Family Burden Questionnaire (FBQ) enquiry that took place in 1996 among the whole of the population of Malta and its smaller sister island, Gozo. The population under study, or the affected or 'at risk' population, was all persons needing long-term community mental health care. This meant people who still need the support of professionals and informal help related to their illness, even after the acute or reversible phase of their illness has passed. 69 interviews in fact took place, 43 for QOL and 26 for FBQ. The original aim was to interview 100 of each, but depletion and attrition took place at every stage of the flow that led from the sampling to the interviewing.

This sample was made up of two first-level sub-samples, one for the Pilot Area of the mental health reform, one for the rest of Malta and Gozo. In the Pilot Area full coverage was attempted, but with the 62 known users with long-term care needs in 1996, 31 interviews, or exactly half the number (see table, Pilot Area Utilisation p 1), were made. The sampling frame was much more difficult to handle for the rest of Malta. In this regard, one may make a number of observations.

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Phase→Questions about Population & Sample ↓	Phase 1: Family Burden and Quality of Life, 1996	Phase 2: Pilot Area Service Utilisation Study, 1997-1999	Phase 3: Autoneed, 1999-2000
What category of users?	Needing Long-term Care	Needing both Short- and Long-term care	Needing Long-term Care
What Catchment Area?	All of Malta & Gozo, divided into 'Pilot Area' and 'Rest of Malta and Gozo'	Pilot Area	Pilot Area
General Population in catchment area, aged 15 and over	290,000 (27,000 for Pilot Area + 264,000 for Rest of Malta & Gozo)	27,000	27,000
Sources sampled	1. Users of MOP for Island of Malta 2. Persons admitted Mt Carmel Hospital 3. Users MOP, Gozo	Users, Pilot Area Health Centre Mental Health Services	Users, Pilot Area Health Centre Mental Health Services
Sample interviewed or studied	43 for Quality of Life 26 for Family Burden	305 out of 488 users (information on diagnosis based on a sample of 161, including all known to need long-term care + a proportion of those not requiring it)	13 for Autoneed

Table 8. 1: Populations & Samples in each of the three phases

As indicated by Table 8. 1, the phase one sample was drawn from three sources. The first sample frame was Mental Outpatients, based at St Luke's Hospital, serving the whole of the island of Malta. A random sample of 789 was drawn out of the 4128 on its list. It was stratified simultaneously by census region and 'residential category' (more below). High depletion necessitated the use of a second sampling frame, which was on the basis of admissions to the Malta island mental hospital more than twice or for a duration of more than six months over two years. A third sampling frame was locality based: persons attending Gozo mental outpatients. Though in the stratification process great care was taken to represent each geographical section proportionately, the depletion or attrition process offset the desired proportionate representation, acting in largely random, though unequal, ways.

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The second phase sample was that of the Pilot Area Utilisation Study. This was not based on interviews, but on the record system¹, and screening by the area's psychiatrists. 'Contact sheets' were analysed, which recorded each contact, stating date, duration, team and category of worker seen and type of service given. 'File front sheets' gave names and addresses of client, main carer, GP and important helpers, dates of first use and hospital admission if applicable, and a space for diagnosis.

	<u>Pilot Area</u>	<u>Rest of Malta & Gozo</u>	<u>Whole of Malta & Gozo</u>
General Population aged 15 and over ²	26,729	263, 738	290,467
Did LQOLP Interview	13	30	43
Did FBQ interview	10	16	26

Table 8. 2: Differing levels population represented by interviewee groups as classified by rating scale and sub-sample

Diagnosis, however, could only be obtained through the third procedure, namely a screening by the treating psychiatrist who, besides, also classified the client as needing or not needing long-term care. While the analysis of the file front sheet has yet to take place, the analysis of the 'contact sheet' data was based on a sample of 305 out of the estimated 488 users, while for the psychiatrists' screening the sample was of 161, out of the same number. Differential weighting for the various categories of client were used to derive the correct figures, reflecting the purposively different levels of representation that each had within the sample.

For the third phase, a random sample of users seen as needing long-term care was aimed at. It was made up of eight strata made up of the possible combinations of firm, sex and whether or not the user was already classified as needing long-term care in 1996. Care was taken to represent each stratum proportionately within the sample. As it happened, time constraints made it possible for only 13 to be interviewed. Though these were balanced among the strata represented, the value of these interviews is very largely qualitative.

¹ Designed by the present author, in consultation with the psychiatrists and nurses in the pilot area mental health services.

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8.1.2 How the findings have been tabulated

The aim of the three-phase Needs Assessment is, in the end, to calculate for how much service of various types is needed, and how far this need is already met. In order to communicate this picture, three steps have been taken.

- i. The three phases and all the rating scales and enquiry procedures are pooled together and presented by domain and area of need. Thus, the domain of work is presented once, bringing together the findings related to this domain in the Quality of Life, Family Burden and Autoneed interviews, all together, rather than separately.
- ii. An estimate is made at the very beginning of the numbers needing long-term community mental health care.
- iii. Figures of need are given in terms of percentage of respondents, including 'No Answer' and 'Does not apply' responses within the 100%. Thus one can make a rough and ready approximation of need in the community by multiplying this percentage by the estimated number needing long-term care.

To further explain (iii) above, great care was taken to give tables in terms of column percentages, including 'No Answer', 'Does not apply' or any other cases often given as missing values as part of the percentage. As a result of this, tables can be taken to mean as a good approximation of the percentage for the population of at risk persons in the territory in question. Thus, a table on FBQ Main Tables p 3 states that 30% of main carers in the Pilot Area were aged 30-39 among the respondents, while 10% are marked 0, meaning 'no answer or not applicable'. This conveys the calculation that 30% and 10% of the Pilot Area population of persons needing long-term care have a main carer of the mentioned age bracket, while nothing is known about 10% of the same population.

² 1996 Malta Census.

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8.1.3 How can we get a valid picture of need?

Interviewing a sample among the whole general population would result in the most reliable assessments of need. A classic work in the line is that of Goldberg and Huxley, which we have cited in the presentation of our conceptual framework and which will help us in our present discussion. Such a population-wide survey was the dream of the National Commission from the very beginning, but was one of a number of projected surveys that failed to materialise at the time for lack of sufficient resources. When later attempted under the auspices of the Commission in Gozo in summer of 1999, it also failed, partly because the number of respondents was much smaller than would be required for such a project.

It is much more feasible to interview clients known to the services, often service users or ex-users. The disadvantage of this is that many people get 'mis-filtered', to speak in terms of Goldberg and Huxley's model. These authors' studies focused on psychiatric morbidity, rather than medic-psycho-social need as such. They imply an ideal world in which a good filtering mechanism ensures that people get self-referred, or referred by formal and informal helpers, and then 'filtered' by professionals to receive treatment at the level appropriate to them, namely, either primary care, or specialist community care or hospital care. But many people do not end up where they need. The authors indicate that many who need care, at primary, specialist or hospital level, end up not getting it. They quantify some categories of the 'misplaced', namely those who need treatment but do not get any, as well as those who need mental health treatment but do not get it since, even though they have referred themselves to primary care, their ailment is not detected as psychiatric. Comparing their figures for those needing hospital treatment with actual admission figures shows that many more need hospital than actually receive it.

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In other words, focusing on service users will itself carry problems of validity. Not all who need the service will use it, and a few who use it might not need it. However, in our study of need we have done our utmost to approximate a reliable quantification. This we have done and are doing by:

- i. Taking figures outside the pilot area as reliable figures of percentage occurrence of need, but not of absolute numbers
- ii. Giving as basis for absolute numbers the calculation of the numbers needing long-term care that based on users of the Pilot Area, which has much more reliable patient databases and thorough screening by the psychiatrists.
- iii. Hereby presenting the figures as primarily estimating need among service users and potential service users (here meaning those who would be quite likely to use the services if ones of a similar level to the pilot area ones are provided).⁶

It must also be reminded that figures of need are not 'out there', but themselves come to us through the filters of our perception and thinking, and of local norms, constraints and potential. The Audit Commission, quantifying the numbers receiving long-term community care under local case management and community mental health teams systems found out vast variations among areas in Britain. It concluded that this was partly due to actual local variation in need⁷, but much more to variations in local norms. It criticised the 'outliers', or the more extreme rates, and advocated keeping as norm rates ranging between suggested limits. As can be seen, no absolute and universal norm was imposed as the correct one. When the present writer, still insufficiently conscious of this point, asked what could be sources of criteria of appropriate referral from primary to secondary care, Dr Linda Gask, did not indicate precise norms. She explained that their unit was undertaking an empirical study about just that, studying GPs' actual practice as basis for casting light on this issue. However, Gask, the Audit Commission and Goldberg and Huxley are all committed to indicating and evolving guidelines of good practice. This would set limits to what would be acceptable variations in the quantity and kind of service user treated at each level, while leaving room to variation caused by local and other factors.

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8.1.4 How many users? How many need long-term care in Malta?

See Table 8. 4: Users of the mental health services at Pilot Area Health Centre, Qormi, 1996-1999 and Table 8. 5: Estimated number of persons needing Long-term and other forms of care, by part of Malta and Gozo, Reference: # estimated on basis of Pilot Area figures; * Actual users on MOP card index 1995..

	Do these require long-term care?				All users	General Population aged 15 and over ¹¹
	No	Continuing MOP would be adequate	Need long-term medico-psycho-social care	No answer		
How many	320	31	79	28	457	26729
% of Users	69.9%	6.8%	17.2%	13.0%	100%	-
% of General Population	1.20%	0.12%	0.30%	0.10%	1.71%	100%

Table 8. 4: Users of the mental health services at Pilot Area Health Centre, Qormi, 1996-1999

Residents at: →	Pilot Area	Whole of Malta & Gozo
General Population aged 15 and over ¹²	26729	290,467
Estimated number of persons needing Mental Outpatients attendance only	30	350#
Estimated number of persons needing long long-term team care	80	870#
Requiring long-term MOP, global	110	1220#
Using MOP, both long- and short-term	434 (1.6%)	4100* (1.4%)

Table 8. 5: Estimated number of persons needing Long-term and other forms of care, by part of Malta and Gozo, Reference: # estimated on basis of Pilot Area figures; * Actual users on MOP card index 1995.

8.1.5 Finding out the different needs of different categories

¹⁰ 1996 Malta Census.

¹¹ 1996 Malta Census.

¹² 1996 Malta Census.

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One aim of the enquiry was to find how level of need and kind of need varied by location. Normal practice in Malta is to classify location by Census regions, the regions used in the official demographic figures. In the preparation of this enquiry it was hypothesised that this was not the greatest discloser of demographic, social or cultural differences. This classification was cross-divided by 'Residential Prestige Category' (based on Boswell, 1994) probably an innovation in Maltese social research. In fact, one early discovery that took place as early as the sampling stage, was that the proportion of population that attends the Mental Outpatients' clinic (included those listed for the Pilot Area health centre) vary by the residential prestige category where they come from. Starting from the lowest, 1.4% of the population attend from D category localities, 1.6 % from category C and 1.5% from category B. Category A (which includes only the most high prestige places like Mdina, Lija, Attard and Balzan) has the lowest proportion attending, namely 0.9%.

8.1.6 Methodological notes

First, for the purpose of presentation for most tables, it was decided to pool together the cases from the three sources for the Phase I (FBQ, QOL) sample for the 'Rest of Malta and Gozo', namely MOP for island of Malta, admissions at Mt Carmel Hospital and Gozo MOP. While care was taken so that the two Mental Outpatients Clinics were represented in proportion to their general populations, reliably quantifying the total user population represented by 'Admissions' would have proved certainly very time consuming and possibly quite problematic.

Second, the lists of patients attending mental outpatients at both St Luke's (island of Malta's) and Gozo's General Hospital were problematic for several reasons. Each had a listing system different from the other, which was, in turn, different from the pilot area's. St Luke's included double entries and probably omissions in its card index, including only rudimentary data and with rudimentary system upkeep. Gozo had an appointments list classified by month, which would have taken time to disentangle the users from the multiple entries. The pilot area had 'file front sheets' and 'contact sheets' kept at a very high level of accuracy, though not including mental health contacts with the primary team or the social work team, and a

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simplification of the front sheet had been introduced at one point resulting in the dropping of important data. No putting away of files had taken place, to date, and it is hoped this is done, when necessary, in a recorded manner. However, the records were there ready for inputting and analysis.

Besides, there was a very clear contrast in the screening of users by psychiatrists to indicate the ones needing long-term care, indicating diagnosis in the same process. At St Luke's there were many 'do not know' answers, while at Qormi Health Centre probably not more than two or three persons needing long-term care were missed.

A note needs to be made on the upkeep of records in community mental health care. While a WHO consultancy had helped in improving hospital records, and the personnel working on this at Mt Carmel are numerous, the ups and downs of project and hope for reliable and ongoing record inputting and analysis of the service was a saga in itself. Nobody was employed to do the job in the end. The keeping of general (but not mental health) figures at Qormi health centre resulted in a national honour being given to an employee because in doing this she was 'going beyond the call of duty'. A request to see figures kept elsewhere by another person who had long been going beyond the call of duty in keeping records illustrated what can happen with such an arrangement: he said a motivational setback had made him stop doing it! One of the challenges of a transitional system is to move from the pioneering, experimental and heroic to the mainstream and reliably secured.

8.2 Who are the users? What living situation and strengths do they enjoy?

8.2.1 Sex, Age, Locality

Our first introduction to the clients will focus on their strengths, their view of the quality of their life and important assets and amenities they enjoy. Central place will be given to their family, their social relations and the network of persons who relate to them closely and help them. This is entirely in line with our option in favour of the strengths, empowering and social views of clients and their needs, over the deficit, rehabilitation and medical models and viewpoints. This part, while attempting an expansive view, will still cling to a note of realism.

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The higher the expectations, the more strikingly will any lack hit us. However, it will see and take note of any and every good that emerges. Our expansiveness of view and values is not being embraced at the expense of objectivity, and a respect for objectivity is a value that, perhaps more than any other, entails a commitment that is 'for better and for worse'.¹⁴

Demographic details (LQOLP Main Tables pp. 1-2 and FBQ Main Tables pp. 1-3) give interesting data. Female clients outnumber male 2:1 for QOL, but are outnumbered almost 1:3 for FBQ. FBQ respondents are the main carers and, unsurprisingly, female carers outnumber males ones 6.6:1. Almost 40% of QOL clients are aged between 40 and 59. Half the rest are between 20 and 39; the other half shared among '60 and over' and 'no answer'. Clients living in localities that would be classified by Boswell's respondents as, in effect, belonging to the D, or lowest, prestige category form the bulk of clients (57.6 of respondents for QOL, 60.3% for FBQ). Those of Category C, next up, constitute about half of that (30.3% and 28.4% of respondents respectively). Category Bs, again, go down to about two fifths of the former: 12.1 and 11.3 respectively. Category As proved very hard to find and, in fact, none of the very small number survived the attrition process, so that none of them were interviewed. The agreement in figures between QOL and FBQ is in fact remarkable.

Though localities of all prestige categories contain a relative mix of various socio-economic groupings, the results of this 'ecological' or territorially-based variable send a clear message that both mental illness and, more so, the use of state services is strongly biased towards people with more modest means. This is firstly because the lower the prestige category the larger its global population, that is, the poorer are more numerous; and secondly because the use of the service decreases, though not very dramatically, the higher one goes from category C. Interestingly, it decreases again if one moves from C to D. This is probably due to the combination of three factors: the poorer tend more often to be ill, the better educated tend to use the services more, the above-average income brackets tend to go more often for private service.

¹⁴ This is expressed by B J F Lonergan (1957, 1958) as 'the pure, disinterested desire to know'.

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8.2.2: Introducing their view of the quality of their life and general well-being

The Lancashire Quality of Life Profile asks, as a rule, two types of questions. The first kind are 'yes'/ 'no'/ 'don't know' answer types of questions, largely asking about objective life conditions and circumstances, such as what type of house one lives in, whether one lives with others, and whether these include family; or how much money does one earn, and whether one has ever applied for a benefit or police help without the request being met. The second kind involve the use of the Life Satisfaction Scale (LSS), start, as a rule, 'How satisfied are you with...', and then refer to an area or facet of one's life situation or living conditions ('..your living/ housing situation', '..the level of safety you enjoy where you live', '..the amount of money you earn', '..the way you spend your leisure time', or '..your family'. The Life satisfaction scale can be answered in terms of one of seven level of satisfaction, as on Table 8. 6: The Life Satisfaction Scale (LSS)

Alternative answer	Score
Could not be worse	1
Displeased	2
Mostly dissatisfied	3
Mixed (about equally satisfied and dissatisfied)	4
Mostly satisfied	5
Pleased	6
Could not be better	7

Table 8. 6: The Life Satisfaction Scale (LSS)

Table 8. 7: Satisfaction with each life domain, in descending order, gives the global results for each domain. A rating for each domain is derived by LQOLP by averaging the results of the Life Satisfaction Scales answered by the individual for that domain. The results give us a highly interesting plunge into the subject. Table 8. 7 places them in descending order, with quite striking results. Maltese mental health services clients express most satisfaction with things afforded them by religion, the family and the community. Religion, safety, family, social relations and 'leisure and participation', in that order, give the highest satisfaction. The lowest, moving in order from the bottom of the list, are finance, health, work and education,

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and living conditions. In a striking way, this seems to confirm the general assumption of this dissertation that Malta has a strong family and community, but weak services.

	Pilot Area		Rest of Malta & Gozo		All of Malta & Gozo	
	Mean	SD	Mean	SD	Mean	SD
Subjective QOL re. Religion	5.88	.88	5.57	1.24	5.59	1.22
Subjective QOL re Legal & Safety Domain	5.23	1.89	5.48	1.45	5.46	1.49
Subjective QOL re Family	5.80	1.26	5.33	1.45	5.37	1.44
Subjective QOL re Social Relations	5.23	1.36	5.25	1.17	5.25	1.19
Subjective QOL re Leisure & Participation	5.21	1.17	5.17	1.24	5.18	1.23
An Inter-Domain Life Satisfaction Rating	5.12	.95	5.08	.67	5.08	.69
Subjective QOL re Living Conditions	4.86	1.50	5.07	.90	5.05	.96
Subjective QOL re Work & Education	5.25	.96	4.86	1.39	4.88	1.36
Subjective QOL re Health	4.59	1.26	4.74	1.05	4.73	1.06
Subjective QOL re. Finance	4.64	1.61	4.07	1.55	4.12	1.56

Table 8. 7: Satisfaction with each life domain, in descending order

This dissertation seeks to differentiate among the Pilot Area and the Rest of Malta & Gozo. Table 8. 8 compares the quality of life ratings for each domain between the two areas. The Pilot Area are most better off, in descending order, in Finance, Family, Work & Education, Religion, Leisure and Participation. They are most worse off, starting from the bottom, in safety, living conditions, health and social relations. Table 8. 9: Standard Deviations placed in descending order finds out that users differ most among themselves in their satisfaction with Finance. Safety, though at a high average, is the second after Finance in generating differences of satisfaction. Living conditions elicit the most similar satisfaction levels. Health seems a mirror image of Safety: clients find it to be the second worst for average satisfaction and, to boot, the second thing that they agree most about.

Among the ratings, in the middle of the averages and at the bottom of the standard deviations, one finds “An Inter-Domain Life Satisfaction Rating”. It is the average among the domains. Joe Oliver¹⁷, the originator of the Lancashire QOL Profile, stoutly resisted frequent

¹⁷ As he explained in a personal communication.

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suggestions that he should create an 'Overall Quality of Life Rating', because it would be easy to read into it a significance that it cannot have on the human level. This position is parallel to his insistence¹⁸ that changes in objective quality of life, that is, in living conditions and circumstances, tend as a rule to impinge on the level of life satisfaction in the domain that they affect.

	Mean, Pilot Area	Mean, Rest of Malta and Gozo	Difference
Subjective QOL re. Finance	4.64	4.07	0.57
Subjective QOL re Family	5.8	5.33	0.47
Subjective QOL re Work & Education	5.25	4.86	0.39
Subjective QOL re. Religion	5.88	5.57	0.31
Subjective QOL re Leisure & Participation	5.21	5.17	0.04
An Inter-Domain Life Satisfaction Rating	5.12	5.08	0.04
Subjective QOL re Social Relations	5.23	5.25	-0.02
Subjective QOL re Health	4.59	4.74	-0.15
Subjective QOL re Living Conditions	4.86	5.07	-0.21
Subjective QOL re Legal & Safety Domain	5.23	5.48	-0.25

Table 8. 8: Differences in Subjective Quality of Life between Pilot Area and Rest of Malta & Gozo, in descending order

	Pilot Area		Rest of All of Malta & Gozo			
	Mean	SD	Mean	SD	Mean	SD
Subjective QOL re. Finance	4.64	1.61	4.07	1.55	4.12	1.56
Subjective QOL re Legal & Safety Domain	5.23	1.89	5.48	1.45	5.46	1.49
Subjective QOL re Family	5.80	1.26	5.33	1.45	5.37	1.44
Subjective QOL re Work & Education	5.25	.96	4.86	1.39	4.88	1.36
Subjective QOL re Leisure & Participation	5.21	1.17	5.17	1.24	5.18	1.23
Subjective QOL re. Religion	5.88	.88	5.57	1.24	5.59	1.22
Subjective QOL re Social Relations	5.23	1.36	5.25	1.17	5.25	1.19
Subjective QOL re Health	4.59	1.26	4.74	1.05	4.73	1.06
Subjective QOL re Living Conditions	4.86	1.50	5.07	.90	5.05	.96
An Inter-Domain Life Satisfaction Rating	5.12	.95	5.08	.67	5.08	.69

Table 8. 9: Standard Deviations placed in descending order

While improvement in housing tends to improve satisfaction within the Living Conditions domain, and improvement in Family relations improves satisfaction in that latter domain, the quest for partial interventions that make a person 'a happier person', or some such-like overall

¹⁸ Communicated during the Conference about Quality of Life, Birmingham, 1998 .

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description that indicates 'goodness of life' is rather elusive. Research has not, at least yet, borne out an operationalised concept that validly conveys 'the' quality of life of a person. In Dr Oliver's spirit, this average rating is presented 'for what it is worth'.

8.2.3: *Family Relations, Social Relations, Religion*

Only one third of clients are married. Almost half are single, while one sixth are either widowed or separated (See LQOLP Main Tables pp 13 ff.). One fourth to one third

		Do your family live here too?			Total
		No answer	Yes	No	
		Count	Count	Count	Col %
How many other people live here?	0	1		10	25.6%
	No answer	2	2	1	11.6%
	1		1	6	16.3%
	2	1	4		11.6%
	3		8		18.6%
	4		3		7.0%
	5	1			2.3%
	7		1		2.3%
	8		1	1	4.7%
Total		5	20	18	100.0%

Table 8. 10: Who clients live with (QOL)

(Table 8. 10: Who clients live with (QOL), considering 'No answer's) live alone. Of seven who said they live with others but 'their family does not live with them', a majority, if not all, were referring to their family of origin. Three at most, if at all, lived with non-family members. Table 8. 11: Only 11 out of 42 who answered see relatives less than once daily (or do not live with them); only 6 see them less than weekly (QOL).

Again, the family shows itself to be strong. However, in a context where services are still weak, this is a double-edged sword. As surely as it shows family strengths, it emphasises the unprovided state of the client without family support. In the present very early and slow-moving pace of deinstitutionalisation one could hypothesise rather safely that lack of family support is one of the strongest predictors of remaining in hospital, with no strong services to stand in for the family.

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		How often do you have contact with a relative?						Total
		No answer	Daily	Weekly	Monthly	Annually	Less than annually	Count
		Count	Count	Count	Count	Count	Count	
How many other people live here?	0		3	2	2	4		11
	No answer		2	3				5
	1		6				1	7
	2		4		1			5
	3	1	6		1			8
	4		3					3
	5					1		1
	7		1					1
	8		1		1			2
Total		1	26	5	5	5	1	43

Table 8. 11: Only 11 out of 42 who answered see relatives less than once daily (or do not live with them); only 6 see them less than weekly (QOL).

Nearly 30% state there were family occasions in the past that they would have liked to attend but missed. Interestingly, Christmas is a time when the number of Maltese in-patients on home leave reaches a high, very much in contrast with hospital in UK²¹ when the hospital population reached a high because there was much more company in hospital than in the outside world. In fact, 76% were at least 'Mostly satisfied' with amount of family contact, 57% answering 'Pleased' or 'Could not be better'.

A close friend is felt to be a necessity by slightly more than 40% who answered this question, but one third of these do not have one. A friend in need is rarer than a friend, for these (almost 40% do not have one). Taking the respondents as a whole, a slight simple majority lack one, but 59% would find one to turn to in time of need.

²¹ Accepted fact in UK at least till around 1980. No information about what happened later is available to the author.

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			Would you say that you are the sort of person who can manage without friends?				Total
			No answer	Yes	No	Do not know	
Do you have anyone who you would call a 'close friend' (i.e. who knows you very well)?	0	Col %	10.5%				.7%
	Yes	Col %	44.8%	26.9%	67.9%	100.0%	45.9%
	No	Col %	44.8%	73.1%	32.1%		53.4%
Total	Unweighted Count		3	22	17	1	43
Do you have a friend whom you could turn for help if you needed it?	0	Col %	10.5%		1.7%		1.4%
	Yes	Col %	44.8%	44.9%	59.1%		50.6%
	No	Col %	44.8%	55.1%	39.2%	100.0%	48.0%
Total	Unweighted Count		3	22	17	1	43

Table 8. 12: Do clients need, and have, close friends? (QOL)

Interestingly, none of the above three factors (needing friends, having them, expecting to find them in need) is significantly linked with the number of people one lives with: more under the same roof make one neither more nor less friendship oriented. Nor is any of them, taken alone, significantly associated with level of satisfaction with number of friends. Many Maltese tend to see friendship as something that can be or - even, is better - dispensed with. A very high proportion of Maltese socialising takes place within the family. In a small and stable community, where small size hardly ever necessitates residential mobility in pursuit of a career, an alternative very rarely becomes necessary. The Maltese community in Saudi Arabia had its heyday a decade or two ago. Participants in it noticed the contrast in the pattern of socialising necessitated there. Families who hardly did any partying except for family occasions back home now had to organise frequent parties as the only way to associate outside the nuclear family and, for the women, outside the home. Lately there are signs that the wish to socialise outside the family is a cause of tension among couples, where one spouse sees this habit as unnecessarily limiting. But the strength of the family in Malta weakens the alternatives, and leaves less of an outlet for socialising for persons without family; probably a characteristic to expect among many who will enjoy the effects of deinstitutionalisation. Paradoxically, the strong family may weaken 'the community', at least for the purpose of socialisation.

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Deinstitutionalised clients without family may face a very monotonous and friendless life, as some do. Formal support must cultivate more 'modern' and open lifestyles, create networks and work to link people with existent, mainstream, groups and activities. Curiously, a high level of satisfaction with level of friendships could very well be due to a low cultural expectation of what extra-family socialising can do to those especially who do not have a family and/or a job. As such, for the latter group it could be more of a hindrance to progress.

8.2.4 The Main Carer

In this and next section we shall examine the informal support that is received by clients. This we shall do first by looking at the characteristics of their 'main carer'. By 'main carer' was meant the person who 'took most care and responsibility' of the client. As it turned out, one third of main carers were parents, one third were spouses, one fourth were siblings. Only one sixth were differently related (such as an aunt).

No carer was under 35 years of age. Only 13% of main carers interviewed were male. Both these figures could be underestimates, because younger and male tend more often to be employed and less easy to find, but the underestimate must have been low, because efforts were made to contact respondents at different times. There were in fact only four male main carers, three being husbands, one being father. A staggering three out of four claimed to be 'unemployed because of the client's illness', but four is too small a number to make firm conclusions.

Mothers are the commonest carers (40%), which seems to link with the high proportion of single clients. Only 7.6% of female main carers work full time, while almost double that proportion work part time, and rather more than that claim they are employed because of the ill person's needs. The frequency of female main carers drops steeply as one moves up the residential status category (D: 97%, C: 80%, B: 50%). Spouse carers at the same time increase (20.4 to 40.0 to 100% respectively).

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8.2.5 Exploring Support Networks

A Support Network Chart was devised and administered along with the Family Questionnaire. At the end of the Family Aspects Scale questions about each domain, respondents were asked who else helped in that domain, and how intensely. This innovation was introduced in the belief that respondents who had just then been talking about housework or free time management would find it easy to indicate who were the persons who helped out in those particular domains. The question asked was, "Regarding housework (or job, parental responsibility, or whichever was the domain just discussed) what part is played and what help is given by family members, neighbours, individuals, religious or informal organisations etc.?"

The 26 respondents mentioned 39 helpers - a mean of exactly 1.5 informal helpers per client. The number of helpers per respondent ranged from 0 (commonest) to 5 (2 instances), as shown in Table 8. 16: Number of helpers per client.

Table 8ap.1²² shows the distribution of the helpers among the 26 respondents. Each client was given an arbitrary case number, preceded by M if the client was male and F if the client was female. 14 helpers (.54 per client) lived at another address, 5 (0.19 per client) lived in the same house. But about 20 out of the remaining helpers (0.51 per client) we were not told whether or not they lived in the same address as the client. The question of how much help comes from outside the household is crucial for our present assessment of informal help. What we know from the above is that it tends to range between slightly higher than one and one half per client, more probably near the lower end. Just as crucial is what help comes from outside the family. Only one extra-family helper is mentioned: a female who fulfils the main housework role for a female client (Table 8ap.2).

Table 8. 18: Helpers (not including client or carer): Relationship to Client, and whether living in same address.', shows sons and daughters (14) to be the most numerous helpers and siblings

²² Tables whose numbering starts with "8ap." are to be found in Appendix to Chapter 8.

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(10) as runner up. In both, males exactly equal females. Parents (4) are double the spouses (2). The rest were 1 aunt and 1 sister-in-law. In other words, the extended family comes far lower than both the (current or past) nuclear family. One case encountered in another part of the fieldwork was of a client whose aunt took interest in her when her parents died. After this, mutual help took place, including a substantial part coming from the part of the niece. But, very strikingly, neighbourhood and extended family support seem to be more potential than fact.

One needs to explain why parents and spouses are not prominent as helpers for two reasons. First, in most cases (all except 5 of the known helpers) the main carer is one of them. Second, siblings and children can be numerous, while parents and spouses naturally (and culturally) are limited to 2 or 1 per client. A third observation is that a rule seems to ordain for spouses and siblings that 'never the twain shall meet'. Table 8. 19: How helpers' relationship varies with main carer's relationship to client (signif. = .057): sibling care and spouse care are mutually exclusive., offers insight into important cultural patterns. Wherever a spouse was carer or helper, no sibling was, and vice versa! This seems to be a strong cultural imperative that makes caring and helping by siblings to be inappropriate when there was a spouse. However about half the clients (11) are cared for by a parent, including 10 mothers. These have the most numerous helpers, about 2 each, with most numerous sibling help (9), and with contribution not only from children (3) but also ex-spouses (2).

Respondents sometimes also mentioned help from the main carer or even the client him/herself. Table 8. 17: Clients or Carers themselves cited as 'helpers', by sex of helper, of client and of carer.' What respondents remembered or chose to mention must have some significance. No 'self-help' at all was mentioned for female clients, possibly for no other reason than that this is expected and that females were only one fourth of the sample. Male self-help elicited 11 mentions, 8 of which had to with carrying a contributory role as breadwinner.

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Respondents were also asked to give an idea of the intensity of the help given by choosing among the alternative answers shown in Table 8. 20: Illustrating the Scoring System for Role Intensity, applied to Housework. This highly enriched our information. Table 8. 20 and Table 8. 21 illustrate the use of this scoring by applying it to housework. Female non-main carer helpers are 1.6 times as common as male ones, but the intensity of their role is only slightly less of the male ones (mean = 3.04 as opposed to 3.00). 3 of 8 helpers cited as having the main role in housework are male, and an effort has been made to trace them through Table 8. 23: Male housework role by age of helper - inadequate information; then by Table 8. 24: Male Housework role grows with age of main carer. It emerged that, though no males ordinarily tend to take that main role, they do seem to tend to take it up when the female main carer, often their wife, becomes too frail or ill to go on doing the job herself.

Table 8. 21: Comparing Role Intensities of help in housework among the various relationships to clients. Though sons and daughters are the most numerous helpers generally, their role in housework is not very common (1 daughter with main role). Siblings do this role more often (N = 4) but have a largely contributory role. With mean intensity = 2.58, they rank lowest among the 'nuclear' family relationships).

Male and Female Help compared

Though women are an overwhelming majority as main carers (87%), they are only 55% of (additional) helpers. They are the only ones cited as helping in the care of children (2:0). Table 8. 25 : Ratio of Female: Male help, in descending order of (a) Frequency and (b) Intensity ('0' indicates absence of such cases)., shows that, beyond the main carer role, traditional male-female roles are weakened. Women end up most often administering the paying of bills and organising house maintenance (2.5:1), but men still tend to have very much the greater role once they participate in these domains. The elderly men doing the housework role equalled the role intensity of women involved in this domain. women were more numerous (1.3:1). Men predominated in oftener doing maintenance work, contributing cash

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and holding jobs, but women, once cast in the role, equalled them in role importance for maintenance and jobs, but had more secondary roles in contributing cash. The general conclusion seems to be that traditional stereotypes for job and main carer role are still strong, but there are important exceptions, reflecting probably both a cultural change and a departure from norm to step into the breach created by the family's special need. The other roles seem to be more flexible and prone to be shared among the sexes, except for the childcare role, which seems still strongly female. Of course, the results in general are highly approximate rather than conclusive, in view of the small numbers.

Table 8AP6 shows that while, as has been said, contributions of female clients have not been mentioned, male clients often carried out the traditional male roles. Female carers tended to predominantly mention their housework and 'house admin' role.

Roles of Different Relations (Table 8ap.4) generally can be seen as a restatement of the division of labour between nuclear and extended family, family of origin and family by marriage and male and female. It also conforms to the observation that substitutes to the traditional role stereotypes, though rarer than the original, tend to take the role just as intensively as the culturally expected incumbent.

One would have thought that uncles or in-laws were strongly present in the certain roles that, by their very nature, are easier to 'decentralise' or 'devolve' out of the household and nuclear family. Being a listener in troubled times or a support amid challenging behaviour could be a good 'avuncular' role. Being an entertainer who helps spend free time could also be 'devolved', though not necessarily to a more parental or senior figure. The figures are, in fact, again disappointing. Equally disappointing were the mentions of informal help requested additionally of LQOLP respondents. In all, there was only one case of Church help with clothing, and of two elderly clients entertained to periodic outings by the local council and a voluntary group.

Much seems to converge on the general conclusion that the nuclear family is very strong, while the extended family is strong as regards contact and emotional closeness, but still

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largely untapped as a source of support. As a result, probably those needing solid support have been surviving only if they had a strong nuclear family. Support can only develop as needed through the agency of formal workers such as case managers and specially trained and oriented social workers. It is expected that they find a basic readiness. In some areas, uncondusive cultural stereotypes need to be challenged. Such is the reluctance of siblings to help where spouses are in the picture when further support is needed, which will be oftener as more dependent patients are discharged, this could be challenged sensitively and, one would hope, successfully.

8.2.6 Religion

100% of respondents described themselves as Catholic. 67% said they attended services on 4 to 31 days a month. Religion was the domain with the highest - though not universal or unmitigated - satisfaction. Religion is another strength to build on. Fadden et al. discovered that Southern European clients and their families find solace and meaning in religion amid their predicament more often than do their northern counterparts. This may be largely linked to a difference between basic Catholicism and Protestantism. However, while community and mental health care in Malta should exploit the strength in both the belief and in the civil society aspects of religion, the figures and experience show the need to cater for diversity, which is steadily increasing. The drop in service attendance from the pilot area to the rest of Malta and Gozo illustrates this important trend.

SPECIAL NOTE

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and while every effort has
been made to reproduce the
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Tables related to Section 8.2.4-8.2.6

			Sex of Respondent (Main Carer)		Total
			Female	Male	
Broad age of respondent	0	Col %	6.5%		5.7%
	34 - 49	Col %	41.3%		35.9%
	50 - 59	Col %	29.3%	50.0%	32.1%
	60 - 75	Col %	22.8%	50.0%	26.4%
Total	Unweighted Count		22	4	26
Civil Status of Respondent	Married/Living with	Col %	82.5%	100.0%	85.1%
	Single	Col %	2.4%		2.1%
	Widowed	Col %	15.0%		12.8%
Total	Unweighted Count		20	4	24
Employment Status of Respondent	0	Col %	1.1%		.9%
	Full-time worker outside	Col %	7.6%	7.0%	7.5%
	Part-time worker outside	Col %	13.1%		11.3%
	Retired	Col %	7.6%		6.6%
	Full-time worker at home	Col %	6.5%		5.7%
	Unemployed because of	Col %	15.2%	93.0%	25.5%
	Unemployed for reasons	Col %	48.9%		42.5%
Total	Unweighted Count		22	4	26
Years Living w. Patient, in Broad Groups	0-19	Col %	34.8%		30.2%
	0	Col %	7.6%		6.6%
	20-29	Col %	33.7%	7.0%	30.2%
	30-39	Col %	8.7%	50.0%	14.1%
	40-49	Col %	13.1%	43.0%	17.0%
	60 & above	Col %	2.1%		1.8%
Total	Unweighted Count		22	4	26
No of hours each week in contact with patient	0	Col %	6.5%		5.7%
	0	Col %	30.4%	43.0%	32.1%
	10	Col %		7.0%	.9%
	21	Col %	6.5%		5.7%
	24	Col %	6.5%		5.7%
	No answer	Col %	6.5%	43.0%	11.3%
	Not applicable	Col %	43.5%	7.0%	38.7%
Total	Unweighted Count		22	4	26
Relationship to Client	Spouse	Col %	26.1%	93.0%	35.0%
	Parent	Col %	39.0%	7.0%	34.8%
	Sibling	Col %	28.3%		24.5%
	Other	Col %	6.5%		5.7%
Total	Unweighted Count		22	4	26

Table 8. 13: Characteristics of Main Carer by Sex

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					Sex of Client		Total
					Female	Male	
Sex of Respondent (Main Carer)	Female	Relationship to Client	Spouse	Count		4	4
			Parent	Count	2	8	10
			Sibling	Count	2	4	6
		Total	Count		4	16	20
	Male	Relationship to Client	Spouse	Count	2	1	3
			Parent	Count		1	1
		Total	Count		2	2	4

Table 8. 14: Main Carer relationship to client by sex of main carer and sex of client.

			Which Residential Status Category?			Total
			B	C	D	
Relationship to Client	Spouse	Col %	100.0%	40.0%	20.4%	35.0%
	Parent	Col %		40.0%	38.9%	34.8%
	Sibling	Col %		20.0%	31.3%	24.5%
	Other	Col %			9.4%	5.7%
Total	Unweighted Count		2	5	19	26

Table 8. 15 : Relationship of Main Carer to Client by Residential Prestige Category (A, B, C, D reflecting descending prestige attributed to residence at that locality – Boswell 1994; see p. 166): Spouses increase rapidly in frequency with area prestige (significance = .001)

By how many respondents	How many helpers mentioned
8 respondents	No helpers
7 respondents	1 helper
5 respondents	2 helpers
3 respondents	3 helpers
2 respondents	4 helpers
1 respondents	5 helpers
	Sum: 39 helpers
	Mean: 1.5 helpers per client
	N = 26 respondents

Table 8. 16: Number of helpers per client

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			If helper is other than Client or Main Carer			Total
			No: is client him/herself	No, is Carer her/himself	Yes	
Sex of Helper	female	Col %	8.3%	83.3%	53.8%	50.8%
	male	Col %	91.7%	16.7%	46.2%	49.2%
Total	Count		12	12	39	63
Sex of Client	Female	Col %	8.3%	25.0%	25.6%	22.2%
	Male	Col %	91.7%	75.0%	74.4%	77.8%
Total	Count		12	12	39	63
Sex of Carer	Female	Col %	100.0%	83.3%	92.3%	92.1%
	Male	Col %		16.7%	7.7%	7.9%
Total	Count		12	12	39	63

Table 8. 17: Clients or Carers themselves cited as 'helpers', by sex of helper, of client and of carer.

		Sex of Helper		Does Helper Live in Same Address as Client?			Total
		female	male	No answer	same address	different address	
Relation to of Helper to Client	not a relation	1				1	1
	mother/father	1	3	3		1	4
	son/daughter	7	7	8	2	4	14
	wife	1			1		1
	husband		1		1		1
	brother/sister	5	5	6		4	10
	aunt/uncle	1	1			2	2
	other	2		1		1	2
	Bro-/Sister-in-law	1				1	1
	No answer	2		1	1		2
Total		21	17	19	5	14	38

Table 8. 18: Helpers (not including client or carer): Relationship to Client, and whether living in same address.

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Relation of Helper to Client * Relationship of Main Carer to Client Crosstabulation

Count		Relationship of Main Carer to Client				Total
		Wife or partner	Husband or partner	mother/father	brother/sister	
Relation of Helper to Client	not a relation		1			1
	mother/father	1		3		4
	son/daughter	7	2	3	2	14
	wife			1		1
	husband			1		1
	brother/sister			9	1	10
	aunt/uncle	1		1		2
	other			1	1	2
	Bro-/Sister-in-law				1	1
	No answer			2		2
Total		9	3	21	5	38

Table 8. 19: How helpers' relationship varies with main carer's relationship to client (signif. = .057): sibling care and spouse care are mutually exclusive.

		Sex of Helper	
		female	male
Housework Role	Appreciable help (score: 1.0)	1	1
	Role not specified (score: 1.3)	1	
	Substantial Role (score: 2.0)	1	1
	Main role (score: 4.0)	5	3
Total	Valid N	N=8	N=5
	Mean	3.04	3.00
	Std Deviation	1.36	1.41

Table 8. 20: Illustrating the Scoring System for Role Intensity, applied to Housework

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			Sex of Helper						Group Total		
			female			male			Valid N	Mean	Std Deviation
			Valid N	Mean	Std Deviation	Valid N	Mean	Std Deviation			
Relation of Helper to Client	not a relation		N=1	4.00	.	N=0	.	.	N=1	4.00	.
	mother/fat		N=0	.	.	N=2	3.00	1.41	N=2	3.00	1.41
	son/daugh		N=1	4.00	.	N=0	.	.	N=1	4.00	.
	wife		N=1	4.00	.	N=0	.	.	N=1	4.00	.
	husband		N=0	.	.	N=1	4.00	.	N=1	4.00	.
	brother/sis		N=3	2.10	1.65	N=1	4.00	.	N=4	2.58	1.65
	aunt/uncle		N=0	.	.	N=1	1.00	.	N=1	1.00	.
	other		N=1	2.00	.	N=0	.	.	N=1	2.00	.
	Bro-/Sister		N=1	4.00	.	N=0	.	.	N=1	4.00	.
Group Total			N=8	3.04	1.36	N=5	3.00	1.41	N=13	3.02	1.32

Table 8. 21: Comparing Role Intensities of help in housework among the various relationships to clients

		Sex of Helper						Group Total		
		female			male			Valid N	Mean	Std Deviation
		Valid N	Mean	Std Deviation	Valid N	Mean	Std Deviation			
Housework Role		N=8	3.04	1.36	N=5	3.00	1.41	N=13	3.02	1.32
Role in Admin, Paying Bills etc.		N=5	2.56	1.34	N=2	4.00	.00	N=7	2.97	1.30
House Maintenance Role		N=1	1.00	.	N=3	1.00	.00	N=4	1.00	.00
Job Role		N=2	1.50	.71	N=5	1.40	.55	N=7	1.43	.53
Role of Contributing Cash		N=1	1.00	.	N=3	1.40	.53	N=4	1.30	.48
Role of Contributing 'In Kind'		N=3	1.33	.58	N=2	1.50	.71	N=5	1.40	.55
Role of Listener/Informal Counsellor		N=1	1.00	.	N=2	1.00	.00	N=3	1.00	.00
Childcare Role		N=2	1.00	.00	N=0	.	.	N=2	1.00	.00
Parental Role		N=1	1.00	.	N=3	1.07	.12	N=4	1.05	.10
Role of Helping with Free Time		N=3	1.00	.00	N=4	1.25	.50	N=7	1.14	.38
Helping Role with Difficult Behaviour		N=0	.	.	N=0	.	.	N=0	.	.

Table 8.

22: Helpers and their Role Intensity in each domain, by sex

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			Age group of Helper				Group Total
			0-19	20-39	40-59	60-79	
Sex of Helper	female	Valid N	N=0	N=1	N=2	N=1	N=4
		Mean	.	2.00	4.00	1.30	2.83
		Std Deviation	.	.	.00	.	1.39
	male	Valid N	N=0	N=0	N=0	N=1	N=1
		Mean	.	.	.	4.00	4.00
		Std Deviation
Group Total	Valid N		N=0	N=1	N=2	N=2	N=5
	Mean		.	2.00	4.00	2.65	3.06
	Std Deviation		.	.	.00	1.91	1.31

Table 8. 23: Male housework role by age of helper - inadequate information

			Broad age of Main Carer			Group Total
			34 - 49	50 - 59	60 - 75	
			Housework Role	Housework Role		
Sex of Helper	female	Valid N	N=1	N=5	N=2	N=8
		Mean	4.00	3.00	2.65	3.04
		Std Deviation	.	1.41	1.91	1.36
	male	Valid N	N=1	N=1	N=3	N=5
		Mean	1.00	4.00	3.33	3.00
		Std Deviation	.	.	1.15	1.41
Group Total	Valid N		N=2	N=6	N=5	N=13
	Mean		2.50	3.17	3.06	3.02
	Std Deviation		2.12	1.33	1.31	1.32

Table 8. 24: Male Housework role grows with age of main carer

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FREQUENCY:		INTENSITY:	
	FEMALE:MALE		FEMALE:MALE
Childcare Role	2:0	Childcare Role	1:0
Helping Role with Difficult Behaviour	0:0	Helping Role with Difficult Behaviour	0:0
Role in Admin, Paying Bills etc.	2.5:1	Role of Helping with Free Time	1.25:1
Role of Contributing 'In Kind'	1.5:1	Parental Role	1.1:1
Housework Role	1.3:1	Job Role	1.1:1
Role of Helping with Free Time	0.75:1	Housework Role	1.0:1
Role of Listener/Informal Counsellor	0.5:1	Role of Listener/Informal Counsellor	1.0:1
Parental Role	0.4:1	House Maintenance Role	1.0:1
House Maintenance Role	0.3:1	Role of Contributing 'In Kind'	0.7:1
Role of Contributing Cash	0.3:1	Role of Contributing Cash	0.7:1
Job Role	0.2:1	Role in Admin, Paying Bills etc.	0.6:1

Table 8. 25 : Ratio of Female: Male help, in descending order of (a) Frequency and (b) Intensity ('0' indicates absence of such cases).

FINDINGS ABOUT USERS, CARERS, SUPPORT

- | | |
|---|---------------------------------|
| 1 | Main role (score: 4.0) |
| 2 | Substantial Role (score: 2.0) |
| 3 | Practical help (score: 1.2) |
| 4 | Appreciable help (score: 1.0) |
| 5 | Informal counselor (score: 1.5) |
| 6 | Role not specified (score: 1.3) |
| 7 | No role cited (score = 0) |

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Chapter 8 (II)

Types and Extent of Mental Health Long-term Care Needs in Malta's Community: the Findings

PART II – Needs, Met and Unmet

8.3 Focusing on Particular Life Domains: Met and Unmet Need

The Autoneed Scale: Overview of Met and Unmet Need against the background of Quality of Life and Family Impact interview results

Now we focus on users' met and unmet need. The Autoneed scale is central to our assessment, and our only outcome measure, which can give us an idea of the extent to which users' needs were met or remained unmet within the enhanced services of the pilot area. We shall first look at the overall outcome results that, in view of the small size of the sample, can give only a very approximate and largely qualitative appraisal of the outcome among the whole pilot area population. Secondly, we shall view the outcome results while taking each domain in turn. For each domain, or 'area of functioning', we shall put together the appraisal of need, based on the combined (or triangulated) results of Joe Oliver's Quality of Life and Grainne Fadden's Family Burden (or Family Impact) scales as well as Max Marshall's Autoneed, while only the latter will tell us something about how far needs were met during the first 5 to 6 years of the pilot area. Groupings of domains follow the Care Program Inventory (CPI – see Table 9.3).

As explained in Chapter 7, the experienced professional who conducts Autoneed interviews with user, carer and key worker is guided and supported to feed data into the software that uses an algorithm to identify needs and the extent to which they have been met. Rather than being simple counts of 'met need' and 'unmet need', Autoneed results are given under five

FINDINGS ABOUT NEEDS, MET AND UNMET

<u>Autoneed Term</u>	<u>Explanation</u>
'Problem'	<u>Detected Problem:</u> Subject's performance goes below certain set criteria.
'Cardinal Problem'	<u>Cardinal Problem:</u> User requests help for problem, or it causes carer stress or it constitutes danger to user or others.
'Need'	<u>Need for Intervention:</u> An intervention can be identified and recommended.
'Suspended Need'	<u>Intervention Pending:</u> Interventions already taking place, whose results are still awaited.
'Placement Failure'	<u>Problem Despite Interventions:</u> Problem persists and no further intervention can be indicated.

Table 8.3. 1: The Headings used in the Autoneed Results, explained (see Marshall ET al., 1995)

Client:	Detected Problems	Cardinal Problems	Need for Intervention	Intervention Pending	Problem Despite Interventions
Client A	4	1	/	/	1
Client B	3	2	2	/	/
Client C	7	2	/	1	1
Client D	4	1	/	/	1
Client E	7	2	1	/	1
Client F	3	/	/	/	/
Client G	7	2	2	/	/
Client H	2	1	1	/	/
Client I	2	/	/	/	/
Client J	1	/	/	/	/
Client K	6	5	3	2	/
Client L	5	2	1	/	1
Client M	6	3	2	1	/
TOTAL FOR 13 CLIENTS	57	21	12	4	5

Table 8.3. 2: Problems and Needs, met and unmet, per Client (each letter indicated a different client)

headings as explained in Table 8.3. 1. The overall results are given in Table 8.3. 2, broken down by client, and Table 8.3. 3 broken down by domain or area of functioning. Eleven unmet needs were detected, averaging slightly less than one per client. Unmet needs ranged from 0 (3 of the clients) to 3 (1 client), as shown in Table 8.3. 3: Number of Needs Calling for Intervention per Client. A general appraisal of the results will be given at the conclusion of

FINDINGS ABOUT NEEDS, MET AND UNMET

this section, after we have explored the clients' performance, conditions and amenities as they emerge in each domain.

Number of Needs per Client	0 needs	1 needs	2 needs	3 needs	4 or more	Total
Number of Interviewees exhibiting that number of Needs	6 clients	3 clients	3 clients	1 clients	0 clients	13 clients
In percentage	46%	23%	23%	8%	0%	100%
(Very) rough estimate for Pilot Area	37 clients	18.5 clients	18.5 clients	6 clients	0 clients	80 clients
(Very) rough estimate for all Malta if same services extended	400 clients	200 clients	200 clients	70 clients	(more than) 0 clients	870 clients

Table 8.3. 3: Number of Needs Calling for Intervention per Client

Accommodation-Related Skills

Family Impact Domain 2: Housework and Household Responsibilities

The carer in 56% of the cases does all housework, while a further 15% do 'most' of it. These 70% or so were asked whether this burden was increased by the presence of illness in the house. About 60% of them said no, but 40%, representing 29% of the population, said the illness was cause of this greater responsibility. 1% found it extremely difficult to manage, 12% 'quite difficult to keep things up to standard', 49% found it 'a bit of a strain', while 32% experienced no problem. Two third experience at least some level of problem in keeping things running smoothly as usual. A third had to increase or decrease housework because of the illness, while 36% found housework a strain 'due to the illness'. In this domain 21% said that quite a lot of what happens depends on the client, a further 6.5% said this happens 'on and off' while an equal percentage felt what happens is dominated by the client, on whom 'nearly everything depends'. Summing up, a consistent third experienced increased problems that varied in severity. Nearly 90% kept standards up regardless, but at the price of added strain.

Autoneed Domain 9: Domestic Skills, and Domain 15: Hygiene and Dressing

Activities of daily living are a very significant and revealing area. While being mundane, the stuff of everyday life in which 'lay' people are completely at home, these activities are

FINDINGS ABOUT NEEDS, MET AND UNMET

essential for survival, and may need formally organised or professional input to achieve this survival in the community. Autoneed respondents included 'net contributors', including ill males who step into their elderly and impaired wife's shoes, or ill females who help the extended family. Others had attended the pilot area day centre or the mental hospital halfway house and were observed by family to have substantially improved. The problem lies with the ones who did or would not attend. Very supportive families sometimes pulled their full weight behind such attendance but others, equally supportive, were bemused at a dependent who became 'stuck', progressively less active, a strain in the present and a worry for the future.

The facilitating skills of home visiting social workers and occupational therapists were very highly appreciated, but the system's capacity to deploy them to get an unmotivated person 'unstuck' was not up to the most difficult cases.

The families with apathetic dependants were among the most worried and pained. Besides, the further acceleration of deinstitutionalisation will require not only the training in skills, but also their sustenance. It is difficult to see how this could happen without solid in vivo training and assertive outreach in the sense of very intensive and assertive, in a sense aggressive, involvement with the more apathetic. While a full Assertive Community Treatment team may be out of reach, many clients could be rescued out of dangerous apathy only through its mode of operation. A proactive exercise in identifying the 'stuck' and 'drawing them out' of their shell, one or a few at a time, should be well within expected capacity. This would need to include 'permanency planning', often meaning preparing for what happens when the parents cannot any longer contribute their support. Bigger day centres, more varied in their groupings, activities and resources, sustaining a home outreach would also seem to be necessary. Direct support of carers who so often are strained by the housework should also be an important focus of organised help.

Personal Amenities

Autoneed, even when dealing with social areas of functioning, speaks of skills and health aspects. However, rehabilitation (on the level of skills) requires also resettlement through the

FINDINGS ABOUT NEEDS, MET AND UNMET

provision of the possessions and amenities required, such as house, job, support network, means of transport, etc, which are the subject of the present section about 'personal amenities'.

LQOLP Domain 7: Living situation; Autoneed Domain 16: Accommodation

Deinstitutionalisation in a systematic way, meaning active work to help people to leave the institution after having settled in it, has only started in Malta with the reform, and did not involve housing in the pilot area. Clients live in 'ordinary' houses, as shown in Table 8.3. 4: The client's current residence. Pilot area clients tend more often to live in owner-occupied houses than those in the rest of Malta. No shared flats, and only one example of 'sheltered housing', were found. 49% lived with family, while 26% had wished to move or otherwise improve their living conditions but did not succeed (LQOLP). Houses visited varied from the very good to the very poor.

	Pilot Area	Rest of Malta & Gozo	Total
No answer	7.7%		.7%
Hospital ward	7.7%	3.3%	3.7%
Sheltered housing		3.3%	3.0%
Private house (owner-occupied)	53.8%	40.0%	41.3%
Private house (rental)	30.8%	46.7%	45.2%
Other		6.7%	6.1%

Table 8.3. 4: The client's current residence

	Detected Problems	Cardinal Problem	Need for Intervention	Intervention Pending	Problem Despite Interventions
Domestic Skills	8	2	2		
Social Life	8	2	1	1	
Work	11	1	1		
Transport and Amenities	6	1	1		
Finance and Welfare	2	1	1		
Literacy	2	1	1		
Hygiene and Dressing	1	1	1		
TOTAL	38	9	8	1	/

Table 8.3. 5: Problems and Unmet Need in Social Domains in descending order of frequency (Autoneed)

FINDINGS ABOUT NEEDS, MET AND UNMET

Autoneed Domain 11: Transport & Amenities

Six out of 13 manifested problems with the use of public transport. But only one was indicated for intervention, in the form of remedial training. The rest were quite happy with either living in a housebound manner or, rather more often, being driven round by relatives, at times very occasionally. Again, this reflects a very 'settled' and rather unadventurous existence. We may, in fact, be dealing with a culture that does not seek as much outside-family entertainment as other, more urbanised parts of Malta and especially other countries. However, if this is the average that satisfies, it does not seem right to take it as benchmark on the 'principle of normalisation'. The problem probably is, however, rather that the normal opportunities are blocked, while the 'over and above the normal' effort needed to reopen them or valid substitutes is not forthcoming. Rehabilitation must push for that 'needed extra'.

	Pilot Area	Rest of Malta & Gozo	Total
<Lm 10		3.3%	3.0%
Lm 20-24	15.4%	3.3%	4.4%
Lm 30-40	7.7%	13.3%	12.8%
Lm 40-59	23.1%	20.0%	20.3%
Lm 60-80	7.7%	16.7%	15.8%
> Lm 99		3.3%	3.0%
n/a	46.2%	40.0%	40.6%
Total, Unweighted Count	13 100%	30 100%	43 100%

Table 8.3. 6: How much money would you need per week to live as you wish? (1996) – Grouped (LQOLP)

	Pilot Area	Rest of Malta & Gozo	Total
0	7.7%	6.7%	6.8%
Yes	23.1%	30.0%	29.4%
No	53.8%	63.3%	62.5%
Do not know	15.4%		1.4%
Total, Unweighted Count	13 100%	30 100%	43 100%

Table 8.3. 7: During the past year, have you ever lacked the money to enjoy everyday life? (LQOLP)

FINDINGS ABOUT NEEDS, MET AND UNMET

LQOLP Domain 6 Finances, Family Impact Domain 3: Finance, Autoneed Domain 10: Finance & Welfare

Table 8.3. 7: During the past year, have you ever lacked the money to enjoy everyday life?', reveals that 29% lacked the money needed to enjoy everyday life. Table 8.3. 6: How much money would you need per week to live as you wish? (1996) – Grouped', gives their self-perceived requirements. Autoneed focused on skills in money use, and detected only one in which an intervention, remedial training, was necessary. Again, however, there were about a third who lacked money use skills, but were nevertheless satisfied.

		Pilot Area	Rest of Malta & Gozo	Total
<u>Is there anyone else who helps out substantially with the daily expenses?</u>				
	Yes and he/she lives in the same house	40.0%	43.8%	43.4%
	No	60.0%	31.2%	33.9%
	A number of people help out		12.5%	11.3%
	No answer		6.2%	5.7%
	Yes but he/she lives in a different house		6.2%	5.7%
<u>How is this person related?</u>				
	n/a	40.0%	31.2%	32.1%
	son/daughter	10.0%	31.2%	29.3%
	husband/partner	10.0%	12.5%	12.3%
	mother/father	20.0%	6.2%	7.5%
	brother/sister	20.0%	6.2%	7.5%
	not a relation		6.2%	5.7%
	mother/father of partner		6.2%	5.7%
Total	Unweighted Count	10	16	26
	Col %	100.0%	100.0%	100.0%

Table 8.3. 8: Third persons who contribute to the household income, in descending order of frequency (Family Impact)

Family Impact interviews show that 24% of families suffered in money matters, 7% being 'much worse' than before. About 24 % too say what happens in money matters depends largely on the client. Reasons are shared more or less equally among 'loss of client's income', 'extra expenses incurred due to illness' and 'money spent foolishly by client'. As a result, 15% have had to cut down on food, clothing or leisure activities, while a half of that have

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fallen behind in HP repayments. 61% receive financial help from third persons, 17% citing persons living in a different address, 6% citing a non-relative (See Table 8.3. 8: Third persons who contribute to the household income, in descending order of frequency (Family Impact).)

Job Skills, Education

LQOLP Domain 3: Work/ education; Family Impact Domain 1: Work outside the Home;

Autoneed Domain 1: Work; 12: Literacy

Out of the 38 LQOLP respondents only 5 – 15%, none from the pilot area – had jobs, 3 being full-time, 2 doing 25-30 hours a week. Family Impact Questionnaire (FIQ) interviews indicates 17% of carers as jobholders, but give 10% for the pilot area carers. None had to change jobs due to the illness, but 2% of FIQ respondents overall (being 2 carers from the pilot area) reported having had to change shifts or time arrangements, an equal number reporting particular difficulties at work, only half of whom attributed them to the illnesses impact. Autoneed found lack of job in 11 out of 13 interviewees, but recommended only one intervention (a job assessment), largely because client or carer did not see job as desirable revealing, again, a low level of expectation in that quarter. Only 2 out of 13 failed the simple literacy test, and only one of them wished to attend lessons to improve.

Social, Participation & Leisure Skills

LQOLP Domain 4: Leisure/ Participation

Leisure use patterns for clients showed great similarity between pilot area and the rest of Malta. For both, in the previous fortnight, only 37% of users had been out on a ride by bus or car (other than to travel to or from work) while 77% had watched television, while overall rates of satisfaction were also very similar.

Family Impact Domain 5: Leisure and Social Life

Nearly 40% of carers reduced their outings and social events as a result of the illness. 66% worry so much about the illness that they are at times not up to social events, while 40% find that looking after the client leaves them no time for them. 13% had a reduction in friends

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calling at the house for the same reason. 28% had a decrease, 7% had an increase in the number of friends contacted. The lack of networking among carers shows itself from the fact that only 23% know somebody in a similar situation, including 20% who feel isolated as a result. Though stigma is probably the most frequent problem associated with mental illness by the Maltese media and opinion leaders, only 18% feel that people may look upon them any differently because of the illness. 28% had some problems with the neighbours, while a further 6 % had serious ones. 99% said they never were obliged by the illness to move house or incur serious financial loss (1% gave 'no answer'). 43% feel the illness very seriously affect their social life while 20% say it has no such control at all.

Health & Challenging Behaviours

LQOLP Domain 11: Health

In the previous year, 62% had seen a doctor for physical illness, 96% for psychiatric or emotional problems, while 11% said there had been times when they needed the help of a doctor or other professional and could not get it. A full 50% had been treated in hospital in the previous year for psychiatric problems, for which 91% were currently on medication.

Autoneed Domain 3: Anxiety or Depression, 1: Psychosis, 2: Side Effects, 6: Health, 5: Organic Disorder, 4: Self-Harm or Violence, 7: Socially Embarrassing Behaviour, 8: Drugs & Alcohol

One can now turn to Table 8.3. 9: Health Problems: 19 problems detected by Autoneed in 13 interviewed clients, indicating 7 interventions (PDI = Problem persisting despite intervention/s). Where a problem is identified, an intervention is recommended, and a 'need' identified only when the intervention is desired by the client, required to allay carer stress or can lead to harm to self or others, defining needs at a basic and conservative level, though quite respectful of client self-determination. However, in health domains, the criterion of severity is given a determining importance. The professionally trained and experienced interviewer must use an amount of judgement in using the Manchester Scale and Baker's REHAB scale to contribute to this appraisal. Autoneed software uses an algorithm to decide if severity thresholds have been crossed. There were three cases of suspended need, that is,

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interventions that were pending, and whose effectiveness could only be appraised after some time.

<u>Domain/Area of Functioning</u>	<u>Objective Problem?</u> (‘Is there a problem?’)	<u>Cardinal Problem?</u> (‘Is intervention required?’)	<u>Need status</u> (‘Is a new intervention recommended?’)	<u>Required Intervention</u>	<u>Certainty</u>
Anxiety or Depression	Yes	No	No		
Anxiety or Depression	Yes	Yes	Yes	Psychological Treatment	Definite
Anxiety or Depression	Yes	Yes	Suspended	Support	
Health	Yes	Yes	Yes	Coping Advice (Carer)	Definite
Health	Yes	Yes	Yes	Specialist Assessment	Likely
Health	Yes	Yes	PDI		
Health	Yes	Yes	PDI		
Health	Yes	Yes	PDI		
Health	Yes	Yes	PDI		
Health	Yes	Yes	PDI		
Psychosis	Yes	No	No		
Psychosis	Yes	Yes	Suspended	Psychiatric Assessment	
Psychosis	Yes	Yes	Suspended	Support and Reassurance	
Self Harm or Violence	Yes	Yes	Yes	Psychological Treatment	Likely
Side Effects	Yes	No	No		
Side Effects	Yes	No	No		
Side Effects	Yes	No	No		
Side Effects	Yes	No	No		
Socially Embarrassing Behaviour	Yes	No	No		

Table 8.3. 9: Health Problems: 19 problems detected by Autoneed in 13 interviewed clients, indicating 7 interventions (PDI = Problem persisting despite intervention/s)

Slightly more than half complained of problems of physical health. 5 out of these 7 emerged as ‘problem persisting in spite of intervention’. This was simply to register that circulatory disease or diabetes or temporary orthopaedic problems persisted. However, not enough information was available to judge about the adequacy of the treatment given, so that all one can conclude is that physical problems are probably common and that clients get regular treatment for them, whose quality is an important issue of quality of life.

The drug treatment of psychiatric illness seems to be largely an adequately met need, with side effects, though of a very mild kind, slightly more in evidence than the symptoms. One case of

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needed bereavement and shock counselling was detected, that may or may not have been missed in diagnosis but for which no treatment was being given that the client was aware of.

Impact on family life

This section is mostly about within-family relationships. It is difficult to summarise the answers about such a subject, so carers are allowed to speak for themselves through the tables, here given within the chapter. It would help to remember who the 26 respondents are. They are 22 females and 4 males. They comprise 11 mothers, 6 sisters, 4 wives, 3 husbands, 1 father and 1 'other (female) relative'. Where column percentages of respondents do not add up to 100% it is because 'No Answer/ Not Applicable' have been omitted to save space.

Family Impact Domain 4a: Relationship With The Client, Including Marriage Family Impact Domain

A majority (62%) feel they are getting on well (Table 8.3. 10), while 31% do not, saying relationship has deteriorated because of the illness, while 6% find the relationship very difficult at the moment. About 6 % feel left out within the family, but 85% do not feel that.

		<u>Pilot Area</u>	<u>Rest of Malta & Gozo</u>	<u>Total</u>
In general, how would you say you get on together at the moment?	Very well	20.0%	31.2%	30.2%
	Quite well	40.0%	31.2%	32.1%
	Some difficulty in getting along together	30.0%	31.2%	31.1%
	Finding it very difficult to get on together at the moment	10.0%	6.2%	6.6%
How does this compare with the way you got on before the patient became ill?	No change	20.0%	62.5%	58.6%
	No Ans/Does not Apply	10.0%		.9%
	Brought us close together	40.0%		3.7%
	Worse	30.0%	31.2%	31.1%
	No Ans/Does not Apply		6.2%	5.7%
Since the patient became ill, have you had the feeling of being left out within the family or complained because of the illness?	No	60.0%	87.5%	85.0%
	No Ans/Does not Apply	20.0%	6.2%	7.5%
	Sometimes, but no strong feeling of being left out	10.0%		.9%
	Feel left out a lot of the time	10.0%		.9%
	Very strong feelings of being left out/neglected		6.2%	5.7%

Table 8.3. 10: Family Impact: Client-carer relationship, including Marriage 1

Spouses need to share together their feelings and worries, and this is very often expected also between adult children and parents sharing the same home. 40 to 49% say this sharing takes place, and that the illness has made no difference (Table 8.3. 11). About 35% observe a decrease of interest and affection, to varying degrees, while about the same number feel that to expect support is to expect too much. There is a marked difference between the pilot area and

FINDINGS ABOUT NEEDS, MET AND UNMET

the rest of Malta, the former being much less prone to expect support from the client (70% as compared with 30%), but also markedly less ready to see their own worries as insignificant when compared with those of the client. One wonders whether this reflects a combination of greater bluntness with greater protectiveness that may reflect an older and more rural way that may be decreasing and that could be targeted for deliberate change. Or it could be because in the pilot area more carers are parents rather than spouses.

Do you ever feel reluctant to talk about your own worries and problems with the patient since he/she became ill?	No	30.0%	43.8%	42.5%
	No Ans/Does not Apply	10.0%		.9%
	Never talked with patient about my worries anyway	20.0%	18.7%	18.9%
	Do not talk with patient about my worries since illness	30.0%	12.5%	14.1%
	Do not talk to patient about worries when he/she is ill		6.2%	5.7%
	Sometimes reluctant to talk with patient about own worries	10.0%	18.7%	17.9%
Your worries seem insignificant compared with the patient's	No	50.0%	37.5%	38.7%
	No Ans/Does not Apply	50.0%	56.3%	55.7%
	Yes		6.2%	5.7%
You feel the patient has enough troubles of his/her own	No	30.0%	25.0%	25.5%
	No Ans/Does not Apply	50.0%	62.5%	61.3%
	Yes	20.0%	12.5%	13.2%
You feel that if you burden him/her too much he/she may become ill again?	No	40.0%	25.0%	26.4%
	No Ans/Does not Apply	30.0%	62.5%	59.5%
	Yes	30.0%	12.5%	14.1%
You feel the patient is incapable of offering any support?	No		6.2%	5.7%
	No Ans/Does not Apply	30.0%	62.5%	59.5%
	Yes	70.0%	31.2%	34.8%
Does the patient show as much interest in what you do/affection towards you as he/she did before the illness?	No change	40.0%	50.0%	49.1%
	No Ans/Does not Apply		6.2%	5.7%
	Shows more interest/affection now	10.0%	6.2%	6.6%
	Slight decrease in interest/affection	10.0%	6.2%	6.6%
	Marked decrease	20.0%	18.7%	18.9%
	Amount of interest varies depending on his/her mood	20.0%	12.5%	13.2%

Table 8.3. 11: Family Impact: Client-carer relationship, including Marriage 2

Increase in arguments with the illness is very much more marked in the pilot area (70% as against 25% elsewhere, Table 8.3. 12), possibly confirming the same trend. However it could also be because clients happen to suffer from different problems in mental health. Sexual relationship has been badly affected in about a quarter of spouse respondents, but temporary separation because of the illness was quite rare (7%), while 12% find it so difficult that they

FINDINGS ABOUT NEEDS, MET AND UNMET

Do you think that the number of arguments you and the patient have has increased since the patient's illness began?	No change	30.0%	68.8%	65.2%
	No Ans/Does not Apply		6.2%	5.7%
	Increase	70.0%	25.0%	29.1%
Have you and the patient actually separated for a couple of days or more because of difficulties in your relationship?	No	90.0%	81.3%	82.1%
	No Ans/Does not Apply		12.5%	11.3%
	Yes	10.0%	6.2%	6.6%
Has the patient's illness affected your sexual relationship?	No effect		18.7%	17.0%
	No Ans/Does not Apply	90.0%	75.0%	76.4%
	No longer have a sexual relationship with spouse/partner	10.0%	6.2%	6.6%
On the whole, are you finding it a bit of a strain to keep the relationship going at the moment?	No strain	10.0%	25.0%	23.6%
	No Ans/Does not Apply	70.0%	37.5%	40.5%
	Some strain but can manage OK		25.0%	22.7%
	Finding it difficult to keep the relationship going	10.0%		.9%
	So difficult that respondent feels will not cope for longer	10.0%	12.5%	12.3%
Have you thought of doing anything or actually done something to bring the relationship to an end?	No Ans/Does not Apply	100.0%	100.0%	100.0%

Table 8.3. 12: Family Impact: Client-carer relationship, including Marriage 3

feel they can no longer cope. Pilot area carers feel in control of what happens within the relationship more often (40%) than the others (24%). But, overall, about 70% attribute to the client more influence on what happens (Table 8.3. 13), finding that what the client does or what happens to the client is what most controls things.

Has there been a noticeable/identifiable change in your relationship because of the patient's illness?	No change or relationship better	40.0%	37.5%	37.7%
	No Ans/Does not Apply	30.0%	18.7%	19.8%
	Yes	30.0%	43.8%	42.5%
Have you found it a strain to keep the relationship going?	No or found it easier	30.0%	56.3%	53.8%
	No Ans/Does not Apply	30.0%	18.7%	19.8%
	Yes	40.0%	25.0%	26.4%
How much do you think you influence what happens in your relationship?	No Ans/Does not Apply	20.0%	18.7%	18.9%
	I have no control over what happens in the relationship	10.0%	6.2%	6.6%
	I have nearly no control over what happens in relationship	10.0%		.9%
	Some things depend on me some things do not depend on me	20.0%	50.0%	47.2%
	Depends quite a lot on me	30.0%	18.7%	19.8%
	What happens in our relationship depends mostly on me		6.2%	5.7%
	What happens in our relationship depends totally on me	10.0%		.9%

FINDINGS ABOUT NEEDS, MET AND UNMET

To what extent do you think the patient controls the way you relate to each other?	No Ans/Does not Apply	40.0%	25.0%	26.4%
	patient nearly does not have any influence over relationship		6.2%	5.7%
	patient has a little bit of influence over our relationship	10.0%	6.2%	6.6%
	patient has quite a bit of influence	10.0%	37.5%	35.0%
	patient has quite a lot of influence	30.0%	18.7%	19.8%
	What happens in our relationship depends mostly on patient		6.2%	5.7%
	What happens in our relationship depends totally on patient	10.0%		.9%
Total	Unweighted Count	10	16	26

Table 8.3. 13: Family Impact: Client-carer relationship, including Marriage 4

Family Impact Domain 4b: Effects on Children and on Parental Role

Carers were asked about their children's living situation. This applied to 36% who had small children. No particular illnesses were reported for these children, but nearly a quarter (8.4%) experienced 'some problems'. 6% (1 in 6) reported some difficulties at school. 11% (close to 1 in 3) reported infrequent visits at home by friends possibly related to the presence of illness, while about half of that had to spend occasional nights away from home till trouble boiled over. About 1 in 6 (6.6%) tend to keep away from the client, avoiding asking him or her

		Pilot Area	Rest of Malta & Gozo	Total
How has your children's health been recently?	No illnesses or other physical problems	40.0%	31.2%	32.1%
	No Ans./Not Applicable	60.0%	68.8%	67.9%
Status of children	Children are grown up		6.2%	5.7%
	Children are living with couple	20.0%	37.5%	35.9%
Have the children been miserable, fretful, worried and trouble concentrating or been bed-wetting?	No	10.0%	25.0%	23.6%
	Some difficulties	20.0%	6.2%	7.5%
	Serious problems – have sought professional help	10.0%		.9%
Is this related in any way to the patient's illness?	No		6.2%	5.7%
	Possibly related to patient's illness	10.0%		.9%
Have the children been naughty, difficult to manage, acted in an odd manner, been unwilling to go to school or truanted	No	20.0%	25.0%	24.5%
Is this related in any way to the patient's illness?	Possibly related to patient's illness		6.2%	5.7%

Table 8.3. 14: Family Impact: Children and Parental Role 1

FINDINGS ABOUT NEEDS, MET AND UNMET

questions, while 1% try to keep away completely. In about 1 in 3 of the households making decisions about the children has become 'quite a bit more difficult'. A section that needs special attention is represented by the 1 in 36, who find this 'much more difficult', have had to seek professional help for their children and feel that control of what happens in this regard resides completely in the client. Still, rather more than a third say their parental role has not been impaired, while an equal number say it was only slightly.

Have the children had to stay off school because of the patient's illness?	No	30.0%	18.7%	19.8%
How are the children getting on at their schoolwork?	No problems or problems not related to illness	30.0%	12.5%	14.1%
	Slight difficulties		6.2%	5.7%
Do the children have much contact with their friends now?	Visits friends and has friends to visit	20.0%		1.8%
	Visits friends but they do not come to house		6.2%	5.7%
	Has no contact with friends	10.0%	6.2%	6.6%
Is this related in any way to the patient's illness?	No	10.0%	6.2%	6.6%
	Possibly related to patient's illness		12.5%	11.3%
Have the children ever complained or become upset because someone has teased them because someone has teased them because of the illness?	Never	40.0%	25.0%	26.4%
Have the children had to spend time away from home because of the patient's illness?	Never	40.0%	18.7%	20.7%
	Occasional nights away from home		6.2%	5.7%

Table 8.3. 15: Family Impact: Children and Parental Role 2

How do the children get on with the patient now?	No change in the way they get on	20.0%	18.7%	18.9%
	Tend to keep away from patient – avoid asking him anything	10.0%	6.2%	6.6%
	Try to keep away from patient completely	10.0%		.9%
Who makes most of the decision regarding the children?	Respondent	40.0%	12.5%	15.0%
	Decisions are shared between them	10.0%	12.5%	12.3%
Has the patient's illness affected your functioning as a parent?	Made it easier or no change	30.0%	12.5%	14.1%
	Made it quite bit more difficult	10.0%	12.5%	12.3%
	Made it much more difficult	20.0%		1.8%
Has the patient's illness affected your functioning as a parent?	Made it easier or no change	30.0%	6.2%	8.4%
	Made it quite a bit more difficult	10.0%		.9%
	Made it much more difficult		6.2%	5.7%
At the moment, are you finding being a parent a bit of a strain or are you managing to cope alright?	No problem	30.0%	12.5%	14.1%
	Slight problem	20.0%	12.5%	13.2%
	Quite difficult	10.0%		.9%
Have the children experienced behavioural, psychological, physical illnesses or decline in school performance which is linked to the illness?	No	40.0%	25.0%	26.4%
	Yes	10.0%		.9%

Table 8.3. 16: Family Impact: Children and Parental Role 3

FINDINGS ABOUT NEEDS, MET AND UNMET

Have you been finding it a strain dealing with the children since your spouse became depressed	No	50.0%	18.7%	21.6%
	Yes		6.2%	5.7%
On the whole, do you feel in control of matters regarding the children?	These matters are quite a lot out of my control		6.2%	5.7%
	These matters are a bit out of my control	10.0%		.9%
	I have nearly everything under control	10.0%		.9%
	I have everything under control	10.0%	12.5%	12.3%
How much influence do you feel the patient has over matters relating to the children?	No Ans./Not Applicable	80.0%	87.5%	86.8%
	A little bit of influence		6.2%	5.7%
	What happens depends on him quite a lot	10.0%	6.2%	6.6%
	What happens depends nearly all on him/her	10.0%		.9%
Why do not the couple have children?	Couple have no children for reasons other than illness	10.0%	6.2%	6.6%
	No Ans./Not Applicable	90.0%	93.8%	93.4%
Total	Unweighted Count	10	16	26

Table 8.3. 17: Family Impact: Children and Parental Role 4

Family Impact Domain 7: Challenging Behaviours

A central part of the burden of illness is the difficult behaviours that challenge both client and family. Looking at Table 8.3. 18: Which behaviours or states are the most common? (Numbers proportional to occurrence, but also differently weighted according to subsample) one can be struck by the fact that the most common tend to be states and behaviours that are also commonly manifested by persons not suffering from major mental illness. A similar observation can be made about Table 8.3. 19: Which behaviours or states are the most worrisome (on average, when they occur)? (Mean, on a scale of 1-6, 6 being most worrisome) Misery, sleeping problems, irritability, withdrawal, underactivity and overdependence, when they occur, all worry carers more than do signs more related to major illness such as self neglect, violence to people, elated moods and hallucinations. One cannot but speculate about the reason. But it is quite likely that 'positive symptoms' are more prone to be eliminated than negative symptoms. Medication tends to be more effective with them and, when that does not succeed, admission is more frequently resorted to. Positive symptoms tend to be more distressing and dangerous, so a settlement is reached in which negative ones end up predominating. But, on balance, the negative symptoms are shown here to represent the greatest burden to families. Attention to 'negative symptoms' (as we have called them rather broadly), and to minimising and dealing with them, must be a central feature in family intervention. The conclusion is even clearer if we look at Table 8.3. 20: Which behaviours cause the greatest amount of worry globally (multiplying 'common-ness' with 'average level of worry caused'; but also differently weighted according to sub-sample). This table, we can say, gives us the global burden for the community of carer families as a social group.

FINDINGS ABOUT NEEDS, MET AND UNMET

	Pilot Area	Rest of Malta & Gozo	All of Malta & Gozo		Pilot Area	Rest of Malta & Gozo	All of Malta & Gozo
	valid N	valid N	valid N		valid N	valid N	valid N
Irritability	7	62	69	Odd Ideas	6	49	55
Withdrawal	7	56	63	Attention Seeking	6	49	55
Worry	7	56	63	Fearfulness	7	43	50
Complains about bodily aches & pains	6	56	62	Gambling - Degree to which behaviour bothers relative	7	43	50
Appetite Problems	5	56	61	Heavy Drinking	7	43	50
Misery	10	49	59	Gambling	7	43	50
Self-Neglect	8	49	57	Underactivity	7	37	44
Obsessiveness-W	7	49	56	Forgetfulness	6	37	43
Overactivity	7	49	56	Overdependence	6	37	43
Nagging/Grumbling	7	49	56	Suicidal threats or attempts	6	37	43
Rudeness	7	49	56	Hallucinations	6	37	43
Violence to People	7	49	56	Elated Mood	5	37	42
Sleep	6	49	55	Offensive Behaviour	5	37	42
Anxiety-W	6	49	55	Odd Behaviour	4	37	41
Indecisiveness-W	6	49	55	Unpredictability	3	37	40

Table 8.3. 18: Which behaviours or states are the most common? (Numbers proportional to occurrence, but also differently weighted according to subsample)

	Pilot Area	Rest of Malta & Gozo	All of Malta & Gozo		Pilot Area	Rest of Malta & Gozo	All of Malta & Gozo
	mean	mean	mean		mean	mean	mean
Misery	5	6	6	Overactivity	2	4	4
Sleep	6	5	5	Obsessiveness	5	3	3
Irritability	6	4	5	Nagging/Grumbling	4	2	3
Withdrawal	5	5	5	Appetite Problems	4	3	3
Underactivity	4	6	5	Attention Seeking	4	3	3
Overdependence	4	5	5	Unpredictability	3	3	3
Odd Behaviour	3	6	5	Violence to People	3	3	3
Odd Ideas	2	5	5	Fearfulness	2	3	3
Gambling - Degree to which behaviour bothers relative	6	4	4	Elated Mood	1	4	3
Forgetfulness	5	4	4	Hallucinations	1	4	3
Worry	5	4	4	Indecisiveness	3	2	2
Rudeness	4	4	4	Suicidal threats or attempts	3	2	2
Anxiety	3	4	4	Offensive Behaviour	1	2	2
Self-Neglect	3	4	4	Heavy Drinking	1	1	1
Complains about bodily aches & pains	3	4	4	Gambling	1	1	1

Table 8.3. 19: Which behaviours or states are the most worrisome (on average, when they occur)? (Mean, on a scale of 1-6, 6 being most worrisome)

FINDINGS ABOUT NEEDS, MET AND UNMET

	Pilot Area	Rest of Malta & Gozo	All of Malta & Gozo		Pilot Area	Rest of Malta & Gozo	All of Malta & Gozo
	<i>sum</i>	<i>sum</i>	<i>sum</i>		<i>sum</i>	<i>sum</i>	<i>sum</i>
Irritability	40	278	318	Obsessiveness	37	148	185
Withdrawal	33	259	292	Forgetfulness	30	148	178
Sleep	34	247	281	Attention Seeking	21	142	163
Worry	33	222	255	Fearfulness	14	142	156
Odd Ideas	13	241	254	Violence to People	19	136	155
Underactivity	26	210	236	Hallucinations	6	142	148
Anxiety	20	216	236	Nagging/Grumbling	31	111	142
Rudeness	30	197	227	Elated Mood	6	130	136
Complains about bodily aches & pains	17	210	227	Indecisiveness	18	111	129
Odd Behaviour	11	210	221	Unpredictability	8	117	125
Self-Neglect	27	191	218	Suicidal threats or attempts-S	16	68	84
Overactivity	17	197	214	Offensive Behaviour	4	68	72
Gambling - Degree to which behaviour bothers relative	45	167	212	Gambling	4	49	53
Appetite Problems	21	185	206	Heavy Drinking	8	37	45
Overdependence	23	179	202				

Table 8.3. 20: Which behaviours cause the greatest amount of worry globally (multiplying 'common-ness' with 'average level of worry caused'; but also differently weighted according to sub-sample)

Satisfaction with the Services, Support & Information Available to Family in 1996 (Family Impact Domain 6)

Family Intervention is a thriving and growing approach aiming to target family needs, correcting a previous exclusive concentration on the client, often justified by confidentiality. Grainne Fadden, the originator of the Family Impact Questionnaire, is also one of the main leaders of this movement. Information about what is the illness and its implications, what to expect and how to cope, are central to this intervention. 25-35% of carers responded that they received none at all of all this; 46 to 52% emerged as very highly or even completely satisfied with the information. As regards the advice they got about how to cope, only 22% were similarly satisfied. What is remarkable is that pilot area shows a consistently and strongly lower level of satisfaction (though we must remember that the 10 respondents in the pilot area sample, were speaking when the pilot area enhanced services had only been in place for 12 to 15 months. Pilot area practitioners have, since then, been foremost in the promotion of family intervention, at least of the collective instruction/ groupwork type.

FINDINGS ABOUT NEEDS, MET AND UNMET

		Pilot Area	Rest of Malta & Gozo	Total
Were you provided with any information about the patient's illness, what it's all about, whether he/she will improve..	No information at all	30.0%	25.0%	25.5%
	No Ans./Not Applicable	50.0%	6.2%	10.3%
	Some, but still understands very little about what's wrong		12.5%	11.3%
	Quite a bit, but not as much as I would have liked	10.0%	25.0%	23.6%
	Feels he/she understands patient's illness fully	10.0%	31.2%	29.3%
Were you ever told anything about the kind of behaviour to expect from the patient as a result of his/her illness?	No	20.0%	37.5%	35.9%
	No Ans./Not Applicable	40.0%	6.2%	9.4%
	A little	20.0%	6.2%	7.5%
	Quite a lot	20.0%	25.0%	24.5%
	Everything was explained fully		25.0%	22.7%
Were you offered any advice as to how you might deal with difficult behaviours shown by the patient	No	20.0%	37.5%	35.9%
	No Ans./Not Applicable	40.0%	12.5%	15.0%
	One or two things were mentioned	20.0%	25.0%	24.5%
	Told quite a lot about dealing with some difficult behaviour	20.0%	12.5%	13.2%
	Given detailed advice what to do when patient did things		12.5%	11.3%

Table 8.3. 21: Satisfaction with Information and Advice

Do you feel that you can contact someone from social/mental health services if something is worrying you or if you need a	Have never done this and don't feel I could	10.0%	25.0%	23.6%
	No Ans./Not Applicable	50.0%	6.2%	10.3%
	Feel I could do so if I really need to but have never done so	30.0%	31.2%	31.1%
	Feel I can whenever I need to, and have actually done so	10.0%	37.5%	35.0%
Do you feel that there is help available from the professionals in times of crisis with the patient?	No, don't feel there is anyone I can turn to	10.0%	31.2%	29.3%
	No Ans./Not Applicable	50.0%	6.2%	10.3%
	Feel reasonably sure I can get help if I need it	20.0%	25.0%	24.5%
	Have no doubt that help is readily available whenever I need	20.0%	37.5%	35.9%
What is your opinion of the services you have been in contact with to date? Are you satisfied or not?	Not at all satisfied		6.2%	5.7%
	No Ans./Not Applicable	40.0%	12.5%	15.0%
	Quite satisfied but there's room for improvement	50.0%	62.5%	61.3%
	Extremely satisfied - things could not have been better	10.0%	18.7%	17.9%
Total	Unweighted Count	10	16	26

Table 8.3. 22: Satisfaction with availability of help and service in general

FINDINGS ABOUT NEEDS, MET AND UNMET

35 or 36% of carers feel they can get a listening ear and advice when they need it, or help in time of crisis, and 25-35 feel this is reasonably available, but 29% feel they would then have nobody to turn to. (See Table 8.3. 22: Satisfaction with availability of help and service in general). Overall satisfaction with the services is 6% 'not satisfied at all', 61% 'quite satisfied, but there is room for improvement', 18% 'extremely satisfied – things could not have been better'.

Met & Unmet need synthesis (Autoneed)

Tables in this section bring together the information about met and unmet need emanating from Autoneed, to complete the record. Comparisons are also made with figures derived through Autoneed for Hamilton (Murray et al., 1996b) described as 'a socially deprived [district in] Lanarkshire, Scotland'. Some users there were seen by a community mental health team, while others were not, presumably being seen by a combination of mental outpatients and networking professionals, similar to the Malta's pilot area. Levels of psychosis were similar, but side effects and 'anxiety and depression' were less commonly detected in Malta. Physical health problems in Malta tended to be frequently recorded and classified as 'persisting despite intervention'. But this may have reflected an instrumental difference: details of medical treatment were not available so that no assessment could be made of it beyond the observation of whether the medical problem persisted or not.

Rough estimates of incidence of problems and needs for Malta and the pilot area are given in Table 8.3. 3: Number of Needs Calling for Intervention per Client and Table 8.3. 26: Needed Interventions by a sample of 13 clients, with rough and ready estimates for the pilot area and for Malta (see also Table 8.3. 3: Number of Needs Calling for Intervention per Client, giving global figures for Pilot Area and Malta). The latter roughly predict the incidence of need if services like the pilot area's were extended to the whole of Malta. If numerical predictions on the basis of a sample of 13 are rough, the 'content' of the need, or the intervention needed to alleviate it will vary even more, but the figures are felt to have an important value for planners.

FINDINGS ABOUT NEEDS, MET AND UNMET

	Detected Problems	Cardinal Problem	Need for Intervention	Intervention Pending	Problem Despite Interventions
Physical Health	7	7	2		5
Domestic Skills	8	2	2		
Social Life	8	2	1	1	
Anxiety or Depression	3	2	1	1	
Work	11	1	1		
Transport and Amenities	6	1	1		
Finance and Welfare	2	1	1		
Literacy	2	1	1		
Hygiene and Dressing	1	1	1		
Self Harm or Violence	1	1	1		
Psychosis	3	2		2	
Side Effects	4	0			
Socially Embarrassing Behaviour	1	0			
TOTAL	57	29	12	4	5

Table 8.3. 23: Problems and Needs, in descending order of frequency, by Area of Functioning

	Cardinal Problem			Need for Intervention		
	Hamilton over 71 clients, actual	Hamilton over 13 clients, expected	Malta over 13 clients, actual	Hamilton over 71 clients, actual	Hamilton over 13 clients, expected	Malta over 13 clients, actual
Domestic Skills	13	2.3	2	5	0.9	2
Finance and Welfare	5	0.9	1	0	0	1
Transport and Amenities	4	0.7	1	3	0.5	1
Literacy	2	0.4	1	2	0.4	1
Work	14	2.5	1	9	1.6	1
Social Life	31	5.6	2	20	3.6	1
Hygiene and Dressing	6	1.8	1	0	0	1
ALL THE ABOVE	146	27.2	22	110	20	21
Accommodation	n/a	n/a	0	n/a	n/a	0

Table 8.3. 24: Comparison, Hamilton x Malta Pilot Area: Social Needs

FINDINGS ABOUT NEEDS, MET AND UNMET

	Cardinal Problem			Need for Intervention		
	Hamilton over 71 clients, actual	Hamilton over 13 clients, expected	Malta over 13 clients, actual	Hamilton over 71 clients, actual	Hamilton over 13 clients, expected	Malta over 13 clients, actual
Psychosis	14	2.5	2	8	1.4	0
Side Effects	29	5.2	0	8	1.4	0
Anxiety or Depression	27	5.0	2	16	2.9	1
Self Harm or Violence	7	1.3	1	5	.9	1
Organic Disorder	3	0.5	0	1	.2	0
Physical Health	13	2.5	7	3	.5	2
Challenging Behaviour	3	0.5	0	1	.2	0
Socially Embarrassing Behaviour	0	0	0	0	0	0
ALL THE ABOVE	167	30.5	25	113	20.5	17

Table 8.3. 25: Comparison, Hamilton x Malta Pilot Area: Clinical Needs

AREA OF FUNCTIONING INTERVENTION NEEDED

A) SOCIAL

Domestic Skills	2 needing Remedial Training
Finance and Welfare	1 needing Remedial Training
Hygiene and Dressing	1 needing Remedial Training
Literacy	1 needing Remedial Training
Social Life	1 needing Engaging in Community Social Activity 1 needing Structured Day-time Activity
Transport and Amenities	1 needing Remedial Training
Work	1 needing Work Assessment

B) CLINICAL

Psychosis	1 needing Psychiatric Assessment 1 needing Support and Reassurance
Anxiety or Depression	1 needing Psychological Treatment 1 needing Support
Self Harm or Violence	1 needing Psychological Treatment
Physical Health	1 needing Coping Advice (Carer) 1 needing Specialist Assessment

NB: Seeing that number needing long term care is estimated as 80 for pilot area, a very rough estimate would predict around 6 needs for the area for each one found in the sample. Similarly, for the whole of Malta and Gozo (estimated persons needing long-term care = 870) a very rough and ready prediction can be made of about 60-70 needs for every need shown in the above table. Of course, the actual mix of interventions will vary considerably from that of the sample, much more than the number would.

Table 8.3. 26: Needed Interventions by a sample of 13 clients, with rough and ready estimates for the pilot area and for Malta (see also Table 8.3. 3: Number of Needs Calling for Intervention per Client, giving global figures for Pilot Area and Malta)

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Chapter 8 (III)

Types and Extent of Mental Health Long-term Care Needs in Malta's Community: the Findings

PART III – Pilot Area Service Use

8.4.1 Introduction

8iii. 1 -Table 8.4.2. 1: Service contacts at the pilot area, month by month (figures from April 1999 cover only part of the contacts)¹ gives a good, scene-setting, introduction. It gives the evolving number of contacts per month, records the dates of the beginning and end of the studied period. At the same time, it gives an idea of the volume of work involved in the keeping and maintaining of records, as well as in inputting and analysing them. The full set of Section 8.4 Tables is presented on the accompanying CD-ROM.

¹ Full set of the tables marked '8III', including additional ones not appearing in this chapter, can be found on 'Tables 4' on accompanying CD-ROM.

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		Month of contact												Total
		January	February	March	April	May	June	July	August	September	October	November	December	
Year of contact	1995.00						8	32	26	36	58	30	42	234
	1996.00	70	60	66	84	46	50	50	46	70	56	52	58	708
	1997.00	76	80	78	84	96	60	72	82	88	60	64	62	902
	1998.00	90	66	82	66	54	86	62	64	46	58	58	60	792
	1999.00	54	60	58	46	32	16	22	10	2				300
Total		290	266	284	280	228	220	238	228	242	232	204	222	2934

8iii. 1 -Table 8.4.2. 1: Service contacts at the pilot area, month by month (figures from April 1999 cover only part of the contacts)

8.4.2 Populations and samples

Table 8.4.2. 2: The numbers of the three populations studied: Users, Episodes, Contacts, also gives the most crucial numbers. The almost 3000 contacts made in four years (over five calendar years) were for the benefit of a little more than 450 users. Their contacts can be grouped into a little less than 900 episodes. As will be further clarified below, a 'care episode' was taken to have closed whenever a whole calendar quarter (one that start in January, April, July or October) passed without showing any contact records.

	Users	458
	Episodes	887
	Mean number of contacts per episode	3.63
	Contacts	2946

8iii. 2 -Table 8.4.2. 2: The numbers of the three populations studied: Users, Episodes, Contacts

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A careful stratified random sampling process took place. Contact sheet information was inputted for 230, or half, of the 458 users. In the contact analysis as such, no diagnostic or long-term need information was inputted. But such information was however inputted for the user-episode analysis, though on a sub-sample basis. Time constraints limited both the amount of information recorded, and that inputted. Special meetings had to be made with consultants and their teams to supply information on diagnosis and on the question, central to this enquiry, of whether the client needed long-term care. Table 8.4.2. 3, 'The sample taken for client-episode information (figures given here are for users, not their care episodes), divided into sub-samples by the type of user information compiled', gives the size of the sample and sub-samples involved. Sample strata of users with known long-term needs were deliberately given a higher level of representation. While these were a smaller proportion of the population, the need for information about them for the purpose of this enquiry was greater. Different weighting was assigned to different strata to reflect such differences.

79 users, or 17% of the 458 are estimated to have long-term care needs (see Table 8.4.2.5). Users with long-term care needs were defined as persons whose social functioning, mainly in terms of their family and job roles, were severely impaired so that, even between episodes of acute illness, they still needed psychosocial team support. Where attendance at mental outpatients was adequate for their needs, these were given a different classification. Persons needing long-term care increased by one third in a space of 4 years, suggesting either that the service was more 'popular' than the hospital MOP it replaced, or that detection improved with time.

Very shortly after the start of the pilot area, a second consultant psychiatrist (with his registrar and temporary junior doctors) started holding his weekly mental outpatients clinic. The social workers, occupational therapist, clinic nurses and psychologist supported both firms. The caseload of the 'older' consultant's team or firm had already the lion's share of persons needing long-term care, while the newer had a larger proportion of persons not so classified.

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		Sex		Name of consultant		Total
		Male	Female	Newer Firm	Older Firm	
Locality	Qormi	88	191	110	169	279
	Siggiewi	21	28	10	39	49
	Zebbug	43	64	51	56	107
	Other	3	19		22	22
Total		155	302	171	286	457
Requiring Long Term Care in 1996	No	122	277	162	237	399
	Yes	33	26	9	50	59
Total		155	303	171	287	458
Requiring Long-Term Care in 1999-2000	No answer		28		28	28
	Long-term MOP Care adequate	9	22	16	15	31
	Not requiring Long-term care	104	216	144	176	320
	Require Long-term Psycho-social care	42	37	11	68	79
Total		155	303	171	287	458

8iii. 1 -Table 8.4.2. 5: The User Population by locality and needs for long-term care in 1996 and 1999-2000

Service Use or Penetration Figures

About twice as many women as men attended the health centre services (Table 8.4.2.6). The difference between the sexes is greatest for diagnoses that are less often associated with chronic impairment. The most striking differences are for neurotic conditions and, less dramatically, for non-psychotic affective disorders. The female majority is very small for schizophrenic and allied conditions. Table 8.4.2. 7: The User Population by main diagnosis and need for long-term care in 1999-2000 confirms that there are many more sufferers from the latter class of conditions among those requiring long-term care (38% of them) than there are from among persons suffering from neurosis (10%). Meanwhile a fifth suffer from affective disorder (psychotic being almost twice as common as non-psychotic).

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Main Diagnosis * Sex Crosstabulation

Count

		Sex		Total
		Male	Female	
Main Diagnosis	Organic		11	11
	Psychoactive substance use	11	3	14
	Schiz., schizotypal, delusional	31	36	67
	Neurotic, etc	64	160	224
	Adult personality disorder	6	13	19
	Mental retardation	4	2	6
	Disorder of psychological development	1		1
	Affective disorder - Psychotic	9	23	32
	Affective disorder - Non-psychotic	30	53	83
Total		156	301	457

8iii. 4 -Table 8.4.2. 6: The User Population by diagnosis and by sex

		Requiring Long-Term Care in 1999-2000				Total
		Not requiring Long-term care	Long-term MOP Care adequate	Requires Long-term Psycho-social care	No answer	Cases
		Col %	Col %	Col %	Col %	
Main Diagnosis	Organic	2.0%	8.2%	3.2%		11
	Psychoactive substance use	2.5%		7.6%		14
	Schiz., schizotypal, delusional	10.3%	13.1%	38.0%		67
	Neurotic, etc	59.1%	36.1%	10.1%	58.4%	224
	Adult personality disorder	2.0%	6.6%	13.3%		19
	Mental retardation		6.6%	5.1%		6
	Disorder of psychological development			1.3%		1
	Affective disorder - Psychotic	4.9%	14.8%	13.9%	3.5%	32
	Affective disorder - Non-psychotic	19.2%	14.8%	7.6%	38.1%	83
Total		100.0%	100.0%	100.0%	100.0%	457

8iii. 5 -Table 8.4.2. 7: The User Population by main diagnosis and need for long-term care in 1999-2000

We now compare the rate of service use at specialist level encountered in the pilot area with recognised international figures. In their classic study (1992), Goldberg and Huxley created a Remodelling Services for New Contexts

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benchmark for international evaluations of service penetration at primary, specialist and hospital care levels. As regards use of specialist service, Goldberg and Huxley put the benchmark at 20.84 users per year per 1000 population (p. 4), but added that comparative studies show up to fourfold inter-country variations, which strongly relativises the value of our penetration figures. Table 8.4.2.8: Expected service use on basis of international figures and assumption that all persons exhibiting morbidity use the service - by locality finds that this would mean that 614 users per year would be expected to use the Qormi specialist services. Table 8.4.2. 10: Calculating mean population of users for a one-year period shows that only 42% of the users expected on this bases were be users of these services.

Main Diagnosis	<u>'Best available estimate' ill persons</u> (Goldberg & Huxley)		<u>Qormi Health Centre</u> <u>users</u>		<u>Qormi HC</u> <u>Service</u> <u>Penetra-</u> <u>tion</u>
	<u>per 1000</u> <u>population</u> <u>per year:</u>	<u>in % of total</u> <u>ill persons</u>	<u>per 1000</u> <u>population</u> <u>per year:</u>	<u>in % of total</u> <u>service</u> <u>users</u>	<u>(users/est-</u> <u>imated ill</u> <u>persons)</u>
ALL DIAGNOSES	20.84	100.00%	8.83	100.00%	42%
Organic	2.75	13.20%	0.08	.7%	3%
Psychoactive substance use	1.37	6.60%	0.35	4.0%	26%
Schiz., schizotypal, delusional	4.08	19.60%	1.53	17.4%	38%
Neurotic, etc	7.81	37.40%	5.66	64.3%	72%
Adult personality disorder	1.62	7.80%	0.42	4.6%	26%
Adjustment & other diagnosis	1.74	8.40%	0.12	1.4%	7%
Affective disorder - Psychotic	1.47	7.00%	0.67	7.6%	46%

Table 8III.6- 8.4.2. 1: Calculating Qormi Health Centre Service Penetration Rate at Specialist Level by Diagnosis (Best, though debatable, estimate: Goldberg & Huxley (1992), p.47)

Table 8iii.6-8.4.2. 9, Calculating Qormi Health Use Figures by Diagnosis, shows that the level of use or service penetration varies strongly by diagnosis, on the basis of the benchmark offered by Goldberg and Huxley.

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Evaluation of Service Use or Penetration Figures

The finding that about twice as many women as men use the services can raise important questions. If the rate of use by women in need were twice that of men, a very serious gender equality and access problem would arise. One hypothesis would be that, since the employment rate of men in Malta is much higher than that of women, and since mental outpatient, day centre and even social worker home visits, barring emergencies, take place only between set times within the 8.00 a.m. - 5 p.m. range, women have much easier access. This would mean that employed persons often would have a more restricted choice, having to either do without the service or have recourse to private psychiatrists' clinics. Who ends up being better off depends on a comparison of private and state psychiatric clinics and community services. It would also have important implications on cost-benefit and cost-effectiveness if the employed get a service that is not of the same level as that of the unemployed. This would seriously weaken claims of cost-benefit, and especially of cost-effectiveness, often used to defend the services.

However, outnumbering of men by women was found to be quite common in a review of studies by Goldberg and Huxley (p. 18), which gave a 1.67:1 as an overall ratio. In that review, studies in Mediterranean Spain and Greece show ratios exceeding 2.5:1, while some US sites and a London site show similar figures to Malta. However, this does not exclude that there may be severe 'socially' determined access problems or culturally determined differential use issues. We shall return to the possible force of cultural and access differences in Malta when we compare service use among the different localities. However, one can note, that there is evidence simultaneously (p. 35) that greater female morbidity figures correspond to commoner actual maladjustment problems *and* that women have a higher capacity to detect morbidity in themselves, and to remember its occurrence from the past.

Differences in penetration rates by diagnosis require some discussion. There were several projects to measure morbidity rates in the Maltese population as part of the mental health reform, but none of them seems to have found the required resources. For the comparisons in Table 8.4.2.9 we take as benchmark the Salford Case Register, presumably selected by Goldberg and Huxley for the high level of its coverage. As we said, morbidity varies by

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country, especially in non-psychotic diagnoses. However, the coverage rates can be taken as indicative. It is remarkable that barely more than a third of persons suffering from schizophrenia or paranoia (38%) use the services, while the highest coverage seems to be among persons suffering from neurosis (56%), with psychotic affective disorders rating second (46%). What happens to the 58% overall who do not use these services? It would be interesting to know how many of these end up at the wrong 'level' of the Golberg and Huxley model: receiving no treatment, receiving primary care without or with detected psychiatric morbidity, or are unnecessarily in hospital. Further research may reveal whether the relatively high rate of use for neurosis and affective disorders reflects a high satisfaction with the service or other explanations. These could include the absence of adequate care at primary level or possibly the repetition of acute episodes even in cases where their prevention would have been achieved by services that are common in the community-based services of countries with moderately better services. One cannot, however, exclude that the main reason might be lower local morbidity.

8.4.3 Use of Services over the first five years, with date, service, gender and locality comparisons

Services at the health centre grew steadily to a peak in 1997, dropping by 12% in 1998. Figures for 1999 are partial, and not a reflection of the year's volume (Table 8.4.3.1, 'Contacts by Year and by Locality', and Figure 8.4.1, 'Contacts by quarter'). The first quarter of each year was something of a peak, with January and March being the months of most frequent service.

Table 8.4.3. 2 shows 'Which health worker seen (in descending order of service volume), by year (often more than one mention per contact)'. Community psychiatric nurses visited the health centre as they attended the psychiatrist and his firm as each held its weekly mental outpatients clinic. They got to know users, got to know them individually and gave them support and guidance, gave depot injections and participated in the firm's discussion. This participation was limited by their having to do receptionist duties to users, while home visits by them could not take place because requests for the provision of transport were not accepted.

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The CPN was seen in 82% of the recorded contacts, the psychiatrist in 55%, the Registrar or Senior House Officer, 36% (rising to a higher frequency than the psychiatrist in 1998 and 1999). Psychiatric social workers were seen in 27% of the contacts, but their attendance dropped to more than a third of what it was in 1998, probably reflecting the decision to refer the social work role in the specialist team to the generic or 'primary team' social workers.

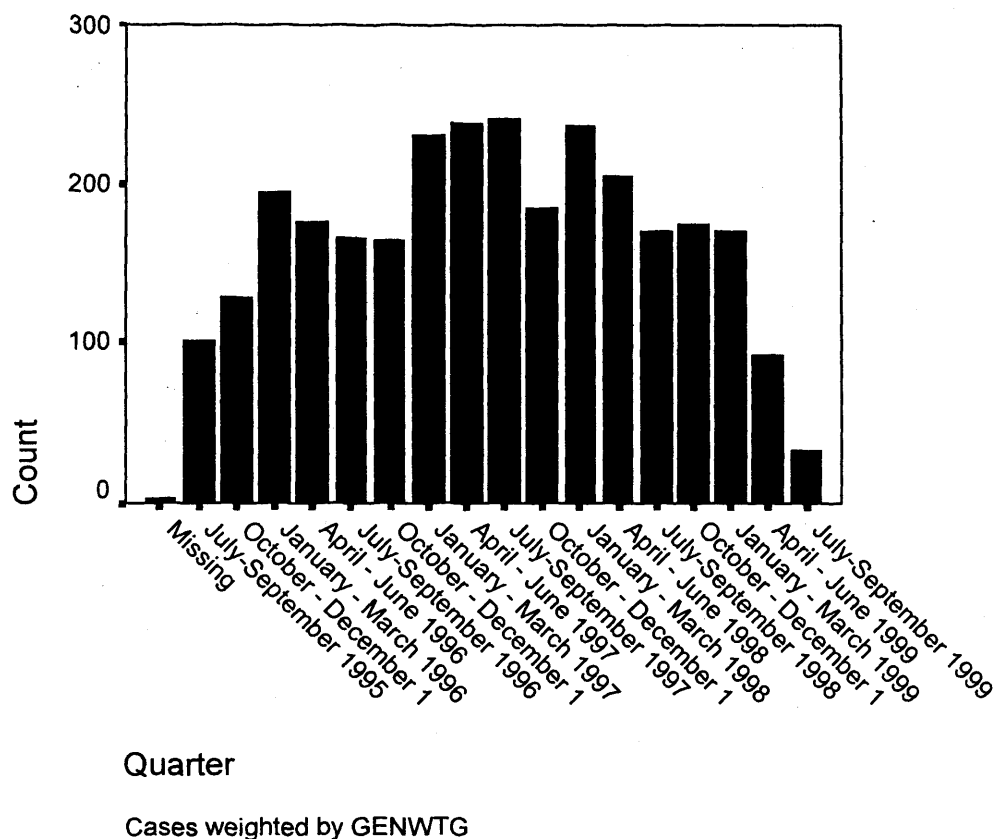


Figure 8.4. 1: Contacts by quarter

Comparing the Localities and the Sexes on Service Penetration and Service Use

We have seen that, on average, 8.83 per 1000 of the pilot area population use the service annually, or 42% of the numbers expected by the Goldberg and Huxley figures. In Table 8.4.3. 3: Contacts by year by locality: absolute numbers and per thousand population, we compare the three localities on average annual number of users. This is differently calculated from Goldberg and Huxley's, but has the internal consistency of definition to validly base our Remodelling Services for New Contexts

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comparisons. The proportion of the Qormi general population that uses the services is more than twice that of Siggiewi, with Zebbug lying quite closer to Siggiewi than to Qormi. As for contacts, differences in the same direction are exacerbated by the proneness of Qormi to have more contacts a year than Zebbugin, who in turn outstrip the Siggiewi on the same score (Table 8.4.3. 4: Comparing localities for average number of contacts per client per year). In fact, the shifting of the outpatients' clinic from St Luke's general hospital, and its increase in interdisciplinary staffing failed to raise the proportion of users for Zebbug. It resulted in a lowering by about 50% for Siggiewi, but raised the figure by nearly 25% for Qormi. This is evidenced by Table 8.4.3. 5: Penetration by locality, based on Populations 16 and over (derived from 1995 Census figures), carrying comparisons with previous use of St Luke's outpatients clinic and of Mount Carmel Hospital on an in-patient basis. Though we have no comparative community morbidity figures, the same table shows that hospitalisation figures on an in-patient basis show no remarkable difference in illness rates. Difference of use is very probably not strongly related to differences in illness rates.

Women users overall were very nearly twice the men, but their ratio to men was only about 6:4 at Zebbug and Siggiewi (Table 8.4.3. 6: Comparing proportions of Women and Men service users, by locality). At Qormi they reached nearly 7:3. The higher service use at Qormi seems to be largely attributable to its female population.

Contact Duration

74% of contacts lasted less than 15 minutes. Only 8 contacts out of 1334 were reported to have lasted more than 1 hour. 356 appointments lasted between 15 minutes and 1 hour, an indication of deeper involvement. Table 8.4.3.7 shows that appointments with psychologists were oftenest long (88.6% of the time), almost double of that of the generic social workers (46.4%), while psychiatric social workers were second lowest at 16.7%, lowest being occupational therapists (15.4% of the time). In contrast, the primary team doctor ('GP') and the primary team nurse (belonging to MMDNA, an NGO conducting generic home nursing) have longer appointments one half and two thirds of the time respectively.

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The explanation seems to be in that these records were very fully kept as regards 'mental outpatients clinic' activities as well as for the psychologist's and generic social worker's activities allied to it. Health centre GPs only kept such records exceptionally and that, in fact, only during the first year and a half of the pilot area. Psychiatric social workers from the hospital reached a peak in 1997, only to drop severely after that. But even while they gave copious service, this was mostly by way of participating in the rather short contacts typical of the majority of MOP contacts. Records elsewhere show that the 'generic social workers' had many more open cases and contacts than recorded here. Generic social workers were originally defined as part of the primary team, then 'filled in' for the specialist social workers when such personnel were not forthcoming.

			> 9 contacts in 4 years?		Total
			No - Lighter Use Level	Yes - Heavier Use	
Duration of contact	< 15 min	Col %	63.6%	79.1%	73.3%
	< 1 hr	Col %	35.6%	20.4%	26.1%
	< 3 hr	Col %	.8%	.5%	.6%
Total	Col %		100.0%	100.0%	100.0%
	Count		500	834	1334

8iii. 7 -Table 8.4.3. 9: Duration of contact: comparing 'lighter' with 'heavier' users

Since we are interested more especially in long-term users, Table 8.4.3. 9: Duration of contact: comparing 'lighter' with 'heavier' users proves interesting. Lighter users have longer contacts nearly twice the time (36 as against 20%) than happens to the heavier users. This raises the question of who tends to be seen (Table 8.4.3.10) and what service tends to be given (8.4.3.9) during these longer contacts. The figures confirm that what we have is mostly records of MOP activities, wherein contacts longer than 15 minutes took place at the rate of about 0.9 of an appointment per MOP session. The longest contacts with long-term users must have been those of the generic social workers (including home visits and community contacts), who did not share common care plans with the MOP team, and the OT day program. The best indication of service of these is, however, not through these utilisation records, but through the findings from the small Autoneed sample. Finally, 'Mixed Tables of Use over the Pilot Area Years' gives a picture of the evolution of the various kinds and categories of service over the years.

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8.4.4 Care Episode and Service Use Patterns

The aim of this part is to study the pattern of service use by various categories of users. Special attention will be given to the question, “What type of service has been given to users identified as needing long term care, by reason of their continuing impairment between acute episodes of illness?”

A look at Table 8iii. 1- Table 8.4.4. 1: General distribution of episode characteristics introduces the variables through which service given through the Qormi Mental Outpatients Clinic has been measured. The appendices that give the figures are indicated in .

Number of Appointments (Bracketed)	1 Appointment	Col %	43.8%
	2-10 Appointments	Col %	49.5%
	11-39 Appointments	Col %	6.7%
Total	Count		812
Attendance Duration, Bracketed	Up to 6 months	Col %	71.1%
	6 months to 2 years	Col %	25.9%
	2 to 4 years	Col %	3.0%
Total	Count		812
Non-Attendance Duration (Bracketed)	Up to 6 months	Col %	57.1%
	6 months to 2 years	Col %	27.9%
	2 to 4 years	Col %	15.0%
Total	Count		774

Table 8iii. 1- Table 8.4.4. 1: General distribution of episode characteristics

The utilisation figures compiled in the pilot area did not look directly at any records of the opening and closing of cases. As proxy to this, the concept of *care episode* has been ‘constructed’, being defined as a continuous series of quarters during which contacts have been recorded. In other words, a care episode has been taken to start during any quarter during which contact has been recorded, and end once there is a quarter (that is, a period of three calendar months starting in January, April, July or October) in which no contacts have been recorded.

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<u>8.4.4:Service Use Patterns</u>	<u>Tables 3: Chapter 8 Appendix II - Boxplots Of Use Patterns</u>	<u>Tables 4: Tables covering all of Chapter 8III</u>	<u>Tables 5: Chapter 8 Appendix III: User Categories compared</u>	<u>Tables 6: Chapter 8 Appendix IV: Light and Heavy Users</u>
Care Episodes: concept, characteristics, use	page 1	*		
Comparative use by main user characteristics: sex, locality, firm, diagnosis	page 2	*		
Comparative use by short and long-term care needs	page 4	*	page 1	
Likelihood of further episodes:who are the ones who come again?	page 7	*	page 3	
'Light and heavy service users'	page 9	*	page 4	page 1 onwards

*Follows sequence in chapter headings

Table 8iii. 2: 8iii. 4-Table 8.4.4. 3 : Correspondence between chapter sub-sections and parts from relevant CD-ROM Appendices

The main set of descriptors are what we will call *care episode characteristics*, illustrated in Table 8iii. 1- Table 8.4.4. 1: General distribution of episode characteristics for the population. Each such 'episode' is, then, described, in terms of the *number of contacts* (or appointments), its *duration* (in quarters or parts thereof) and, equally interestingly, its *non-attendance duration*, that is, the number of quarters or parts thereof during which no further contacts were recorded. These, derived from contact information, were in turn re-inputted in terms of the again newly derived variables in Table 8iii. 4 onwards. However, because of limits met in the use of care episode, the construct of *bout of service* was also used. In the same way that episode was delineated in terms of quarter, 'bout of service' was defined in terms of calendar year. A new bout of service was started only *when service was resumed after one or more calendar years in which no service was recorded*.

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			Does patient require long-term care?			
			Requiring Long-term Psychosocial Care		Not requiring Long-term Care	
			Count	Mean	Count	Mean
Number of Care Episodes (bracketed)	1	Mean Number of appointments per episode	40	4.53	65	2.84
		Total service duration in quarters/parts thereof	40	2.44	65	2.03
		Total number of appointments	40	4.53	65	2.84
	2	Mean Number of appointments per episode	6	5.83	31	3.74
		Total service duration in quarters/parts thereof	6	6.33	31	4.90
		Total number of appointments	6	11.67	31	7.48
	3-5	Mean Number of appointments per episode	7	6.08	19	2.32
		Total service duration in quarters/parts thereof	7	9.57	19	5.68
		Total number of appointments	7	19.43	19	7.56

Table 8iii. 3: Use pattern by long-term care need during first and subsequent episodes

Do users needing long term care receive it?

This enquiry centres mostly on long-term care. The pilot area consultants had identified the users needing long-term care, by reason of residual impairment in their main life roles even between acute episodes. The most central question in the rest of this chapter is therefore how far these got the long-term care they needed, and what pattern of service they received. Table 8iii. 4 discloses that persons with long-term needs got twice as many mean contacts over the 4 years (10 as opposed to 5) and were seen about once every 2 months while episodes lasted, as opposed to once every 2.3 months for those not needing long-term care. But total service duration over four years was about five quarters, not significantly more than those needing short-term care, and remaining without contact for about two-thirds of the time (calculated in whole calendar quarters).

	Does patient require long-term care?	N	Mean	Std. Deviation	t	Sig. (2-tailed)
Total number of appointments	Requiring Long-term Psychosocial Care	28	9.79	12.24	2.063	.048
	Not requiring Long-term Care	111	4.90	5.30		
Total service duration in quarters/parts thereof	Requiring Long-term Psychosocial Care	29	4.97	4.36	1.760	NS
	Not requiring Long-term Care	111	3.46	2.89		
Average appointments per quarter during episode	Requiring Long-term Psychosocial Care	50	1.5067	.7447	2.003	.049
	Not requiring Long-term Care	188	1.2816	.5369		
Number of Care Episodes	Requiring Long-term Psychosocial Care	53	1.43	.89	-1.506	NS
	Not requiring Long-term Care	115	1.66	.92		

Table 8iii. 4: Use pattern by long-term need

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We next try to find out whether length and general pattern of service depended on other factors than long-term care need. Table 8iii. 1 gives the main conclusions in a nutshell. Women and men, and residents of Qormi, Zebbug and Siggiewi did not differ significantly among themselves in the pattern of service received. However, the factor that made most difference, in all but the speed or frequency of contacts, was the psychiatric firm by which they were seen. Table 8iii. 3 onwards spell out the quantities leading to these conclusions.

	<u>Long-term</u> <u>Care Need</u>	<u>Main Two</u> <u>Diagnostic</u> <u>Groupings</u>	<u>Sex</u>	<u>Psychiatric</u> <u>Firm</u>	<u>Locality</u>
Total number of appointments	.048	.037	NS	.006	NS
Total service duration in quarters/parts thereof	NS	.041	NS	.001	NS
Average appointments per quarter during episode	.049	NS	NS	NS	NS
Number of Care Episodes	NS	NS	NS	.036	NS

Table 8iii. 1: Synoptic view of links between user factors and use characteristics

	<u>Main two diagnostic groupings</u>	<u>N</u>	<u>Mean</u>	<u>Std.</u> <u>Deviation</u>	<u>t</u>	<u>Sig. (2-</u> <u>tailed)</u>
Total number of appointments	Schizophrenic, schizoid, delusional	14	11.64	9.74	2.294	.037
	Non-psychotic affective disorder or Neurotic	77	5.49	5.60		
Total service duration in quarters/parts thereof	Schizophrenic, schizoid, delusional	16	6.25	4.27	2.203	.041
	Non-psychotic affective disorder or Neurotic	76	3.78	3.06		
Average appointments per quarter during episode	Schizophrenic, schizoid, delusional	37	1.3880	.5510	.680	NS
	Non-psychotic affective disorder or Neurotic	126	1.3241	.4874		
Number of Care Episodes	Schizophrenic, schizoid, delusional	28	1.79	1.29	.690	NS
	Non-psychotic affective disorder or Neurotic	81	1.60	.88		

Table 8iii. 2: Use pattern contrasting the two main diagnostic groupings

	<u>Sex of Client</u>	<u>N</u>	<u>Mean</u>	<u>Std.</u> <u>Deviation</u>	<u>t</u>	<u>Sig. (2-</u> <u>tailed)</u>
Total number of appointments	Male	88	7.39	9.69	1.401	NS
	Female	137	5.79	5.67		
Total service duration in quarters/parts thereof	Male	89	4.22	3.80	.658	NS
	Female	138	3.91	3.27		
Average appointments per quarter during episode	Male	154	1.3923	.6139	.409	NS
	Female	256	1.3658	.6483		
Number of Care Episodes	Male	100	1.65	1.02	-.652	NS
	Female	160	1.74	1.07		

Table 8iii. 3: Use pattern by sex

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	Which Psychiatric Firm?	N	Mean	Std. Deviation	t	Sig. (2-tailed)
Total number of appointments	Newer Firm	87	4.79	5.91	-2.794	.006
	Older Firm	138	7.43	8.24		
Total service duration in quarters/parts thereof	Newer Firm	87	3.11	2.69	-3.462	.001
	Older Firm	140	4.61	3.79		
Average appointments per quarter during episode	Newer Firm	137	1.3428	.5891	-.743	NS
	Older Firm	273	1.3923	.6571		
Number of Care Episodes	Newer Firm	90	1.54	.78	-2.110	.036
	Older Firm	167	1.80	1.17		

Table 8iii. 8: Use pattern by psychiatric firm

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Sig.
						Lower Bound	Upper Bound	
Total number of appointments	Qormi	137	6.47	7.56	.65	5.20	7.75	NS
	Siggiewi	24	6.88	7.26	1.48	3.81	9.94	
	Zebbug	55	6.44	7.97	1.07	4.28	8.59	
	Total	216	6.51	7.60	.52	5.49	7.53	
Total service duration in quarters/parts thereof	Qormi	138	4.07	3.48	.30	3.49	4.66	NS
	Siggiewi	24	4.38	3.66	.75	2.83	5.92	
	Zebbug	56	4.05	3.61	.48	3.09	5.02	
	Total	218	4.10	3.52	.24	3.63	4.57	
Average appointments per quarter during episodes	Qormi	248	1.3885	.6228	3.955E-02	1.3106	1.4664	NS
	Siggiewi	41	1.4106	.5893	9.204E-02	1.2246	1.5966	
	Zebbug	106	1.3290	.6519	6.332E-02	1.2035	1.4546	
	Total	395	1.3748	.6265	3.152E-02	1.3129	1.4368	
Number of Care Episodes	Qormi	152	1.72	1.07	8.67E-02	1.55	1.89	NS
	Siggiewi	30	1.57	.94	.17	1.22	1.92	
	Zebbug	68	1.74	1.05	.13	1.48	1.99	
	Total	250	1.71	1.04	6.61E-02	1.58	1.84	

Table 8iii. 9: Use pattern by locality

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Total number of appointments	Between Groups	3.669	2	1.834	.031	.969
	Within Groups	12424.313	213	58.330		
	Total	12427.981	215			
Average appointments per quarter during episode	Between Groups	.321	2	.161	.408	.665
	Within Groups	154.326	392	.394		
	Total	154.647	394			
Total service duration in quarters/parts thereof	Between Groups	2.040	2	1.020	.082	.921
	Within Groups	2679.740	215	12.464		
	Total	2681.780	217			

Table 8iii. 10; ANOVA for use pattern by locality

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Diagnosis, on the other hand, has been shown through Table 8iii. 6 to be a significant predictor of totals for both appointments and service duration. Table 8iii. 6 focuses on the two diagnostic groups that have been found through post-hoc tests to result in the greatest difference in service pattern, namely schizophrenic, schizoid, delusional as contrasted with non-psychotic affective disorder and neurotic combined in view of service pattern similarity. The latter category got half the former's total for both appointments and duration. Contrasts with other diagnoses were not so clear cut.

			Does patient require long-term care?			
			Requiring Long-term Psychosocial Care		Not requiring Long-term Care	
			Count	Mean	Count	Mean
Principal Diagnoses	Schiz., schizotypal, delusional	Total number of appointments	35	12.71	14	11.00
		Total service duration in quarters/parts thereof	35	6.88	14	5.43
		Average appointments per quarter during episode	35	1.44	14	1.33
		Number of Care Episodes	35	1.75	14	2.00
	Neurotic, etc	Total number of appointments	9	6.71	79	6.00
		Total service duration in quarters/parts thereof	9	3.57	79	4.14
		Average appointments per quarter during episode	9	1.39	79	1.34
		Number of Care Episodes	9	1.13	79	1.76
	Affect dis Psychotic	Total number of appointments	6	4.50	8	5.25
		Total service duration in quarters/parts thereof	6	3.50	8	3.50
		Average appointments per quarter during episode	6	1.00	8	1.28
		Number of Care Episodes	6	1.17	8	2.00
	Affect dis Non-psychotic	Total number of appointments	6	5.00	22	4.14
		Total service duration in quarters/parts thereof	6	4.33	22	3.29
		Average appointments per quarter during episode	6	1.11	22	1.20
		Number of Care Episodes	6	1.50	22	1.57

Table 8iii. 11: Use pattern by long-term care need and by the four commonest diagnoses

However, when the main diagnoses are crossed with long-term care need, something curious happens. Within each diagnosis, the difference in service pattern between long- and short-term care need largely disappears (Table 8iii. 11: Use pattern by long-term care need and by Remodelling Services for New Contexts

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the four commonest diagnoses). Service pattern for persons with schizophrenia is hardly different whether they are in need of long- or short-term care, and the same applies to the three other most frequent diagnoses.

But then a look at Table 8iii. 12: Use pattern by long-term care need and by sex, locality, firm also shows that when split by sex, similarity between long- and short-term need patients fully applies for women, but shows the expected big difference to apply for men. Equally noticeable is the low service use of persons needing long-term care hailing from Zebbug. On the other hand, the difference in pattern between the newer and the older firm seems to be largely explicable by the fact that the older firm inherited all the previously known long-term cases. The newer firm got only a few, while serving almost as de-facto semi-specialised clinic for persons with reversible acute states.

Here we can summarise the general upshot of this section. First, a Mental Outpatients' Clinic is not the treatment of choice for long-term patients who have continuing needs even between acute episodes, whose more strikingly medical side such a clinic can largely tackle. Community Mental Health Teams do this better by regularly deploying social workers and other rehabilitation and therapeutic workers. But even the continuity of case management does not necessarily exclude gaps in contact from the case manager. However, during these gaps, a service of resources and supports is most often assured. It was beyond the present enquiry to directly assess the use of the support and rehabilitation facilities beyond Mental Outpatients. As a result, the gaps in continuity of care from Qormi's MOP clinic tell us less about what happens in the pilot area, and more on what does not happen outside it. In the rest of Malta and Gozo, the gaps between MOP episodes mean most often that no service is given. This reflects the gap in the service since specialised community-oriented teams have in no way generalised beyond the pilot area, even though the pilot scheme is more than six years old at the time of writing. The second reflection is related. The very small number of persons needing long-term care that were added in the pilot area during the period also reflects the slow speed of deinstitutionalisation. A third reflection is that Zebbug has an access or use problem, especially for its people needing long-term care. However, one can never be sure whether the absent are not attending private clinics, which are however monoprofessional, in

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some contrast with the pilot area services. The question of the use of private clinics arises as regards men, which is our fourth reflection. For women, service for long-term needs is distinctly longer than that for short-term needs. With men, 'long-term' is even longer and

			Does patient require long-term care?			
			Requiring Long-term Psychosocial Care		Not requiring Long-term Care	
			Count	Mean	Count	Mean
Sex of Client	Male	Total number of appointments	42	11.05	73	4.79
		Total service duration in quarters/parts thereof	42	5.25	73	3.30
		Average appointments per quarter during episode	42	1.59	73	1.28
		Number of Care Episodes	42	1.48	73	1.66
	Female	Total number of appointments	33	7.11	118	4.97
		Total service duration in quarters/parts thereof	33	4.33	118	3.56
		Average appointments per quarter during episode	33	1.36	118	1.28
		Number of Care Episodes	33	1.38	118	1.66
Patient locality	Qormi	Total number of appointments	43	11.83	117	5.50
		Total service duration in quarters/parts thereof	43	5.83	117	3.78
		Average appointments per quarter during episode	43	1.57	117	1.30
		Number of Care Episodes	43	1.59	117	1.67
	Siggiewi	Total number of appointments	8	16.00	24	4.53
		Total service duration in quarters/parts thereof	8	7.50	24	3.47
		Average appointments per quarter during episode	8	2.08	24	1.21
		Number of Care Episodes	8	1.33	24	1.60
	Zebbug	Total number of appointments	23	3.63	46	3.92
		Total service duration in quarters/parts thereof	23	2.67	46	2.83
		Average appointments per quarter during episode	23	1.14	46	1.28
		Number of Care Episodes	23	1.26	46	1.77
Which Psychiatric Firm?	Newer Firm	Total number of appointments	12	6.67	114	4.72
		Total service duration in quarters/parts thereof	12	3.44	114	3.20
		Average appointments per quarter during episode	12	1.44	114	1.31
		Number of Care Episodes	12	1.33	114	1.58
	Older Firm	Total number of appointments	63	11.26	77	5.19
		Total service duration in quarters/parts thereof	63	5.65	77	3.88
		Average appointments per quarter during episode	63	1.53	77	1.24
		Number of Care Episodes	63	1.45	77	1.79

Table 8iii. 12: Use pattern by long-term care need and by sex, locality, firm

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short-term even shorter and also less used than with women. No explanation is suggested why male long-term impaired get longer service. But the briefer and less common use of short-term needs service by men probably reflects more than a possibly less common morbidity but seems to be also substantially related to the attendance problems of employed persons, here mostly men.

	<u>More than 9 contacts in 4 years?</u>			<u>Is the difference between lighter and heavier significant (chi-square)?</u>	
	<u>No - Lighter Use Level</u>	<u>Yes - Heavier Use</u>	<u>Total</u>	<u>For Newer Firm</u>	<u>For Older Firm</u>
Service given - Assessment/Review	67.5%	64.9%	65.9%	(not significant)	(not significant)
Service given - Medication	43.2%	47.3%	45.7%	.012	(not significant)
Service given - Depot injection	2.8%	13.5%	9.4%	.000	.000
Service given - ECT	.7%	2.2%	1.6%	.024	.000
Service given - Counselling 1 to 1	.5%	.9%	.7%	(not significant)	(not significant)
Service given - Counselling to more than 1	.2%	.4%	.3%	(not significant)	(not significant)
Service given - Group work		.1%	.1%	(not significant)	(not significant)
Service given - Help with resources		.3%	.2%	.034	(not significant)
Service given - Hospital admission	.2%	.1%	.1%	(not significant)	(not significant)
Service given - Other		.1%	.1%	(not significant)	(not significant)
	1134	1802	2936		
Total	100.0%	100.0%	100.0%		

Table 8iii. 15-Table 8.4.4. 16: Differences between lighter and heavier users in the proportion of cited cases in which particular services were given.

FINDINGS ABOUT PILOT AREA SERVICE USE

A look at the linked appendices, guided by Table 8iii. 2: 8iii. 4-Table 8.4.4. 3 : Correspondence between chapter sub-sections and parts from relevant CD-ROM Appendices, affords a look at the distribution of various types of service, including the questions of who were those who had more than one episode, and the characteristics of light users and of heavy users. According to Table 8.4.4. 11: Profiles of users with various bracketed numbers of contacts.'(Tables 4 in CD-ROM Appendices), the median level of service is 1 contact for women and users suffering from substance abuse. It is 2-4 contacts for men, neurosis, and non-psychotic affective disorder and for each of the three localities. 'Heavier users' were significantly more prone to see the SHO or Registrar (nearly as often as they saw the psychiatrist) or, within the newer firm, to see the psychiatric social worker. Table 8iii. 13-Table 8.4.4. 16: Differences in which services used by between lighter and heavier users.', shows heavier users to be significantly more prone to receive depot injections (13.5 as opposed to 2.5%) and ECTs (2.2 as opposed to 0.7%).

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Chapter 9

Which Further Framework Specifications for the Maltese Context? - Matters of Synthesis

9.1.1 Introduction

What, then, would be a good form of service for the Maltese context? This chapter draws together the several strands of the enquiry, to propose ways in which mental health community care services can be adapted to the Maltese environment. It is not intended to give a blueprint, in which a plan is presented that goes into all the concrete details. But it will make suggestions, often broad, that one hopes that local planners and implementers would find useful.

In this chapter we spell out the practical 'lessons' we have learned and make as clear as possible the characteristics of the model of service that our analysis recommends. Precisely because we need to learn the right questions, we have to take an 'issues' approach, just as we did in Chapter 6 ('Which Model Components? - Matters of Congruence'),

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<u>Service Design Issues</u>	
<u>1. Preliminary Issues, mostly related to Framework and Cost</u>	
Issue 1.	What service delivery framework is to be used?
Issue 2.	What does good practice require?
Issue 3.	What has particular resource implications?
Issue 4.	What has mostly process and people implications?
<u>2. Issues mostly related Level U-1, the Inner User World : Responding to user need in openness to user-centred values</u>	
Issue 5.	How will the service be centred on the client's needs?
Issue 6.	What would a social or empowerment model require?
<u>3. Issues mostly related to Level U-2, the Wider User World – Family, Community and Civil Society: Sharing responsibility among state, family, civil society, neighbourhood</u>	
Issue 7.	What responsibility is to be undertaken and how shared?
<u>4. Issues mostly related to Level C, the Country-Context Level</u>	
Issue 8.	How will the service be located within the service's centralisation/ decentralisation and mixed economy structure?
<u>5. Issues mostly related to Level S, the Services Level</u>	
Issue 9.	How cater for different levels of vulnerability?
Issue 10.	At what times will the service be available?
Issue 11.	How is the service to be streamed?
Issue 12.	What span of clients will be targeted by the service?
<u>6. Issues mostly related to Level O, the Organisation Level</u>	
Issue 13.	How promote co-ordination?
Issue 14.	How promote efficacy?
Issue 15.	How promote change?

Table 9. 1: The Complete ARC List of Service Design Issues for Community Mental Health Service. Issues are classified by ARC level to which they '*mostly*' belong, since issues are typically more or less inter-level.

ARC, or Active Remodelling for Congruence, is intended for use in any country context. The working hypothesis for the extension of ARC to other contexts is that the levels would be more or less the same, as would their key dimensions, the core themes and the key organisational issues. These would be expected to be the more similar, the more similar is are

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country's context and its salient issues. The more different, on the other hand, the more the items of the ARC framework will require adaptations.

Table 9. 1: The Complete ARC List of Service Design Issues for Community Mental Health Service is the fruit of laborious interactive and reiterative work, involving to-ing and fro-ing between general conceptualisation and application to our present case study, and between system levels and issues for service design. It is hoped that the ARC Issues List is now streamlined enough to make it a tool to simplify adaptive model adoption in the field of community mental health services. It expands the list of issues tackled at least partly in Chapter 6. It shall now be used as basis to complete our recommendations for Malta.

1. Preliminary Issues, mostly related to Framework and Cost

Issue 1. What service delivery framework is to be used?

Issue 2. What does good practice require?

Issue 3. What has particular resource implications?

Issue 4. What has mostly process and people implications?

These issues have been extensively covered in Chapter 5 and, secondarily, in Chapter 6. A hybrid Service Delivery Framework was recommended, styled *flexible case management*, and described (section 5.6) as:

a judicious mix of (or ability to 'change gear' between) community-based and hospital-based care, networking and teamwork, narrow-targeted statutory responsibility and streaming according to vulnerability is introduced, in congruence with our basic aims and awareness of the relatively low level of our resources.

FURTHER SPECIFICATIONS - MATTERS OF SYNTHESIS

Applying 'flexible case management'

We saw that the full and unlimited application of case management carries certain hazards. The most radical interpretation was that case management in Britain should be scrapped. Presumably, that would mean returning to an alternative higher up the list, possibly Community Mental Health Teams (without 'case management responsibility') or even Mental Outpatients plus casework and networking. Possibly it simply meant "stop investing so much in case management, invest more in therapies, interventions and resources: we can only be agnostic about delivery frameworks, so let us not invest so much in them." Others interpreted the conclusions as showing that case management is delivering. It was thought out to remedy 'neglect in the community'. Now admissions are increasing. Since we do not have proper therapies and interventions in the community, more admissions mean more treatment and therefore the end of neglect. Therefore, case management should remain the cornerstone of mental health community care.

But when speaking about the context of Malta, we find that we do not have a system where case management is a statutory requirement that has been authoritatively extended to cover all persons in need of care 'above a certain level'. Rather, we have a country that at present has patchy casework and a pilot area that increased the intensity of such casework, operating in tandem with higher availability of a mental outpatients clinic with which it more or less networked.

We found delivery frameworks as such to be more or less neutral as to mental states and the enjoyment of social amenities, unless the model carried specific 'therapies and interventions' or higher staffing levels as an integral part of it (as happens with Assertive Community Treatment). This is very much in line with Huxley's discovery that case management tends to be most effective in the areas where it invests most input in terms of attention, explicit goal setting, and specific programs and resources.

FURTHER SPECIFICATIONS - MATTERS OF SYNTHESIS

One could argue that case management too has its own specific goals. Taking its strict definition, case management's own contribution is co-ordination and continuity. Case management *should* make things better because it makes sure that co-ordination and continuity of care overcome fragmentation. Max Marshall's review found out that case management in fact *was* better at 'keeping contact', but the effect size was rather small, requiring 14 extra patients for case management to have succeeded in keeping one in contact more than did CMHTs (Community Mental Health Teams).

What should an importing 'adopting adapter' make out of this finding? There seems to be little else to do than to look at the menu of six SDFs (Service Delivery Frameworks), and see how far to go up the list to find better fit, given resource limits. From a Maltese point of view, the finding seems to mean that CMHTs must have already achieved a pretty good level of continuity for case management not to improve much on them. Community mental health teams also, if they were centres of good practice, as tend to be the teams that accept to be studied in research, must also have had a continuing interdisciplinary care plan. They probably already had more or less applied important aspects of the Care Program Approach. But if what you have is, as in Malta, rather patchy co-ordination, you should go for improving it. There is no claim that MOP or hospital-based treatments have reached the same level of case retention as that reached by CMHTs and case management. So it is advisable to introduce 'reliability of follow up' by introducing at least CMHTs. What case management has that CMHT does not have is that what the latter is expected to do as a matter of ethics, the former must do on the basis of a statutory obligation that is fully recorded and audited. Max Marshall found little discernible improvement, and he attributed it, at least partly, to the top-heavy bureaucracy that case management entails, which must tend to offset the benefits that accrue from it.

Regarding Malta and other systems that are at a middle level of development, one tends to say:

- let us introduce the co-ordination and continuity, of which both CMHTs and case management were vehicles, and which we as yet have only patchily;

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- let us introduce an obligation that is built into the systems,
- but let us pitch the load of obligation and paperwork at a 'lighter' and more selective level
- let us be generally be parsimonious in the use of the more resource-intensive framework ingredients. Particularly, these are teamworking (use networking for the simpler cases), case management responsibility (limit the extension of this, otherwise the system will be overburdened) and sets of components from Assertive Community Treatment (narrowly target them, possibly to a section only of a team's caseload)
- let us vigorously encourage and facilitate the features that belong to good practice (see Issue 2 in Chapter 6) especially where it is more a matter of people and process implications than a matter of resources that we cannot afford.
- let us keep a balance between provision of case managers and resources: too much or too little of the 'delivery framework' as compared with what it delivers will reduce their joint effect.

Keeping it lean and flexible: limiting bureaucracy

Being at a lower level of development and in a smaller country one tends to have less regulation. A visiting group was studying the culture at the Maltese general hospital. One member of the team was taken ill – and a bed was arranged in a ward with little ado. The visitors wondered at flexibility that allowed this very temporary expedient to take place without having to go through the formalities of hospital admission. But in Malta we also tend to have a burden of complex regulation without the capacity to update them. This gives the very wide impression that all rules are to be taken with a pinch of salt. It is certainly up to the managers to give clear messages as to which regulations are enforced strictly and which softly. But under-regulation has implications that are just as bad as over-regulation. Under-regulation can mean that when there is abuse of power, as when authoritarian doctors or recalcitrant members of other professions obstruct co-ordination, their compliance will, in effect, be 'optional' rather than required.

If we stop at the level of 'just CMHTs' and no obligation in the line of the co-ordination and continuity of case management is introduced, there will be too little accountability for the effect, little more will materialise than what will emanate from individual spontaneity or conscience. Research into cognitive dissonance has discovered the ineffectiveness of teaching

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values and approaches if these are not followed in the work setting in which the students eventually operate. In other words, a firm model is needed, with the specific goal of continuity and co-ordination authoritatively built in and strongly and effectively monitored. Top-heaviness and excessive bureaucracy should not be limited by making co-ordination and continuity 'optional', but by introducing a measured flexibility. 'Bureaucracy bashing' should become part of the system, Tom Peters (1987) style. This consists in not only designing services that are 'streamlined' in the first place, but also by encouraging and rewarding the participation of all in a perpetual campaign of spotting system rigidities and working to turn them into examples of responsiveness. This, of course, is different from the 'taking the law into one's hands' that can, in a system that does not sustain sufficient dialogue, accountability and continuous improvement, become the only alternative to cynical or helpless resignation.

Top-heaviness tends to come about sooner in a simpler and less 'management intensive' system (see Manning N, 2001). To make matters more difficult, fragmentation could possibly be bigger. One psychologist recounted what 'interdisciplinary work' meant at Mt Carmel Hospital, admittedly at an earlier time when she had to cover four psychiatric firms, without being able to attend their rounds. 'You enter the big hospital hall. One consultant is going into one corridor, a social worker into another, and a registrar standing and seemingly on the point of finishing a conversation. You're lucky if you speak to just one.' Below a certain level of provision, effectiveness becomes a hit or miss affair. But, given certain basics, one must use regulation, design and enforcement that are adapted to the system's characteristics, rather than to ape a better system, inviting the combined 'under-regulation-over-regulation' syndrome. The use of computers in keeping a database of clients and care programs, if well planned, could be a way of increasing communication with minimal bureaucracy.

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2. Issues mostly related Level U-1, the Inner User World : Responding to user need in openness to user-centred values

Issue 5. How will the service be centred on the client's needs?

Issue 6. What would a social or empowerment model require?

A number of strategic objectives or key service design features are recommended in order to respond to the need assessment that has been discovered in Chapter 8, supported by the other chapters. The latter support includes the values and philosophy as advocated in Chapter 3 and the demands of congruence and evidence as they emerged in Chapters 5 and 6.

Create and sustain a system that targets all important needs.

In parallel with the Looking After Schedules intended for local use in children's service, a system needs to be introduced and sustained that ensures that all important needs are seen to. This could be done through training that makes workers aware of the need for comprehensive coverage of key needs, doing periodic research to assess need, and ensuring that such research is efficiently communicated to practitioners in a manner that facilitates its use and monitoring in practice. Particular tools would be care program software that features checklists such as the CP Inventory (see Table 9. 4: The Care Program Inventory - a tool in the service of holistic care), and uses instruments such as the clinical version of Autoneed (expanded to better incorporate 'the social model'). So would care program IT following Michael Shepherd (1995, pp. 250 ff.) model, that links needs, support and resources in a very practical way, as has been found in their use in expanding the Autoneed interview for the present enquiry.

Target needs as defined by the social model, giving importance to stimulating aspirations.

It is easy for a country without all the desirable resources to concentrate its efforts on medical and 'health' need. This is especially a danger in Malta, with a relatively high standard of medical services but social care provision and social models that are struggling to secure their foothold. It makes no sense, either economically or humanistically, to try to make ends meet by giving priority to the extra health needs of the less needy and neglect the social needs that

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are more essential to the dignity and well-being of the more needy. The latter can often also reduce waste of resources.

Correct the arbitrary rationing that comes from biased and incomplete penetration of the service.

It is remarkable that three villages in one pilot area, that was largely homogeneous culturally, showed clear differences in the rate of uptake of the service. This could have had to do with bus routes, cultural differences and the differences in the linking pattern of GPs working both at the centre and in the villages. But this emphasises that more attention, for the sake of equity and prioritisation according to need, will be needed once the service is expanded to areas that reflect greater differences in the above-mentioned factors. In a system that is soon overloaded, it takes decisive 'marketing' to cut through the crowd of the referred to reach the unrefereed more needy.

Give special attention to the most vulnerable while ensuring good service for the more needy among acute users.

The pilot area shows a very high demand for acute services, probably exacerbated by the mentioned weaknesses of the primary care system and the lack of counselling services. Equally lacking are the self-management instruction, through both education and group work, which results in dangerously high and prolonged use of minor tranquillisers and persistence of problems. While this needs to be seen to, it should not allow the eclipsing of the demand of giving first priority to the most vulnerable, a declared policy within the reform policy document.

Create a ring-fenced service of support for persons needing long-term care.

The pilot area study showed that the networking between an enhanced mental outpatients and broad-role local social workers has not consistently featured the prioritisation of the long-term and most vulnerable and joint and long-term care programs. It lacked a care system that is both capable of assertively drawing into the service people who are 'stuck' in their progress

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and of delivering the needed upgrading and sustaining of skills and amenities in the case of clients needing more help. Service for the more needy tended to stop between acute bouts not because it was not needed, but because there were not the resources and systems to deliver it. This will become more important as more clients, and more vulnerable clients, are newly deinstitutionalised. Besides, the position of those who are 'settled' in families at the price of great hardship and very impoverished living will become harder to sustain, as relatives get older, spontaneous family support less available, re-institutionalisation costlier and such harsh living conditions less socially acceptable.

Support the family through family intervention, giving attention to all the domains mentioned, including all the domains reflected in the Family Impact study, such as marital relations, looking after the children, communication skills, respite, leisure, housework.

Attention should be given especially to domains and aspects that have been shown by the research to be more commonly or seriously an area of hardship. Family aspects should be an integral part of the essential domains to be assessed, and family intervention both an aspect of all help and the subject of public and targeted education, special groupwork and group instruction programs that is progressively gathering evidence-based support (Falloon et al., 2000).

Use the potential of traditional societal values: religion, community

The high regard given to these values should encourage the capacity of workers to relate to spiritual aspects, where these emerge, in a way that is both correct and helpful but discerningly unimposed. Religiously motivated help is a vast potential that can be beneficially tapped while actively promoting sensitivity and equity in response to diversity in this area.

Stimulate change in the support system, tapping existing potential but breaking free of the limitation of existing stereotypes

Informal support systems are a very solid strength, but they tend to spontaneously fall into limiting stereotypes. Siblings are a great source of support, but they move out of the helping

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picture as soon as the client gets married. The joining of the two sources of support seems to occur only when spouses separate, the estranged wife keeps helping while siblings see that it is 'okay' to step back in. Men rarely do the housework, except for retired men when their wife gets too frail or ill. Most surprisingly, the 'strong community' in Malta has hardly yielded any cases of substantial help from outside the family. True, stigma from friends and neighbours seemed hardly noticeable, there were kind shopkeepers that dealt helpfully and honestly with clients who could not manage money, and a feeling of similar widespread helpfulness once paths cross. But the traditional strong family orientation effectively drew a line that hardly ever extended further than cousins and uncles. However, we are rarely dealing with cultural near-tabooes (as in the case of expecting a client to move in with a married sibling of the same sex) but almost always with spontaneous habits that are ripe for change, if only the right stimulation and support is given to change. The development of the skills, the rationale, the supports, and the sustained input to effect this change should be a key aim.

Tap, support, acknowledge and correct roles of both genders in caring, working for greater active solidarity and sharing.

The stimulation and support of more family and extra-family care will undoubtedly draw out more help from women. But we found that male help is also very substantial, though often in different areas. One cannot afford to leave available potential untapped but here, again, skilled and decisive action to correct cultural stereotypes should be built into programs to stimulate and sustain support.

Work to transform the life of user and their family from one that suffers from limitations to one that is richer and more participatory.

Because much leisure and socialising activity in traditional Malta takes place within the family, persons with long-term mental health problems often end up being largely left out. Being very often single adults living with parents, or often within families where stress, overwork and strained relations are part of the picture, makes things more difficult. Here again, somebody must help so that leisure and socialising can break away from the trodden paths. Both within-family and outside it, both in sheltered and in mainstream settings, such

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enriching calls for specific programs in which the employed worker stimulates local individuals and networks as an integral part of community care programs.

3. *Issues mostly related to Level U-2, the Wider User World – Family, Community and Civil Society: Sharing responsibility among state, family, civil society, neighbourhood*

Issue 7. What responsibility is to be undertaken and how shared?

Maltese parents hardly ever sue their children in court for financial support, which they used to do, when in particular need. (Brincat, Dr Joe, LLD, MP on “Monitor”, Net TV program, 8.2.99) The law giving right for care from ascendants and descendants is still there, but social security benefit now hardly ever leaves room for such claims of need. Social security and social assistance, given by central government, were introduced in Malta in advance of several Southern European countries. Contrasting such countries with more northern ones as regards personal care responsibility, Ditch et al (1996, p. 113) state that,

..in the Southern European countries such as Greece, Italy, Portugal and Spain... there appears to be little negotiation, and caring responsibilities tend to be regarded as an inevitable part of family relationship, rooted in the private sphere and independent of state purview.

In Ghana, responsibility extends to mental hospital care, in a way that reflects level of provision and cultural expectations (Laugharne R & Burns T (1999), p 361-2):

Most patients attending the clinic are accompanied by relatives who are expected to take responsibility for the patient's care. All in-patients must have a relative sleeping at the hospital with them. If there are no beds the patient is sent home with the relative, and they must return if a bed is available

Munday and Ely (1996; see pp. 46, 49, 112-113, 197) describe several European countries (France, Belgium and Spain) as putting on the family the responsibility of residential care but not home care. This creates a perverse incentive for family to prefer the latter. Germany has partly corrected this, after a fierce controversy, by expecting insurances to cover home care.

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Britain is very rare, if not alone, in having introduced state-sponsored case management for persons in need of care in the community. What is considered to have nudged Margaret Thatcher to such a universalist provision was the realisation that three quarters of UK pensioners could not afford to pay their own residential care (Walker R (1988). p. 71; quoted in Benington, J & Taylor M (1994), p 43). This made them a government financial responsibility. Case management became the cornerstone of an effort to save on such state expense.

Case management is about taking responsibility for long-term care in the community. The key question here is how far the Maltese state can afford to take up this responsibility. There are limits to how far (a) caring can be improved and expanded, (b) existing caring can be shifted onto government responsibility. The lesson from home care is that people's expectations of the service reflect other factors than level of need, and that satisfied high expectations generate more high expectations even where self-help is within the family's possibilities.

British case management is a quasi-statutory responsibility which is also highly regulated (see Mandelstam (1995), especially Chapter 9). Our research review in Chapter 5 strongly suggests that taking up case management responsibility without having the resources to either closely check if admission is necessary or to ensure proper care outside hospital may lead to an increase of admissions motivated by defensive practice. One should not run away with the idea that the wide British responsibilities result in care that is more than 'just adequate' and basic. In fact it is precisely this patchiness that is behind the frequent resort to admission by mental health case management.

The answer seems to be that the Maltese State must afford to provide case management as best guarantee of reliable service, but target it to the most needy. It must also send the strong message, through 'word and deed', that it must continue to *share* the responsibility with family, neighbourhood and civil society.

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This it can do in various ways:

1. Target the service narrowly, using clear criteria, and empowering the case managers and other service practitioners to enforce these without the interference of extraneous influence.
2. Do this, however, without creating 'dependency traps'. This term is introduced in analogy with the 'poverty trap' concept. If only the very most needy are helped, once you improve and move a step or two up in your functioning, you are left to your own devices. This can get you stuck at a still low level of functioning. This could also become financially wasteful, by leading to dependency on the more costly services (Regulations on narrow targeting should be balanced by ones promoting preventive work (See Mandelstam (1995), p. 214, 216).
3. Prefer short-term interventions and therapies that raise the functioning level and increase long-term independence (such as family intervention, much rehabilitation and skills teaching, and temporary 'ACT-style' intensive work to get a user 'unstuck' and to accept effective help).
4. Introduce 'permanency planning', preparing for a reliable and acceptable future placement in the community, especially for users dependent on parents who risk becoming institutionalised once their caring parents become too old or frail.
5. Invest in software that helps build up and keep a database of all needing long-term care, making preliminary assessments of all of them (gradually if necessary), identifying those that most merit intervention and having a 'policy' regarding each. This could mean keeping the case closed or only identifying a contact in case new problems arise. A case could be kept on a waiting list until its turn comes for the short-term assertive and intensive operation needed to get the client 'unstuck' from a deeply entrenched configuration of problems or passivity.
6. Support and stimulate non-profit and private provision. The NGO (financial support) Scheme can both expand its present encouragement of emerging initiative, and be proactive by making 'calls for tenders' on needs and gaps first identified by government. The potential of Church organisations to promote, stimulate and organise support by the

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neighbourhood is very difficult to underestimate, but it requires well-thought-out, solid and sustained official support.

7. The declared policy to start involving local councils in the provision of welfare services is to be pursued (see, for example, unpublished proceeding of 'Social Work in the Community' Seminar, Malta, SWDP, 28.10.00). This can become a 'new generation' expression of Maltese civil society's readiness to help. However, as Pace (2001) argues, this must be done with full awareness of the 'economies (and politics) of scale'. Any comparison with the devolution of social care to local authorities in the UK breaks down as soon as one realises that Malta itself is the size of an average British local authority, while its councils have populations of never exceeding 30,000, at times lower than 1000. Projects like old people's homes and broad-category day centres could be provided, as long as they are subject to inspectorate scrutiny. One relevant possibility is the stimulation of neighbourhood volunteer support that caters for elderly, as well as persons with mental health problems and disability (On pre-existing Maltese examples of these see Tout pp 181-184). But one must carefully avoid the danger of too much look-alike generic projects functioning at a low level of expertise. Small local hierarchies can trap case managers and social workers in situations deprived of promotion prospects, professional guidance and supervision, and their protection by professional authority from the interference of local politicians and power networks. Meanwhile, Government policy is now rightly encouraging local councils to unite in joint ventures, and this could make them capable of taking up some projects that are more demanding.
8. Sharing the case management role with NGOs. This may sound strange, against the British model in which the case manager is representative of government responsibility to oversee and to purchase the care of all who need it. However, it is rather like the analogous GP role in the British NHS. British GPs are self-employed, yet still the operatives of state care and even purchasing responsibility, exercising this on a contractual basis. In Malta it is unclear how far devolved purchasing will be a part of case management. A sensible balance would seem to be a gradual and well-regulated devolution of purchasing for selective resources. If NGOs can cover 'community follow up' through their social workers, it is much better to devolve case management

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responsibility to them than to add a further carer 'overseeing' their work. This is more economic in avoiding duplication and, more so, in spreading the message that the state is out to share the caring. Of course, NGO case managers would have to be subject to contractual agreements and regulations that safeguard standards and 'a level playground', in specific aspects, vis-à-vis their state-employed counterparts.

4. Issues mostly related to Level C, the Country-Context Level

Issue 8. How will the service be located within the services' centralisation/ decentralisation and mixed economy structure?

Table 9. 2 : The Country Context Level on the ARC Levels and Dimensions Chart (reproduced in full in Table 3.2) shows the country context to have many dimensions. These include the prevailing conception of the welfare state as a whole, the state of governance and the political economy, the interplay of political and economic power and the action of actors, elites and movements. We shall only take Issue 8 as focus, being the highest in priority as well as a means also touching upon the other mentioned dimensions within the available space limits. The approach will, again, be one of discerning a number of high-level policy objectives.

Give community care a central place in the shaping of the future while respecting local realities

There has been no lack of consensus in Malta about the expected shape of welfare services. However, the Cassandras – mostly the constituted bodies and speakers representing commercial, entrepreneurial, financial and possibly academic circles – are gaining a widening listening. Their message: it can't go on for long. The big question is whether we can be proactive enough to control the change, or whether we shall be slow and improvident enough for the system to take us where we 'will not'.

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C-Level: The country context:	52 New Management	C 1. Welfare state as a whole
	53 Welfare State	C 2. Philosophy re role of govt, and mixed economy of care
	54 Governance	C 3. Mode of consensus building
	55 The Market	C 4. Philosophy re role of government.
		C 5. System of mixed economy of care
		C 6. Purchaser/provider split
		C 7. Internal markets
		C 8. Privatisation, role of private sector
		C 9. Contracting out
	55 Political economy	C 10. Economic and institutional frameworks, constraints
		C 11. Elites, political economy level
		C 12. 'Other' factors and events leading to macro-level change.

**Table 9.2 : The Country Context Level on the ARC Levels and Dimensions Chart
(reproduced in full in Table 3.2)**

In its search for congruence, ARC may sound like a recipe to accept the context and fit into it. But the remodelling is 'Active', and congruence is also with values, humanistic and ethical, as well as instrumental and methodological. Community care is such a big actor in the mixed economy of a country that it can be a powerful trendsetter and change driver. The saddling of the community care reforms with the new management and marketisation reforms in the UK was a good point of strategy to emulate, even though one might not agree with the British direction.

Of course, acknowledging and accepting contextual realities is indispensable to having any hold on the future. Compulsory competitive tendering by state providers, involving the sacking of state employees if they lose the tender is, for example, alien to Maltese expectations of the security of tenure of state jobs. It will only become thinkable if the national economy has become widely acknowledged as unstable and visibly in very great straits. Job security seems to this writer to be a local value very much worth protecting. It links with the value of empowerment, an important theme in our study of the context. One central issue of governance in Malta at present is how worker empowerment can be compatible with client empowerment and with the good service of the public. Manager will

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find a very mixed bag of workers with vastly differing levels of motivation. Trends in improving accountability and discipline are strong but uneven. Here, the local inclination is to be acknowledged but also given direction.

Learn the lessons about the limits to market effectiveness

These lessons are discussed in our Chapter 4 under the heading 'Looking at right-wing recipes: markets, competition, downsizing' which concluded, among other things, that,

The lack of right-wing tradition, the smallness of the market, the limits to capability that promise that the transaction costs and running costs will offset any gains made, the low capability the government system has for micro-costing, all conspire to make market competition in the provision of service low in volume and mild in tone (Section 4.3.4).

But the fact that hospital autonomisation has now initiated a new process whose directions are yet largely uncharted will make the lessons mentioned in that section more important to keep in mind. Purchasers on behalf of the state must be very careful not to create the type of market that raises prices by drifting towards cartels. For government to lose the know-how and capability in important areas would lay it more abjectly at the mercy of cartel or monopoly providers. NGOs' capabilities to come up with their own funds should not be over-stretched. Government should learn which providers it should deal with on an 'arm's length' competition basis, and which are the ones to deal with more on a partnership basis. It must think out which contracts to expect to be normally renewed and which would be open to the best bidder next time round (see Pace 1998).

Promote good management and quality in the welfare services

The reform has never set a target number to deinstitutionalise – which would be necessary to make sure that there is a correspondence among the numbers that are prepared by rehabilitation for resettlement, the number given outlets and the numbers that can be supported. Such imbalance spell mixtures of over-capacity and under-capacity that, in turn, spell waste. The model drift in the pilot area and the failure of several research projects to get off the ground, are other examples. They show that, though managerial and planning capability showed very clear improvement over the past, there is more room for the spirit of new management that wants better managers, better-trained ones and ones given greater

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power. In this regard, it is good to see that courses in social administration, public policy and management and health services management are being increasingly subscribed to. An interesting case in point is the social administration course at the University of Malta which was designed to give management know how to persons involved in the social and health services, coupled with study of social policy and relevant social and ethical aspects. This would avoid the shock that the British system experienced, especially in the beginning of the reforms, when managers trained in industry, without the relevant social knowledge and socialisation, were engaged to manage the welfare and health services.

Carefully manage the dividing line between state and private services

One of the biggest dangers to the Maltese welfare state is that key systems of generous middle class universalism are destabilised. Margaret Thatcher flinched on the verge of privatising the British health services, because the people wanted it. However, there is no guarantee that the probably stronger Maltese wish for free health will not be undermined, in true Maltese gradualist manner, to the point of getting the general population where it never suspected it was getting. Up till now the private hospital system is too limited in its range of services and too expensive to lure more than a small minority of specialists away from the state hospital system. However, hospital autonomisation has announced working conditions for doctors on contract basis, still too vague for doctors to pronounce any reaction to. A long-term goal should be for the state not to allow state health care to lose its attractiveness to a large majority. Once too many people are paying private insurances, there is a danger that they withdraw their support for a universalist free hospital system. Such welfare backlash provoke a downward spiral of lowering standards and lowering support reinforcing one another beyond a point of no return.

The compromise of concurrent state and private responsibility for the same case is part of the support of the present affordable equilibrium, but this had natural brakes on it as long as no creditable private hospital service existed. Great attention should be given to this unregulated area which leaves much room for conflict of interests and incentives to inferior service. It will take keen perceptiveness and deft footwork to ensure that a modicum of regulation is

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introduced to avoid 'more of the same' becoming the culprit in destabilising the system because the contextual change is not reacted to.

In community mental health services it is quite possible that the unemployed and mostly women have gained from the interdisciplinary services taking place free of charge at the reformed health centre, while the employed and mostly men used the paying but monoprofessional health services in private clinics. Probably a change is difficult to afford. As long as state practice has features absent in the more lucrative private practice, there is need of regulations and safeguards to ensure that the prioritisation of cases in the public services works on principles of equity that are often openly absent in private practice. Particularly, non-medical and paramedical disciplines in the team need to be sure that prioritisation criteria are clear and transparently followed. Otherwise, there will be a built-in obstacle to interdisciplinary co-operation.

It was publicly stated that the recently proposed strategy suggests an interesting type of public-private partnership. Health centre 'primary care without practitioner continuity', as we saw, keeps the patient away or overloads the specialist level. Private GPs would be engaged on contract basis at the health centre to give the continuous care needed, exclusively to patients with mental health problems, but covering all their general practice needs. One hopes this will be achieved.

If safeguards against private-practice or political-type prioritisation are ensured, and the go ahead is given, primary level social workers can also network more freely with local private general practitioners.

Boldly experiment with new ways of community resource purchasing and local budget devolution to the case management team level

The purchase of packages of care by case management teams wielding budgets devolved to their level is an extremely prominent feature in British community care. Maltese community resources of the type shared with the elderly are all either provided by a single Malta-wide

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provider on a long-term partnership basis, expected to continue (such as Meals-on-Wheels, Telecare (alarm system)) or provided directly by the state (such as handyman service or most true day care centres). The nearest thing to competition regards home helps. These work on self-employed contract basis and their large numbers make substitution due to inadequate service easier.

Specific mental health services tend to involve pluridisciplinary specialists, and can only be provided by government or NGOs like Richmond Fellowship Malta or Eden Foundation on a large-scale contract with government. The NGOs' contribution becomes all the more possible if there is a policy of relative demedicalisation of community services. This seems to be the only way to safeguard the primacy of the social and personal in the lives of people who do not need a health-dominated regime in their lives as is characteristic of hospital. In fact, Kinsella reported (talk at the Holiday Inn Crown Plaza, Malta, 1997, under the auspices of the National Commission Persons with Disability) that it was the freedom of the demedicalised NGOs that resulted in the empowerment inherent in such social models as the supported living model (see Kinsella 1992).

Still, scope should be deliberately created for both devolved budgeting and even well placed competitive provision, mostly of the long-relationship and partnership type, but with a pragmatically open mind to opportunities for arm's length competition. The fact that they will be a minority should not mean that opportunities are missed because the system is not ready for them.

Local councils – both as purchasers and providers - and NGOs should be guided or even pressed to organise ventures at scales compatible with economies, involving joint ventures if necessary.

Devolved budgeting, promoted in the Reform Policy Document, would be needed at local team level to tap or stimulate local resources and opportunities. NGOs, clubs, private education or neighbours could provide support, activities or needed education and training that would be impossible without some reliable finance. Special, stopgap or personalised needs

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could also be appropriately financed by a revamped and newly resourced Fond Ghaj-Ri, a fund created to meet such needs with the required flexible and rapid responsiveness.

One of the interesting ideas that was officially aired some time ago but not followed up was that of giving the beneficiaries of free hospital or health services a 'virtual bill'. This would be a calculation of the cost that would have to be paid if the services were not free, as a disincentive to waste. Such a 'notional bill', communicated to case management teams – only detailed enough to make them aware in an ongoing way of the cost of what they provide, and of the state of their devolved budget as a team – could ensure equity in resource allocation. Attention should be given so that the duty to ration is not overdone, and that advocacy for better and more resources is also given its rightful place.

Another interesting issue is around the 'meals-on-legs' idea. This is the jocular way in which Dr Rizzo Naudi, first minister for the elderly, described the practice of including meal preparation as an optional service to be requested from Home Helps. A British manager responded to this idea that he would prefer company-provided food, being easier to monitor for quality. In fact, the capability of monitoring quality in personalised support and service is one of the challenges that will have to be risen to.

5. *Issues mostly related to Level S, the Services Level (S)*

Issue 9. How cater for different levels of vulnerability?

Issue 10. At what times will the service be available?

Issue 11. How is the service to be streamed?

Issue 12. What span of clients will be targeted by the service?

The suggestion to use ACT characteristics as basis of streaming, reserving them for the most vulnerable, has already been made in section 6.4, where these issues are tackled, including ways to give this service within limits of affordability.

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The pilot area team, as described in Section 9.1.3, assumed a role over four levels: specialist (acute and long-term), primary health care and generic territory-based social work (for a tabulation of levels see levels b1 onwards in Table 9. 3). An ideal service would probably have different teams for each level, plus an additional Assertive Community Treatment team (see Table 5.6 for characteristics) for the most vulnerable. This writer is convinced that it will be some time at least before we can afford it. Meanwhile it is suggested that it is better to move as soon as possible to the coverage of the whole of Malta with affordable teams than to again create teams in pilot areas which we cannot afford or would not wish to generalise to Malta as a whole. A sustainable plan would be one that took a broad view, and it is suggested that the consideration of a further level be also brought into the picture. This would be a locally- or 'regionally-' based social work team to support adults needing long-term care.

It is suggested that the next step in provision should be on the basis of two levels:

1. A specialist mental health team, with a strong interdisciplinary team identity with a part-time visiting psychiatric firm providing MOP. The specialist team would cater simultaneously for acute and long term (though separateness could be envisaged – see Table 9. 3), but would exercise flexible case management with part of its caseload. Case management would have a ring-fenced allocation of resources for it, mostly in terms of a recognised list of clients and a guaranteed and monitored section of their time dedicated to it. Some members of this team would be specially deployed on case management and would have special responsibilities for the development of its role and its supporting resources. Simple cases would be carried out basically on a single-practitioner basis. Part of the case management workload would carry ACT characteristics. This will be shared round among the members, in view of the essentially team nature of ACT coverage.
2. A locally based 'health-cum-social services' generic social work team that would network closely with the GPs, both health centre ones and private ones (with the above-mentioned freedom from private-practice influence). It would be primarily accountable to social work authorities, but with safeguards of conformity to acknowledged health policies (such as the avoidance of overstaying in hospitals) and continuity of care with hospitals and

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other short-term residential or specialist services. It would be the main practitioner of case management for adults (especially elderly and persons with disability) referable to localised case management. It would include individuals with special responsibilities for the promotion of case management with each main client group. It would liaise closely with local support and services provided by local NGOs, local councils, volunteers and neighbours. It would balance the encouragement of subsidiarity with the fostering of professionalism, while asserting a legitimate official service lead as part of a deliberate and well-monitored policy.

The latter team at regional level should be the next-step and much needed locally based social services team. It would be a pity if this outstanding social services goal is pursued separately from the above equally outstanding health services goal because of uncoordinated social and health services planning.

A single Malta-wide ACT team (see Table 5.6 for characteristics) (probably not, or not itself, providing full after-hours cover) could help if affordable and if enough vulnerable clients are identified (which may not be far away if the very service makes possible discharges that would currently be unwise). Persons with special roles within either team would network closely with counterparts in other areas, and be accountable, though a matrix authority structure, to managers or co-ordinators of that special role on the Malta level. Their networking with providers relevant to their special role should be facilitated, and backed by higher authorities. The specialist team could later divide into an acute and case management team. But there is nothing to stop a single specialist team to work with two psychiatrists visiting the area, one deployed on the acute, the other on the specialist. Both the specialist team and the generic should have their team manager. Accountability to a single team authority should command allegiance whichever the discipline (but see below re interdisciplinary co-ordination. See Onyett p. (1992) on some good and some bad possible patterns).

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<u>Level where based or deployed</u> →	<u>Coun- try Level</u>	<u>Island Level</u>	<u>Region Level</u>	<u>Inter- Local- ity Lv.</u>	<u>Loca- lity Level</u>	<u>Pilot Area/s Level</u>
Service Framework item ↓						
a1. Organised Volunteers (o)				o*		o-
a2. Semi-Trained Rehab & Support Workers (r)			r*			
b1. Generic Territory-Based Social Work (p)			p*			
b2. Primary Health Care (p)						
b3. Specialist (Acute) (s)			s * ?	s * ?		
b4. Specialist (Long-term) (s)			?	s * ?		
b5. Assertive Community Treatment as stream within specialist team(s)						
b6. Dedicated Assertive Community Treatment Team during normal hours only (s)		s+				
b7. Dedicated Assertive Community Treatment Team round the clock (s)		s++				
c1. Day programs, more generic (d)			d*			
c2. Day programs, more specialised (d)	d-	d*				d-

* = level recommended for present capability; - = lower than recommended level: + and ++ = two subsequent desirable levels if capability allows it: ? indicates both alternatives considered

Table 9. 3: Levels of deployment or basing of teams and other service framework items that seem to be the 'next steps' in view of Malta's level of readiness and capability. Joined boxes indicate functions amalgamated within same team or service.

The above is tabulated in Table 9. 3: Levels of deployment or basing of teams and other service framework items that seem to be the 'next steps' in view of Malta's level of readiness and capability. Joined boxes indicate functions amalgamated within same team or service. The table recommends deployment levels also for other key items, namely volunteers and semi-trained rehabilitation workers as well as day programs, generic or specialised. In the case of specialised teams, whether to split acute from long-term will only be clear in view of very immediate realities. It is now hoped that pilot areas will only be used for new items and that, for what has been tried out, the pilot phase is now replaced with a generalised plan. Such a generalised plan can still leave room for pre-envisaged improvements to reflect improved capability. A less-than-desirable level is indicated only as a 'half a loaf' alternative in case the 'no bread' option looms.

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6. Issues mostly related to Level O, the Organisation Level

Issue 13. How promote co-ordination?

There is in Malta no extensive common philosophy about community care that brings together the care of elderly, persons with mental health or disability problems. Nor are there structures that bring together the state bodies under the Ministries for Social Policy, for Health, Housing and Local Councils as well as involved NGOs to co-ordinate policies on community care. Many important initiatives have been taken in each of the three fields and there have often been bilateral and ad hoc contacts on specific issues. The very fact that developments in all the important parts are now so advanced makes it become more imperative for a philosophy and structures for co-ordination to be developed.

It would be unsatisfactory if care for old age, disability and mental health take different and uncoordinated, in not unaddressed, positions regarding the basic service delivery framework, the main goals and basic language. That would create confusion in the many resources common to the three or to two systems, including community resources, service tools and planning, training and evaluation resources, as well as personnel, like social workers, who often move across systems. This would be more important for members of the public who have to move across systems with much less guidance. It would be good if, hot on the heels of the wide-ranging review taking place now in the state and NGOs' children's services, a co-ordinated rationalising and development exercise is undertaken for adult and community care. Many of the questions tackled mainly with regard to mental health would then be made with respect to the community care as a whole. One question is whether a white paper or other processes would be best, and whether a permanent inter-sectorial council would be appropriate.

Common philosophies, parallel practices, similar tools and co-ordinated structures should not detract from the differences of predominant character and emphasis that distinguish these three fields. It should still be flexible enough to allow for mental health to gain from empowering models that tend to predominate in disability services. Community resources that are mostly at

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the service of the elderly are to be with equal facilitation made available to the other groups. Mental health should have room for its intimate link with health professionals, health services and health priorities to be expressed, but robust enough in its social character to bring home its empowering contribution to the services.

In a recent conference about ethics and interdisciplinary care, a consensus arose that stoutly denied the often-expressed opinion that interdisciplinary co-operation does not work in Malta. Rather, it was reflected, this ranged from the very good to the very bad. Observers feel that this depends most but not exclusively from the way authority is exercised. Like so many things in the Maltese system, good practice is optional, and left to individuals' consciences and consciousnesses. Data on British CMHTs suggest that teams where medical dominance was strong had greater staff turnover (Onyett et al., 1994). In Malta turnover is often – though decreasingly – difficult, and a defensive reaction is often to seek 'splendid isolation' through ways of blocking communication. Specific training, interdisciplinary training, and authoritative sanction should be deployed on the side of those who promote and against those who obstruct a spirit and an environment that encourages interdisciplinary co-operation. Conducive exercises should also take place at the team level, such as clarifying and negotiating who would have the autonomous, leading or joint power of decision, in the end, about various types of action which can arguably be more or less the province of one or other discipline (Ovretveit 1993). A total quality management approach in this would help, implying that problems to good practice are tackled in the best way possible, whatever their source.

Case managers cannot exercise their co-ordinate work on the ground if the authorities higher up the line do not co-ordinate, and vice versa. The role of the Mental Health Commission as *the* intersectoral organ should be strengthened by strengthening the representative role of part, though not all, of the members. They should still be able to distinguish where they speak in a personal capacity and where they represent an authority or group. Onyett's (1992) concept of a consortium of providers, including NGO and private ones, to co-ordinate the making available of resources, would be all the more appropriate in Malta if the sharing of

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responsibility with civil society is to be carried out while safeguarding maximum equity and efficiency. This should strengthen the sharing emanating from the charging of NGO workers with official case manager roles as advocated earlier.

Issues 14 How promote efficacy?

The literature about the British community care reform is replete with controversy and protest about a basic conflict between new managerialism and the caring ethic of the helping professions (see Jordan & Jordan 2000). With its emphasis on economy, efficiency and effectiveness it often spelled cutting down on services that already existed, and applying brakes to the development of new ones. It sounds easy to advocate a simple principle:

Balance the tension between efficiency and caring in faithfulness to caring values

One can easily draw out the argument of what we have called 'reluctant managerialism' or 'reluctant residualism' (section 4.3.3). This says something like, 'What Thatcher did out of right-wing beliefs, we do out of lack of resources.' In other words, any objections to a new managerialism in community care boils down not to applying managerial methods in order to improve efficiency, which any caring person would agree with, plus 'budget cuts', which a caring person only agrees with as long as it is 'the best we can afford'. Seen from this point of view, let us adopt the management approaches of the British reform, because they promote efficiency and therefore good caring and service. But let us make sure that we budget and spend generously. After all, it is in the nature of maturity and responsibility to have to balance contrary, though not contradictory values, like care and control in both social work and parenting. It is even the sign of effective thinking to continually manage a creative tension between such opposites – a process called 'Counterpoint thinking' by a proponent of creative thinking (Melchior, 1996). Creative thinkers are not given fixed solutions but generative ideas that pull in different directions, while being encouraged to use their judgement in particular cases. From this point of view, case managers who protest at being simultaneously advocates and rationers are not showing adult and creative maturity.

One person who would not buy this argument was Maureen McIntosh (in a personal communication) referring to her relevant research and theoretical discussion (1997), but other

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authors can also be cited. One of her 'stories' was of an elderly person who suffered a stroke. He received no social work support, help with problems solving, counselling around the sudden disconcerting change in his life. There was nothing to facilitate a transition to a new balance of dependence-independence that can often be mismanaged with painful and enduring consequences without help at the time of crisis. Instead, he was sent brochures of several companies that provided meals-on-wheels, complete with the features and cost of each, so that he could exercise his sovereign free choice as a customer.

Adult care is seen by many in the UK services as pressing to impoverish the social work and other caring roles, by emphasising duties that are administrative and of a pure broker-purchaser or 'checklist wielder' type. No doubt, many elderly, even victims of stroke, may need the community resources most of all, and only marginally the 'social worker's facilitative and other professional skills'. Oversupply of these services can spell bad services as their undersupply. The challenge of conserving these skills in a system with smaller resources in spite of probably a solid support for caring values by society and authorities alike is one that is certainly a challenge to 'counterpoint thinking' that must be faced every day. Hopefully, increasingly refined solutions will be developed for the sake of the proclaimed values. It augurs well that now the glass ceiling that blocked social workers from high management positions has been broken. The Malta University social work course has introduced management courses into the basic work qualification, and one hopes that the perceptibly improved harmony between a caring and a management rationality will improve steadily.

Transfer of funds from hospital to community to be managed very carefully for better quality of life but with an eye on short-term and long-term costing

American military authorities claimed 74% savings in transferring patients from hospital care to case management (Carter, 1997). Max Marshall et al's (1998) review shows that Assertive Community Treatment clearly reduced costs on hospital care but not on care as a whole. The costliest item in the community care of most mental health ex-patients is on housing. This makes persons who already have housing worth targeting particularly, though not exclusively. A study has found that, at least in a particular part of Malta it would cost the state very substantially less to organise supported living for local persons with disability than to give

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them institutional care. The study focused on persons who are living with their family, many of whom would be expected to need new care arrangements once their parents become too old or frail.

The slow supply of housing and community support is severely limiting the rate of deinstitutionalisation in Malta, in spite of the Ombudsman's declaration that the majority 'do not need to be there'. Transfer of funds from hospital to community is needed. However, significant savings on hospital care in Malta can only take place when a unit or ward is closed, not on the level of individual patients. Hospital closure, with its attendant more hefty savings, is an impossibility, since there is only one on the island. A ward closure expected to save money backfired. The relief at having closed the notorious high security Ward 10 provoked a traumatic nurses' strike and additional expense to have extra staff to provide a high security cover in the new ward (see Vella, 2000). However, community care will be slowed down to the point of perpetuating more costly modes of care until a decisive project, well costed, with set targets and with balanced resources, with initial seed money, is set in motion. It would target those who can be supported in existing housing they have access to, which is a way that could go hand in hand with savings. But it would still target also those who will be placed and supported in the community in spite of higher costs and for the sake of a better quality of life. This does not exclude that, for some, hospital living may be better (see, for example, Rodriguez-Ferera S & Vassilas C A (1999).) It must still be kept in mind that the increase of community support through case management has, in Britain, gone hand in hand with an increase in admissions (Wall, S, Hotopf M, Wessely S & Churchill R (1999).).

Unfortunately, any attempt to charge for services in a means-tested or income related way in Malta is liable to cause inequity. The better off, mostly the self-employed, are known, in spite of improving government controls, to massively under-declare their incomes, so that the biggest burden would fall on the middle, rather than the higher, income brackets. It would be a pity if this has to be resorted to before the present vigorous efforts to improve fiscal morality have substantially removed this serious shackle on the sustainability of a discerningly supportive Maltese welfare state.

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Apply the skills of narrow targeting, prioritisation and streaming, while avoiding 'neglect traps'

In a situation of limited resources, the only alternative to strict prioritisation is arbitrary rationing, which goes against efficiency and equity, or the loss of sustainability. There are many signs that the capability for such tight management is improving, but the required 'triage' calls for more much. However, one should heed Esping Andersen's (1996, p. 262) warning with regard to social security:

Narrow targeting is, generally speaking, inefficient because it is administratively costly, because it typically fails in its objective of securing adequate welfare to those in need, and because it nurtures poverty traps.

A similar warning, this time regarding community care, is given by Mandelstam (1999, p 214)

The perceived reduction in practice of home help for older people with needs deemed to be lower priority - in favour of those at greater immediate risk - goes precisely against the reference to preventive service in the guidance on s. 45 of the 1968 Act.

While the costlier and heavier services should be narrowly targeted, small improvement should not mean the withdrawal of care when this leads to deterioration or suffering or short-sightedly loses sight of prevention. Intervention should be on the basis of a type of 'permanency planning', that gives continued support to reach and maintain a targeted level that is satisfactory and, if possible, has some empowering and fulfilling 'punch' in it (See also Conway et al. 1994 and Cotterill L and Barr W, 2000).

Use Work Tools that support the Reliable Coverage of Critical Need

The CP Inventory, or Care Program Inventory (Table 9. 4) has been put together by the present author to compile all the Domains and Areas of Need, that seem to be salient in the provision of long-term mental health community care.

- The domains and areas included bring together the areas included in the three main rating scales used in the present research, that is, LQOLP, FBQ and Autoneed. Similarly included are domains featuring in rating scales originated by Mark O'Callaghan and offered by him for use used at Villa Chelsea, Richmond Fellowship (Malta)'s halfway house.

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- A widening from the rehabilitation model into domains that seem to be made necessary by an approach that is empowering, aspirations-led and congruent with the strengths and the social model.
- A further widening from a pure 'rehabilitation/ skills teaching/ illness treating' approach to one that sees as equally important the sort of thing that social workers, exercising their highly integrative and holistic profession, have always made their province. We here mean the problem-solving and decision making required to get on with life and move forward, and the securing of a number of personal amenities, ranging from a home and a job or somewhere to spend one's day actively, to a network of support.

The CP Inventory is being proposed for use, for several purposes. It has a research function, enabling questions and data to range over a rich variety of areas that are in fact all important, and also preparing the way to classification and coding in qualitative analysis. In practice it serves as a checklist, to enable carers and professionals to make sure that all basic needs are met. This checklist can be seen as parallel to the 'Looking after Schedules' (see Ward 1990, Dept. of Health et al 2000). The rationale of the Looking After Schedules is to act as a checklist of needs. British social workers started discovering that, while children were under their care, and often very intensive care too, certain needs used to fall by the wayside. It would be discovered when it is rather too late, that while social workers were busy defending and seeing to the therapy of an abused child, everyday needs like education or dental care might have been forgotten.

The CP Inventory is being proposed as a practice tool for Malta and similar middle-development countries as a help to ensure a number of qualities that flow from the values and criteria of good community care that we have adopted. The CP Inventory would help basically by strengthening reliability. Without some sort of comprehensive checklist, time-consuming and resource-consuming efforts to create a supported niche for an individual in the community can go to waste. The absence of an essential element that was missed can make the arrangements collapse. This can spell high cost not only in terms of resources but also in

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terms of disappointed human aspirations, more painful if the missing element, if put there in time, could have saved the continued community stay while there was still time.

THE CARE PROGRAM INVENTORY

<u>A PERSONAL STRENGTHS AND RESOURCES</u>	<u>B ACCOMMODATION-RELATED SKILLS</u>	<u>C JOB SKILLS, EDUCATION</u>
11 <u>Aspirations: 'the Dream'</u>	21 Hygiene, dressing, self care	31 <u>Education</u>
12 <u>Ideals & spiritual resources</u>	22 Cooking	32 <u>Cultural development</u>
13 <u>Personality, personal skills, assets</u>	23 Cleaning	33 <u>Job skills needed</u>
14 <u>Background, past achievements, education</u>	24 Laundry	34 <u>Other practical skills</u>
15 <u>Interests, pursuits, hobbies</u>	25 Household upkeep, safety	39 Other
16 <u>Physical exercise</u>	26 Mobility, transport public amenities	
17 <u>Physical environment</u>	27 Money, managing own affairs	
18 <u>Acquired Job skills</u>	28 Shopping skills	
19 Other	29 Other	
<u>D SOCIAL, PARTICIPATION & LEISURE SKILLS</u>	<u>E HEALTH & CHALLENGING BEHAVIOURS</u>	<u>F ACTIONS, RELATIONS AND PSYCHOLOGICAL</u>
41 <u>Leisure and participation skills</u>	51 <u>Psychotic symptoms</u>	61 <u>Decision issues</u>
42 <u>Communication skills</u>	52 <u>Organic disorder</u>	62 <u>Improving relations</u>
43 <u>Social/relationships skills</u>	53 <u>Underactivity</u>	63 <u>Psychological or other behavioural</u>
44 <u>Family Role skills</u>	54 <u>Side-effects</u>	64 <u>Emotional</u>
49 Other	55 <u>Dangerous and destructive behaviour</u>	65 <u>Informational</u>
	56 <u>Neurotic symptoms</u>	66 <u>Practical</u>
	57 <u>Socially embarrassing behaviour</u>	67 <u>Therapeutic alliance</u>
	58 <u>Substance abuse</u>	69 Other
	59 <u>Physical illness</u>	
<u>G PERSONAL AMENITIES</u>	<u>H INFORMAL RESOURCES</u>	<u>I FORMAL RESOURCES</u>
71 House	81 Family	
72 Job	82 Friends	
73 Finance	83 Neighbours	
74 Possessions	84 Volunteers	
75 Access to means of transport	85 Neighbourhood: social	
76 Opportunities for leisure	86 Clubs, associations, church/es	
77 Opportunities for participation	87 Social environment	
78 Support network	88 Local cultural activities	
79 Other	89 Other	

(coding for separate areas in this domain not here given)

Table 9. 4: The Care Program Inventory - a tool in the service of holistic care

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The CP Inventory is not accompanied by the rich system of benchmarks and guidance that one finds to a high degree in the Looking After Schedules. However, existent and new material can be gradually supplemented to it to give it the extra strength it needs, beyond the usefulness it already has. Besides, the use of both the Looking After Schedules and the CP Inventory can be a further important contribution to the parallelism advocated in this dissertation between child care and adult care, and between social and health community care. This would give the further strength and robustness to a caring system that a fragmented one lacks.

A holistic inventory like CPI is also a tool for proactive and rational planning. All the arguments comparing rational/comprehensive with incrementalist, and proactive versus reactive planning, can be applied in very enlightening ways to the question of how and how far such a checklist is useful

Issue 15. How promote change?

There are two main risks in the introduction of an adapted case management in Malta. The first is that the term is devalued, just like the terms 'day centre' and 'open ward' and 'half way house' were for a long time devalued by the existence of facilities that sustained only a part of the necessary attributes and critical success factors. A better managerial consciousness is developing, but the gradualism, the well-below-optimal resourcing and the not-quite-viable interventions that often prevail frequently result in waste disguised as savings. Case management would be no different from casework, not even from unorganised brokerage, unless the necessary conditions are in place, such as (see Wessex Regional Health Authority (c. 1998)):

- Service is subject to a written agreement, which signifies accountability.
- The provision of the service is a quasi-statutory responsibility (similar to Highway Code: failing to provide as agreed does not directly break the law, but "may be seen as contributing to negligence in legal proceedings.")
- Care manager or key worker carries authority to co-ordinate, monitor.
- Both health and social needs to be assessed.

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- A single individual program for meeting those identified needs to be designed, signifying the part to be played and the commitment and accountability of each provider.
- A care manager/key worker appointed to ensure implementation and review.
- Individual clients and carers to be included in the process and given opportunity to sign their program to signify their agreement
- Client to decide which informal carers to attend and receive copies of the programme and review.
- Representative of both Social Services and Health Services to sign the care programme, thus committing the resources deemed necessary.

This risk is to be avoided by both pre-defining the process goals on the basis of tried and tested models, and also by defining the environmental and organisational requirements for this to succeed (See NHS Executive 1996, Pace 1998b).

Progress in the pilot area was marked by very assiduous work to get the basic resources in place, hard work to get the model refined in its initial stages, a number of reviews that contributed to improvement, and a major review that was part of the strategic planning process. The system would now be expected to move further into the realm of performance management, through clearer setting of goals and more consistent monitoring of it. Arguing that even evidence-based performance standards are not enough, Geoff Shepherd (2000; see also Kuipers 2000) advocates a *Depth Process Necessary for Effective Change*, comprising:

- Obtaining local agreement on objectives: the need to secure local ownership so that participants experience the process as theirs, with the help of leadership and 'vision';
- Working through resistances and obstacles: tackling capacity issues ("do we have enough resources, training?"); dealing with anxieties about changed role, insecurities re. status and use of hard-earned personal skills; broadening the base of support¹
- Implementing change: 'on site' training; use of existing structures; experimentation with pilots.

¹ One could add: exercising the art of respectfully amalgamating or joining the cultures of persons who, from different, if not rival, groupings, need to join forces.

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- Reviewing progress: using clear, realistic outcomes; local ownership of the audit process; ensuring the audit cycle is complete.
- Setting up maintenance systems: continuous monitoring and continuous quality improvement.

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Chapter 10

Post-modern Questionings – Matters of Validity

10.1 Introduction

This dissertation has set out to be an extended discussion of what would be appropriate services for mental health community care in Malta. Besides the above substantive and local question, it has addressed the methodological question of what would be a valid method of developing services appropriate for any particular country, or 'new' context. The basis for our conclusions has ranged from quantitative methods for needs assessment, through more qualitative, participant-observer and historical, to interpretative social method of investigation. Its use of the concept of congruence has led it to cross the borders into cultural analysis. Out of respect for today's concern for making clear one's underlying values, it has declared its embraced values from the outset.

It seems as if the journey has reached its destination. But its two main products – the suggestions for a service model for Malta, and the method for adaptive policy adoption – now seem more like batons in a relay race handed on to others to carry forward. During the journey we at times looked with lenses at minute specimens. At others we surveyed wide vistas. Besides the products, the diagrams and the maps we also have a committed collaboration to show, which is in no way over yet.

But now it seems right to take a step back and ask what it all adds up to. How reliable are its findings, and how strong is the force of its conclusions? Through what lenses must its descriptions of need be magnified, reduced or re-aligned, in order to produce a picture that is objective enough to warrant action?

POST-MODERN QUESTIONINGS - MATTERS OF VALIDITY

The reader is also referred to the description of the aims of the present chapter given at the end of Chapter 1. The questions about validity, as framed by the researcher towards the start of this project and reproduced at the end of Chapter 3, represent the impetus, itself motivated by the concern for validity as well as for cultural integrity and continuity that, in the end, begot the present chapter.

Speaking of 'validity', it is (Bowers, 1964, p. 742)

...used by social scientists in three related senses: denoting (a) soundness of conceptualising, (b) applicability of research techniques, and (c) pertinence of data', referring on their 'value or worth...for some specified purpose, as judged in relation to some standard or criterion'.

While in the literature of the social sciences we are mostly used to viewing validity in relation to measurement in tests and prediction, the literature about grounded theory has drawn our attention to the meaning and need of a type of qualitative validity. Perhaps the type of validity in the more traditional social research literature that is nearest to that which we wish to talk about here is 'construct validity'.

Instruments designed to measure characteristics that do not lead to specific predictions on a single criterion cannot be evaluated so directly. Other evidence must be sought to provide a basis for judging whether the instrument adequately measures the concept it is intended to measure. This less direct approach has been described as construct validation. (Selltitz et al. (1976) pp. 170-71).

This definition can apply to our coming discussion of predominantly 'qualitative' validity, with one proviso. We need to replace 'measure characteristics' in the above extract with the wider 'represent characteristics'. Instead of speaking exclusively of instruments measuring concepts, we are widening the field to concepts and account (description, explanations...) and asking how well they represent, convey or communicate the reality that we set out to investigate. This gets us into the realm of theory of knowledge or epistemology. The question of such validity has very much come to the fore in the last decade or two, most influentially under the impetus of postmodernism which has emerged, with feminism, as one of 'two of the most important political-

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cultural currents of the last decade' (Sarup, M (1993). p. 156). Anna Yeatman (1994, p 28) rightly pinpoints as

arguably the core feature of postmodernism: the critique of epistemological foundationalism. Put simply, this critique is based in a rejection of mirror theories of knowledge, where knowledge, if it is to be true or accurate knowledge, mirrors an order of being outside itself.

In its first and longer part (10.2 – 10.4), this chapter will focus on the necessary dialogue between social policy (and social research) and postmodernism. This part is based on the conviction that the two nowadays keep meeting each other all the time, increasingly influence the same audiences, but often do not quite see eye to eye. This has come to the point where one cannot ignore the needed debate without feeling that the validity of all one's conclusions, their implications and their 'force' is deeply tainted by doubt and a lack of groundedness. In the second main part of this chapter (10.5 onwards), the discussion will move to questions related to aspects of cultural analysis relevant to our study of cultural congruence as a criterion for policy appropriateness.

10.2 How far can social policy go along with postmodernism?

"Nihilism and pessimism are often associated with postmodernism but that neglects the growing body of literature that is wrestling with the possibility of engaging in politics and yet remains sceptical of any secure epistemological basis for such an engagement," is how Mann (1998, p. 82) paraphrases Smart (1990). In that article Mann acknowledges the importance to social policy of issues raised by post-modern analysts. While he is not impressed by the depth with which they analyse social policy issues, he does not go as far as supporting Taylor-Gooby's (1993) contention that social policy and postmodernism are not compatible. In fact, he clamours for a dialogue between the two, appealing for postmodernists to be a little more reflexive and a little more attentive to debates within social policy.

In this chapter we shall look at postmodernism from the point of view of the commitment taken at the beginning of this dissertation in favour of the poor and vulnerable. This will

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be also joined by a look at its foundations in theory about knowledge and knowledge's validity. Social policy would be particularly threatened by theories that propound negativity and scepticism with respect to both the validity of knowledge and that of values. Though social policy did not originally display deep theoretical levels, at least in its initial British form of social administration, it has with time shown increasing reflexive and self-critical depths. Moreover, throughout its history, it has been through and through a value- and ethics-led discipline (see Mishra 1989, pp. 73-75). However, it does not seem that its foundations in cognitive theory have often been analysed and widely aired. In this chapter an attempt is made to evaluate postmodernist positions, as an occasion to evaluate the grounding of its validity. Much of what will be said will be at a basic enough level to apply to many other fields of knowledge and to the social sciences and the rationale of the helping professions more particularly. It is commonplace to hear that no knowledge is final and absolute, but people tend to soldier on following their uncritical common sense in their everyday life, while indulging in deep scepticism and cognitive agnosticism if engaged in a discussion about the grounding of their knowledge. Postmodernism seems often to be no more than the current standard-bearer of such scepticism, not necessarily built on or originated by postmodernist theory.

The discussion will take place with social policy in mind, and will be couched in terms and use illustrations relevant to the organisation of mental health services. It will take a critical look at postmodernist views and propose a response that hopes to take seriously their objections to more traditional and less critical views of the knowledge involved in framing policy.

The critical realist school, represented for our purposes by the work of Bernard J F Lonergan (see, for example <http://www.lonergan.on.ca/l/sites.htm>) but wider (see Passmore, 1968, pp 279-297) is used as basis for response for several reasons. In the first place, it is very well geared to the issues as raised by postmodernists. Lonergan died well before postmodernism started to be well known, and the present writer, to date, knows of no other work that deals with postmodernism from a critical realist point of view. No doubt there are, though, as one would expect on seeing the vigorous interest in his school

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evident today from the Internet. In the second place, his thinking has an affinity with the tradition of the epistemology that has been taught at university and other centres of learning in Malta (see Montebello 1995) though rarely as re-synthesised and re-invigorated by Lonergan. Thirdly, critical realism can accommodate relativity in knowledge without falling into relativism or nihilism. It has succeeded in drawing from eminent authors in both pre-modernity and modernity to create a synthesis that has the critical depth and flexibility to accept and tackle the tentative and provisional nature of all our formulations. This it does through clear theory and not by default. Lonergan does not seem to have been a 'post-modern' by temperament, and embraced hefty meta-narratives. Yet his theory of knowledge is not tied to any, is in itself quite lean in implied beliefs, and keeps an open mind on whether systems of thinking should be lean ones or hefty meta-narratives. In fact, applying such a lean theory of knowledge to the issue, the present writer will hold that the problem with meta-narratives as well as 'modernism' is not that they say too much, but that they say too little. In addition, it will also be held that postmodernism too says too little and ends up being reductionist. Being too trigger-happy with Occam's razor can slash our knowledge into a Procrustean bed that does not offer an acceptably grounded restfulness, but the discomfort of a wriggly instability.

Focal features of post-modernity and postmodernism

In post-modernity, or contemporary 'late modern' culture, accepted knowledge has not only come to terms with, but even emphatically embraced, pluralism and fragmentation. Postmodernist writers see this as a second-stage liberation from the overarching and broad worldviews that characterised both pre-modern and modern times. Modernity, ushered in by the Enlightenment, they say, performed a first liberation of human knowledge from worldviews based on religious authority. But modernity replaced them with worldviews or meta-narratives based on 'Reason', and these are equally unacceptable to the contemporary mind. Postmodernist or post-structuralist writers are claimed to be the theoreticians of post-modernity. They point particularly to the extremely though not universally influential world-views of Hegel and Marx as the sort of overarching and

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overbearing meta-narratives that should have no place in post-modern culture as it is in fact – and, they say, rightfully –developing.

Lyotard repudiates the big stories, the meta-narratives of Hegel and Marx: he believes that no one can grasp what is going on in society as a whole. It seems fashionable nowadays to say that there is no single theoretical discourse that is going to offer an explanation for all forms of social relations or for every mode of political practice. Postmodernists and others are always making this point against Marxism: they insist that it has totalling ambitions and resent its claim to provide explanations for all aspects of social experience. (Sarup, 1993, p. 147).

But postmodernists go further by taking the argument into the realm of epistemological foundations. Derrida's (1973, 1976, 1978; original French versions all published in 1967) process of deconstruction has become a shared foundation of much postmodernist writing. While not claiming to explain deconstruction to persons unfamiliar with it, this discussion will draw attention to relevant aspects of it.

Derrida equates what the human self knows and *is* with its 'discourse', that is the language used to express or communicate any information. He goes as far as saying that there is no knowing subject apart from discourse, because meanings cannot be grasped outside language, and language provides the context in which meanings take shape. He sees discourse as the only operative and definable aspect that can represent the 'contents' or characteristics of the person's developing identity. However, discourse has inherent limitations which previous writers do not seem to have perceived. As in dictionaries, words can only be defined in terms of other words. In limited and everyday uses of language we point out to things. Thus, a person who has seen green or smelt geranium can give meaning to the words 'green' and 'smell of geranium' provided that, besides having experienced them, somebody has pointed out to that person the 'object' indicated by those words. But the words that are the stuff out of which ideologies or meta-narratives are made can only be defined in terms of words in the same discourse. Deconstruction is an exercise that starts off sounding like an interpretation, but is not, as it leads to a quest to find meanings of words in terms of other words. The process never snaps out of the circularity of words defining other words to refer to anything in a 'world' outside the text. Attempts to close the circle will show that the meanings are unclear and unstable. As a result, all theory that purports to tell us

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something about a world outside of, prior to or independent of the discourse fails in its enterprise, because it never jumps out of itself into a world outside it.

Implications

Deconstruction has become an exercise to undermine all meta-narratives, all theories that purport to explain a wide area of reality in terms of a unified set of related meanings. It has fast become the standard-bearer, a sort of 'official theory', of much post-modern thinking that wants to do away with overarching and overbearing systems of meaning, especially ones that claim to disclose a unitary set of related meanings in the social world. Theories like several variants of Marxism, Hegelianism, Freudianism, social Darwinism, various types of capitalism, new managerialism etc. are deconstructed, and shown to be invalid as being both unstable and inconsistent as systems of meanings, and as, as such, having no valid reference to anything in any real world. Such postmodernist theorising has important features arising from the following four aspects.

- 1) Postmodernism is seen as liberating by finding a better place for diversity. Grand theories are set aside, instead of being imposed on groups to whom they are alien. Thus, black pregnant teenagers in a facility for teenage mothers may, unlike their middle-class white counterparts, not identify with the values and explanations given to them by their white middle class counsellors. Postmodernist analysis enables them to undermine such a set of values diverse from their own. Similarly, persons with disability are enabled to discredit an imposed system that problematises them by seeing them as abnormal and needing to adapt their needs to the system of 'normal' society.
- 2) Postmodernism is seen as relativistic. Postmodernist analysis proceeds by undermining any theorising that purports to disclose the meaning of the social world. Any such theorising can be subjected to deconstruction, which reveals the instability of its meanings, and the impossibility to jump out of the circle of 'meaning defining meanings' into the real world. As such, such post-structuralist or postmodernist thinking is an exercise in undermining meaning. Deconstruction does not claim to re-interpret, or give new meaning, or remove previous theory in order to replace it with

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theory that is better in terms of criteria that it sets. In fact, the acceptance of the fundamental instability of meaning is not seen as a basic flaw in postmodernism. Rather it is seen, in a real way, as its 'badge of honour', its sure sign that it has freed itself of the false expectation of modern thinking that discourses made up of inter-relating sets of meaning could relate to or disclose a real world for us. The reactions of persons who see life as an enterprise committed to values differ. Many deplore this as the biggest threat to any values in contemporary culture. Some hail it as a freeing from a way of analysing that was too 'Greek' or 'Platonic' in Western culture, thankfully replaced by a view that is more Hebrew, biblical, liberating, etc. A very cogent argument has been developed (Critchley 1999 pp. 161-182) that, in spite of its angry, undermining iconoclasm, Derrida and Levinas's deconstruction displays 'ethical moments'. Such signs of an ethical concern and basis, one must admit, are quite difficult to decipher and probably bear an elusiveness and 'instability' at least just as deep as that of discredited meta-narratives. Others commentators accept deconstruction with resignation as the sign that, after all, neither knowledge nor values have firm foundations, neither persons nor cultures have any 'depth', and there is nothing to do about it.

- 3) Postmodernism is seen as self-contradictory. Derrida never deconstructs his own Marxism. Observers comment that if deconstruction can undermine white middle class values or 'normal society' values, all is required for it to deconstruct black society values or 'the social model of disability' is to apply deconstruction to them. *All* thought systems are, after all, claimed to be unstable and cut off from any real world. Postmodernist writers tend to involve themselves in political and social matters only as 'underminers' and attackers. When they do show interest in political action and social values they are immediately open to attack in the very same way that they attack other justifying sets of meanings. If they confine themselves to attacking systems of meanings, even then it is difficult to see how they can do this without using the very 'tools of knowledge' that they deny. The moment they propose anything constructive, they are implicitly advocating a set of meanings whereby to interpret the real world.

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Postmodernism is a special challenge to the foundations of social policy

Postmodernism is an important influence on the value and knowledge basis of social policy and social intervention. Ideas related to the 'social construction of reality' and deviance theory have for many years influenced centres of learning where social policy, social work and other disciplines related to social intervention. But ideas about the foundations of knowledge as such were never part of the literature used in training, except by the minority who had special epistemological or advanced methodological interests. Amid all this, postmodernism has assumed the mantle as the great methodological and epistemological champion of the respect for diversity, which is so central to contemporary intervention-oriented social thinking. Because it addresses the wide-felt need to free us from the chains of imposed thinking, whether we ourselves or minority groups are victims of this imposition, it has gained an important place in training. But its novelty is that *it brings into the mainstream applied social studies course the discussion of the validity of knowledge and its basis*. Formerly one had to look hard and far afield to find epistemologies that criticise – or even support - the basis of the thinking of social policy and social intervention. The modern convention has been that the university teaching of particular sciences and disciplines interests itself in their foundations only very superficially.

Postmodernism wants to convince us that the way into post-modernity is to look these problems in the face as a central part of developing our basic outlook to the world. But then, this only takes us as far as pulling apart any theorising that we encounter. We then seem to be caught in a dilemma: either accept postmodernist thinking on foundations and resign ourselves to nihilism and scepticism, or fall back into modern overbearing and imposed meta-narratives that threaten the crucially important value of respect for diversity or, still worse, pre-modern reliance on faith and authority.

Until quite recently, one could largely ignore epistemology. References to foundations were short-lived episodes that were quickly brushed aside, like one coyly brushes aside feedback of the type, 'Sorry, but your underwear is showing' - 're-normalising' the

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atmosphere by furtively restoring foundations to their previously ignored status. Now that it is being turned into a central issue, what sort of answer should be offered, if any?

10.3: In search of 'lean and acceptable' foundations

Characteristics of the desired response

An acceptable response would be one that 'accounts for the phenomena' (Plato's *sozein ta phainomena*; see Duhem 1990, original edition 1908), or gives an account that conforms to what is observed. It cannot any longer confine itself to picking out the contradictions or faults in the view presented by others, such as postmodernists. And, most importantly, it must be applicable to itself. Postmodernism has a theory of knowledge that is a negative one that criticises other views, and ends up undermining itself when applied to itself. The ideal response would be a view of the foundations of knowledge that, besides criticising other views, presents its own version of the process. And, since the theory is about the knowledge process, it will become unacceptable if, once applied to itself, it shows itself incompatible with itself.

On setting out one cannot predict that one necessarily can find an ideal theory. The quest might yield, for example, that

- such a theory is not found or found to be impossible or a negative theory that only demolishes others but says nothing positive
- the theory is so relativist that it fails to give any strong groundedness, either in its cognitive or its psychological/ existential sense, or with regard to any basis for ethics
- the theory fails by rejecting the obvious relativity in knowledge
- the theory is sound but unacceptable to the 'establishment' in existing universities and centres of training or too alien to their way of thinking or beyond the understanding of mainstream students
- the theory is so complex and unifying that it is rejected as being an overbearing and overarching meta-narrative uncongenial to contemporary culture
- the theory cannot be backed up by serious and extended arguments and literature if it is explored further
- the theory is sound and acceptable.

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The Problem-Solving Method suggested as the basis of a 'lean and acceptable' theory

The 'problem-solving' method has unique strengths. It pervades the literature and the intervention methods of most, probably all, socially interventive disciplines. These range from social work, through counselling, nursing (it has, somewhat imperialistically, been called 'the nursing method'), social policy, planning theory, etc. Its variations are only slight, and its basic steps can be listed as:

1. registering that there is a problem
2. identifying or formulating the problem
3. thinking out possible answers or solutions
4. evaluating and selecting which answer or solution to accept and/or pursue
5. implementing the solution
6. monitoring and evaluating what is being or has been done.

Its first strength is, therefore, its pervasiveness in the literature and practice of the social disciplines. People have obviously found it not only practical, but also compatible with clear thinking and with the application of embraced values. While it can be used as basis for criticising others' theories, it is a theory in its own right, and purports to tell us what happens, rather than just what cannot happen. Its pervasive use also means that it is acceptable, at least as far as it goes and the way it is understood and used up till now, both to the disciplines' established authorities, and to its new adepts and students.

One of its immense strengths is that it brings together knowing and doing. Followers of postmodernism will tell you that, of course, deconstruction shows you that the only objectivity you can get is intersubjectivity, because knowing is very much after all what you decide or baselessly feel to be so, a type of doing. Deconstruction is about knowing, knowing is weak, but doing has nothing to do with it. But the problem-solving method is as applicable to knowing as it is to doing. If I want to find out why the dinosaurs disappeared and if I want to decide how to make my facial rash disappear, I can apply a problem-solving approach to both. However, steps 5 and 6 above may be or not be a part of the process when I am seeking an answer to a problem of knowing rather than doing.

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Especially when applied to *doing*, problem solving can be explicit about its values. Derrida's deconstruction is shown to have ethical moments that betray ethical concern – but again, appearing with the fleeting elusiveness of an illusionist who measures her or his success by our inability to spot them. Problem solving is not embarrassed by its ethical foundations, but can comfortably and openly bring them under scrutiny, and as basis of scrutiny, probably at each and every one of its stages.

When applied to *knowing*, problem solving is very comfortable with the 'obvious relativity' that is so clear to the post-modern or late modern mind. Generating possible solutions and conceptualisation and tentative narratives, and then checking how well they answer the question posed, does not sound like overbearing, absolute, imposed and unrevisable truth! Its basic logical form is, 'If A, therefore B; but B, therefore A'. This is very useful and effective in excluding a whole host of alternative 'A's, which turns out, in real life, to be immensely useful, but can never exclude that somebody might suddenly come up with a better formulation later. Better formulations range from ones that show the former ones to be completely incorrect, to ones that show them to have been 'approximations' of greater or lower value. But then, 'relativity' is not a badge of honour or something one is happy about in itself. Tentative solutions are accepted and pursued not in terms of whether they are 'grand' or 'small' theory, but in terms of whether they are the best formulation available and whether they are good enough as an answer to the problem.

Compared with the postmodernist version of the knowing process, problem solving does not see the self as only identifiable in the 'text' of the discourse formulated. So far from being inextricably embedded in the discourse, the knower compares the formulation with the problem and with experience (in the end, *sense* experience – what is seen, felt, smelt, etc.: 'pointed out', in a way). Problem solving applied to a relatively simple everyday problem can serve to illustrate. A person is woken up at night by an increase in illumination in the darkened bedroom. The problem is 'what caused the light' and the candidate answers in terms of two guests occupying other bedrooms in the house – but

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then, the way the light sways makes him decide it was due to the headlamps of a passing car. The view of a knower being successively a questioner, then a generator/ recipient of alternative formulations, then a judge of which seems the 'right' answer does not conform with the model of somebody embedded in the discourse. Knowing happens on three levels: experience (basically sense experience), tentative understanding, judgement ('reasoning' – the much-maligned 'Reason' but with a more friendly small 'r').

Social sciences have different theories of the self and the subject. But it is one thing to discuss about automatic processes that could be aspects of psychoanalysis, gestalt psychology or certain moments or aspects in Marxist analysis, deliberately restricting the processes one is studying, and it is another to take the wider view represented by problem solving. Problem solving embraces processes that one inevitably turns to, including such questions that spontaneously arise as the validity of problem solving itself. Unlike postmodernist analysis, when applied to itself it can still see itself as faced with a question, as supplying possible answers on the level of imagination and understanding, as reasoning to decide if the theory supplies an answer compatible with the 'needs' of the question.

Curiously too, problem solving is not in all its answers 'relative'. If you have no answer you still have a problem. If your answer is revised, you still often have had at least an approximative and partly valid answer. If you are not sure which answer is right, you still care which answer is right. To deny that you care what is the right answer implies that you care that what you are saying right now is what you consider to be a right answer. To deny that questions arise spontaneously in your mind, and that your thinking inevitably undertakes a process that works towards an answer is only an option for self-inflicted silliness. A lecturer once encouraged his students by telling them that 'the only silly question is the one that does not get asked'. One can slightly change that into, 'Not having spontaneous questions is normally humanly impossible; not to pursue them is both, on the one hand, forced, artificial and 'unnatural' and also, on the other hand, silly and no good to anyone.'

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Similarly, though persons may differ as to values, it can be relatively observed that they, as a matter of a very general and practically universal rule, spontaneously hold values. To deny particular values is often to replace them with others, and to deny all values implicitly accepts that the person has a 'valuing' capacity and interest.

The upshot of the last two paragraphs points out to some statements that seem very difficult, and probably impossible, to escape from, namely, that the subject is a questioner and as such, 'interested in knowing', and also a 'valuer', that is, 'interested in valuing'. We might even say that certain and inescapable knowledge boils down to more or less just that. This may sound very limited, but at least it is enough to give adequate validity to the problem-solving method in a way that does not seem to exhaust or undermine itself in application. In fact it allows, potentially at least, knowledge to grow in strength. Should we say, 'grow from strength to strength'? It all depends what, to you, is 'strong' – an interesting question – and whether the starting point of knowledge measures up to that accepted benchmark.

Are we not falling into the trap of overarching and totalising theories, by claiming that one process explains knowledge in all its variants? It is claimed here that there is nothing wrong in totalising or wide-ranging theories as such, but only in over-extended theories. Nobody would accuse Newton of totalising when he discovered that the law of universal gravitation applies to all known bodies. However, anybody who expects a glass of water on the Mir space station to behave in the same way as on earth is erring not by totalising the correctly universal law of gravitation, but by wrongly over-extending a manifestation of it beyond the limits of applicability. Similarly, it does not seem to be over-totalising to say that all species manifest survival of the fittest at least in particular circumstances. But those who embrace *social* Darwinism have overextended the theory beyond where it legitimately applied. That is why social Darwinism is an unacceptably (over-) totalising theory, while biological Darwinism is not necessarily so. In the same way, the invariant foundation of human knowledge not only does not, if properly handled, overextend itself. It even helps develop criteria to detect cases of over-extension or unjustified totalisation. As such, this method does not claim to encompass the whole of knowledge, though it

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does, like other theories of central importance, map out a whole *in* knowledge. On these grounds, we can claim that the method is not overbearing and over-arching, but that it provides 'lean but valid foundations', ones which marry groundedness with generous room for 'relativity'.

Grounded theory: post-modernity without postmodernism

One interesting remark to make concerns grounded theory. Grounded theory is an 'expansion industry' in the realm of qualitative analysis that is friendly to the post-modern concern for respect for diversity. Grounded theory does not set out to develop theory that gives a direct account of 'reality' as such, but works to elicit the theory implicit in the discourse of actors or persons who are involved with and in this or that area of reality. Thus, the reality of pain among cancer patients is studied by systematically studying the discourse of cancer patients, building up a theory not arbitrarily, but by building it up from many bits and pieces of utterances through which the patients expressed and communicated the reality. No critical distance is taken from what the patients say about it. Inconsistencies are seen as simultaneously held theory elements that are considered as valid in the sense that 'this is what the subject says' (and presumably thinks and experiences).

However, the basic method used is a problem solving and not a deconstructive one. A look at Miles and Huberman (1994; see p 8, and its other references to 'grounded theory') shows how the method is built on a greater confidence in the discourse of actors than Derrida accords to the texts he deconstructs. The informants' discourse is not deconstructed but respectfully analysed. Respect requires a whole set of techniques that minimise arbitrariness and maximise the discovery of relations that exist in the worldview and 'socially interpreted experience' under study. Besides, the researcher himself or herself is not embedded or indistinguishably entangled in the discourse, but is expected to keep a distance, compare, select, judge and evaluate. Different representations are tried out until a satisfactory 'answer' is selected. Miles and

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Huberman's Figure 5.1 ('The ladder of Analytical Abstraction (Carney 1990)', for example, indicates how the aggregation of data leads to 'Level 3: *Developing and testing* propositions to construct an explanatory framework'. Figure 5.4, 'Interaction between display and analytical test' shows how text and chart are tools in the furtherance of the researcher's understanding. Such charts are called data display, usually aiming to indicate classification, causalities or sequences contained, or the propositions. But the researcher, far from being embedded in the text or the charts, keeps distance from them and keeps matching them not with a reality she cannot see and compare to, but to the raw data and the research questions that lead her. Alternative answers are tested until a satisfactory answer is found that adequately or optimally both 'covers the data' and 'answers the question'.

In other words, grounded theory avoids imposed thinking systems by working with methodical respect to discover the thinking system of the participants, not by arguing that in discourse the self and the text and the meanings are inextricably entangled in vicious circles that have nothing to do with anything objective. In other words, *the problem-solving method is a satisfactory framework to explain the use of grounded theory, while deconstruction is not.*

One interesting fact to note is that the researcher's theory, insofar as valid, is in the end not about the discourse but about the social reality. Arrows indicating causality and sequencing, charts about classifications and text helping in disclosing their meanings represent what pain and its experience is like, in the end. If the researcher forgets for a moment what the patients think and decides to put down what she thinks the theory she expresses is not a theory about discourse but a theory about pain. Any theory can be couched through such combinations of text and charts, whether or not it is the writer's own views or somebody else's that is reported. In other words, while there is room for a grounded (or arguably objective) theory to tell us what a group of people think about something (such as pain), there is also room for theory that is grounded (or arguably objective) in what it says about the 'something' itself. Medical and psychological 'theory' (or explanatory frameworks) about pain belong to this category of 'theory

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grounded directly in “physical” reality’. ‘Physical’ is here used to indicate realities whose nature is not changed by people’s meanings and discourse. This distinguishes them from ‘social’ realities – things, like cancer pain, for example, that have a reality that is influenced by the meanings that people invest in them. The matter is obviously made complex by the fact that our world is an extremely complex combination of ‘physical’ and ‘social’ realities that we can find very hard to disentangle from one another. It is hard enough trying to disentangle the social from the physical. Things get much harder because all the social meanings overlap, build on one another, conflict, crowd one another out, vie for attention, in a world where getting a clear notion of the physical is still, after all, a largely unfinished enterprise.

While objectivity is sought, oversimplification, totalising theories and overbearing and overarching meta-narratives do not come as a surprise. The theory of lateral thinking, that of chaos and emerging order as well as the systemic view of management expect oversimplifications that prefer a simplified order to chaos. Finding room for enough differentiation so as to cater for the needs of diversity is often for them too much hard work. Thus, socially operative orders can become a scarce resource, and the line of least resistance – if not the only feasible alternative – is often the monopolisation of public space by a the views of a section or minority. Without invalidating that statement, one can re-couch it as saying that, by definition, those who have power are the ones whose version of reality dominates public space.

10.4: Mental health community need must be both grounded and open to post-modern concerns: envisaging varied degrees of relativity

Our main issue is that, in their quest for an epistemology that responds to the post-modern concern for the acceptance of diversity, postmodernist writers have not only undermined the grounding of all knowledge, theoretical, practical and ethical. They have also gained a strong foothold in the mainstream of the literature of the socially interventive disciplines. This means that epistemological issues have ceased to be a matter of interest merely to a small minority of students and scholars, and this has been

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done in the name of what could be called an 'anti-epistemology', that is, one which attacks central foundations of knowledge, without offering alternative foundations. The virtual ignoring of epistemological bases can no longer go on without weakening the credibility of social policy and related disciplines in an increasing number of minds.

The problem-solving method is being suggested as the required vehicle, at once acceptable and accessible, that can bring questions of grounding into the accustomed scope of mainstream literature. While being accessible, the theory can be further deepened through a corpus of epistemological literature for those who want to pursue the subject further. So far the aim has been to build the bridge, and to give a foothold that is sufficiently secure to give an adequate grounding.

Problem solving is a good vehicle because it is involved both in knowing and in doing. We disagree with Derrida when he says that when we formulate we take no distance from our discourse. In fact, we are exercising our critical faculties all the time. But we also use our critical and weighing faculties when we decide what to do.

In order to 'unpack' the problem – using the sort of 'unpacking' techniques we have found useful in applying ARC – we can in fact detect not just two levels of the use of problem-solving in the interventive social sciences, namely, knowing and doing. Table 10. 1: Eleven levels of social problem solving, and seven validity or relativity issues that arise with the increase of complexity. tries its hand at such 'unpacking'. If one stops and gives a reflective look at them shows that social policy and social research tend to make statements at all the levels of complexity – and that social policy tends to revolve around the levels that are the most complex. By way of explanation one may clarify the meanings of 'physical fact', 'own need', 'social fact' and 'stance'. A physical fact is a 'given' of sense experience about something outside us, independent of social construction and of the needs of humans. In our very much socially reconstructed world it is very much like talking about limits in mathematics which we can never reach but are always 'there and beyond'. But a statement that 'the client's front door is not broad enough for her wheelchair to pass' revolves on a physical matter, but the wheelchair is

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also surrounded with uncountable aspects that spring from social construction. The 'merely social' is also difficult to envisage, because social matters are connected with physical ones, things that are perceived 'before' or 'independently of' the social significance we give them. Even such a social phenomenon as the curious human need to label people has to do with perceiving people, touching them and bumping into them, and the consequences of that, starting from those that emanate from the laws of physics.

<i>Eleven Levels of Social Problem Solving</i>	<i>Seven Related Issues Involving Relativity and Validity</i>
Level 1: Formulating a simple physical fact	Issue 1: 'Which formulation shall I adopt?'
Level 2: Formulating a 'simple need' / 'void' regarding oneself Level 2a: Formulating own need Level 2b: Considering action re own need	Issue 2: 'What shall I choose? What shall I do?'
Level 3a: Formulating another's need Level 3b: Considering action re another's need	Issue 3: 'What would be a valid representation of the other's need?'
Level 4: Reformulating another's formulation or communication Level 5: Formulating a 'social fact'	Issue 4: 'How far, how, should the other's version of the need be adopted or modified?'
Level 6: Formulating a fact within a functional and meaningful relationship with the subject	Issue 5: 'How far, how, should I disentangle my bias from my formulations?'
Level 7: Formulating diverse needs Level 8: Formulating conflicting needs Level 9: Reformulating conflicting formulations of need. Level 10: Formulating conflicting action choices re need.	Issue 6: 'What 'stance' shall I take? What should be its rationale and justification?'
Level 11: Considering action on any situation ranging from 4 till 10.	Issue 7: 'What action shall I support? How? At what cost?'

Table 10. 1: Eleven levels of social problem solving, and seven validity or relativity issues that arise with the increase of complexity.

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'Need' is curious in being very often both 'a given' and 'human' – and, as such, impossible to stop it becoming 'social'. The experience of pain is no less a 'given' than seeing 'an image of' a stone fall (or, the stone in such an image). The urge to look for relief is also a given. How we do it, how we expect it to work, who we trust, whether or not we endure it, all the meanings as well as all the functional relationships around it throw us up into the higher ones among the eleven levels.

As we move up the levels, as indicated by Table 10. 1, we encounter various issues that challenge us. The reader is invited to carefully consider the seven issues identified in that figure.

As I struggle to find formulations that communicate my message to the reader, I do find some sympathy with Derrida's idea that I am inextricably entangled in my formulations. If not, he says, I can jump out of my words and compare them with 'the real thing' I want to convey – but I do not see more than I write: so how can I? But then I also see that I am sometimes rather satisfied and sometimes rather dissatisfied with what I write. I seem to be comparing it with an ideal. I often try again, and compare different formulations, and select among them. That means I *do* keep a critical distance from my discourse. But this does not mean that I see the 'real thing', see my 'discourse', and compare the picture with the reality. It is difficult to accept how a writer who is so critical of what others say denies that we are critical of what we ourselves say all the time, and therefore keep a critical distance. For the moment let us simply note that the tentativeness and unexcludable improbability of our formulations is a fact we can only escape by performing it and, as such, show our implicit adherence to it. If there are different ways of formulating my experience of the billiard ball I saw move or the pain I felt, it neither denies the existence of the fact in the first place nor the other 'human' fact that one formulation can be better than another. The human thing to do is to improve a formulation if the current one is unsatisfactory. But as we plunge into 'human' matters we are moving up the ladder of issues we formulated in Table 10. 1. These include issues of diversity, of bias, of personal choice.

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The relativists' despair: Or, how many relativities will make a relativism?

The relativist's or the nihilist's despair at making sense of the world or of bits of it can be compared with that of an organiser who is requested to 'Organise a conference on a Mediterranean Island, featuring both business and pleasure, for the managers of Ploggs and Phloggs Ltd (UK).' With no more information than that, there is no hope she or he will succeed. But the problem is not that there are too many variables, but there are too many unknowns. Once the variables become known at least up to a point, the conference can almost surely be a success. Numbers, background, type of business, preferred pleasures, etc., can become known sufficiently to practically guarantee success.

	<u>1st Relativity:</u> <u>to imaginations</u> <u>and</u> <u>formulations</u>	<u>2nd Relativity:</u> <u>to personal</u> <u>choices</u>	<u>3rd Relativity:</u> <u>to diversity of</u> <u>need and</u> <u>experience</u>	<u>4th Relativity:</u> <u>to the bias of</u> <u>formulators</u>	<u>5th Relativity:</u> <u>to stance taken</u>
<u>Questions of</u> <u>Relativity:</u>	<i>Relativity to varying imaginations and tentative formulations</i>	<i>Relativity to varying possible and actual personal choices.</i>	<i>Relativity to the varying needs and experiences of people.</i>	<i>Relativity to the varying own needs and interests of formulators.</i>	<i>Relativity to the varying stances (with respect to values and others' interests) taken by formulators.</i>
<u>Salient at:</u>	<i>All Levels</i>	<i>Levels 2b, 3b and 11</i>	<i>Levels 3a-11</i>	<i>Levels 6-11</i>	<i>Levels 7-11</i>

Table 10. 2: Five key dimensions of relativity, and the Levels at which they are salient

Our next step will be a consideration of the statistical notion of 'degrees of freedom'. If we have three algebraic equations and three unknowns, our degrees of freedom are nil: all the unknowns are fixed, and we have no freedom to set or choose any one of them as we like. But if we have three independent equations and five unknowns, we have two degrees of freedom: we can decide to assign any value that we want to two unknowns. After that, our degrees of freedom have been exhausted: all the unknowns have become

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known, and no longer subject to free choice. In fact, in general, 'the number of degrees of freedom is equal to the number of quantities which are unknown minus the number of independent equations linking these unknowns' (Blalock, 1960, p. 156).

We shall compare the 'degrees of freedom' to the notion of 'degrees of relativity'. It is clear that social phenomena have many aspects of relativity. Besides, these relativities seem to accumulate, one on top of the other. If we want to find the best way to meet a client's need, we find out that this is relative to her particular sensibility, which will be different from the next person's. It is relative to our concept of what is the problem, which is hypothetical and approximative, and to the model of care that we entertain (whether the medical, the rehabilitation, the strengths and the social model, etc.). It is relative to how critical and rigorous we have been in our methodology, as well as how correct, in the end, we happened in fact to be (whether or not ours was a 'valid' methodology). It is relative to how far, after all, our formulation of the problem was metaphorical in some of its aspects; the cultural milieu we are working in, the culture embraced by the client and by us, the biases that come into play because of personal interest and other sources pressing for distortion. It will also depend on how far we care, who and what we care for (the same applying to other persons involved) and on the question of whose viewpoint prevails. It sounds as if we have many unknowns and hardly any equations to go by! If one level of relativity generates a relativity that stops us pinning down the answer, what absoluteness can be claimed when we come to the global question, the result that should be clear once all the unknowns are known, namely, what should our intervention be? Does not every level of relativity further increase the range of different values any of the involved unknowns can have? Is this picture of compounding relativity not, after all, the ultimate justification for the most thoroughgoing relativism and nihilism, one that says that 'anything goes' and 'nothing is valid'?

The answer that is being proposed is that *there are various ways in which the degrees of relativity can be 'pinned down' or 'kept in check'*. The more unknowns are 'pinned down', or the more levels of relativity are 'fixed', are 'accounted for', the less there is

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room for unmanageable fluctuations. Equally, the more aspects of any assessment that one makes become grounded, the more the scope of relativity is narrowed.

But what do we mean by ‘pinning down’, ‘fixing’ or ‘accounting for’? It would seem that there are different major categories of the relativity that worries those that succumb to relativism or are tempted to. It is suggested that ‘pinning down’, ‘fixing’ or ‘accounting for’ mean different things, largely depending on the major category of relativity one is dealing with.

	<u>1st Relativity:</u> <u>to imaginations</u> <u>and</u> <u>formulations</u>	<u>2nd Relativity:</u> <u>to personal</u> <u>choices</u>	<u>3rd Relativity:</u> <u>to diversity of</u> <u>need and</u> <u>experience</u>	<u>4th Relativity:</u> <u>to the bias of</u> <u>formulators</u>	<u>5th Relativity:</u> <u>to stance taken</u>
<u>Questions of Relativity/ Room for relativism</u>	<i>Relativity to varying imaginations and tentative formulations</i>	<i>Relativity to varying possible and actual personal choices.</i>	<i>Relativity to the varying needs and experiences of people.</i>	<i>Relativity to the varying own needs and interests of formulators.</i>	<i>Relativity to the varying stances (with respect to values and others' interests) taken by formulators.</i>
<u>Questions of Objectivity or Validity / Room for minimising relativism</u>	<i>Correctness with which formulation fits the facts and answers the questions.</i>	<i>Consistency of action choices with embraced formulations; correctness in representing choices made.</i>	<i>Correctness with which others' needs are formulated.</i>	<i>Freedom from bias in making one's formulations.</i>	<i>(here the 'correctness if predominantly a question of ethics rather than objectivity)</i>
<u>Related Values</u>	<i>Free rein to one's desire to know</i>	<i>Doing consistent with embraced formulations</i>	<i>Respect for diversity</i>	<i>Disinterest</i>	<i>A 'responsible' stance</i>

Table 10. 3: Methodological and ethical aspects in relativities: room for relativism, room for minimising relativism

Relativism seems to despair of valid knowledge about need because it first puts various relativities in the same bag, and then brands them all at one stroke as unacceptable. However, through the present exploration of ‘degrees of relativity’ we can demonstrate that relativities are various and distinguishable. Here it is suggested that, taken one by

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one, relativities can prove to be manageable. Each relativity will be shown to have an acceptable and an unacceptable 'mode of management'. 'Acceptable' here means conducive to validity. 'Unacceptable' would refer to aspects or possible uses that undermine validity. Rather than despairing of ever limiting these relativities, it is suggested that there are ways to manage each relativity in the acceptable direction. It will be admitted, however, that in the end we are basically incapable of ever disentangling completely the unacceptable from the acceptable. Still, a picture will be formed of an achievable improved and improving balance between the two. The reader is invited to follow the discussion and, then, to make up his or her mind as to (a) how far and in what way the validity and the worth of the findings has been grounded, and (b) how the discussion improves the sense of proportion needed to decide what significance, what weight, what import, to attribute to the findings

Pursuing validity through the relativities: the place of methodology, ethics and values

It will be here maintained that for relativities it is a matter of 'divided we fall'. Each relativity on its own is 'manageable', in its own way. 'In its own way' seems to imply 'not quite as one would wish'. In a way, that is correct. Table 10. 3: Methodological and ethical aspects in relativities: room for relativism, room for minimising relativism', has to admit that each relativity creates room for relativism. But also, there is an antidote to each, whereby relativism can be minimised. People's formulations can be erroneous (1st Relativity), but good methodology plus giving a free rein to the disinterested desire to know can spot errors and correct them (following Popper's modest but important claim in this regard). People will make different choices (2nd), but if they communicate rather than hide them, and if they pursue the ethical ideal of consistency between thought and action, this relativity can be objectively represented – but of course, this will not always succeed, so relativism, which involves formulations that deviate from the objective, will also find its way in. People's diverse needs (3rd) call for an objective representation, correctly representing X's need, even though it is not X who formulates it. This too does not happen automatically, but calls for objectivity, and can also allow mistakes to happen. Bias (4th) may be – or not be – the culprit; and this calls for intellectual honesty, which can improve results though not infallibly. Finally, all action is based on a stance (which

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includes any 'non-stance' too) (5th relativity) regarding values and interests, and here ethics in choosing one's stance 'responsibly' and in pursuing consistency between thought and action, the 'formulated' and the 'performed', limits the relativism. Ethics and 'stance' are the linchpin of the management of 'relativities', that keep the 'anything goes' of relativism, intellectual and ethical, in check.

10.4.3: Implications on needs assessment and related action

Is the knowledge in the 'interventive social sciences' purely technical and communicative?

Interventive social sciences, such as social policy, are a mixture of what Habermas (see Baumann (1978), pp 239-241) would call 'empirical-analytical sciences' and 'cultural sciences'. These approximately correspond with an emphasis on either one or the other of two concepts we borrowed from Sorokin's (1947, see p. 314) cultural analysis, the former emphasising functional, the second 'logico-meaningful' relations. But the cultural sciences also deal with functionality or causality. Once a system of meaning becomes operative, it will intervene in the world around it, and dominant social groups tend to impose their meanings using means that, in the end, are coercive and socially controlling. Social policy, being an 'empirical-technical' science, is mostly preoccupied with technical intervention. We might be tentative and uncertain about many of our formulations, but they are the basis of our intervention, and they take us a long way. Our critical approach, being simultaneously empirical in always checking to make our formulations 'fit the facts' progressively better, as well as 'methodological' in seeking to follow the rules that lead to more valid knowledge, gives a generally increasing validation to our formulations.

Such knowledge is not transcendental. We can only come by 'inescapable truths' on the transcendental level, and these pretty well add up to the following list: I am, I am

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interested in knowledge, I care about values. Very little in a way. A very precious little bag of 'facts', though, that can only be denied at the price of the type of contradiction that Derrida commits between what he says and what he does.

But all we say in social policy, as an empirical-analytical science, is about what could and what should be done, in terms of our guiding values and our formulated and adopted aims. It tries to improve the effectiveness of our interventions with respect to our aims. As long as it improves this effectiveness, it is useful and therefore valid. The criterion of validity of an interventive science is its effectiveness. So the answer to relativists is that we have limited choices, basically. Firstly, whether to refine and improve our science, or not to refine and improve it, using the best methodology, and the intellectual honesty and commitment that comes from giving free rein to our pure, disinterested desire to know. Secondly, whether to act, for the sake of effectiveness in line with our aims, consistently with out methodologically and empirically best formulations, or to give up this quest.

But social policy involves also a cultural science. Through it we communicate meanings. Meanings are in important ways the carriers of such 'relativities' as our values and our stances, our renderings, to ourselves and to others, the others' experiences and the formulations of others' experiences. Hermeneutics, which started off as the science of interpretation of sacred texts, in the minds of many dethroned epistemology. It is based on an idea that has been increasingly influential into later late modernity or post-modernity: that there is no privileged point of view, and that the dialogue between holders of different views requires a specific science of interpretation.

Derrida, in a real way, 'decentred' hermeneutics by introducing deconstruction, which very ably discovers the final instability of meaning. We are inclined to go a long way with Derrida, just as we espouse the hermeneutic idea of diversity of viewpoints. We do believe too that, in the end, we define meaning in terms of other meanings and that, in the end, this involves a circular process that does not add up. This, in fact, we see as an excellent way of characterising the imperfect and tentative nature of all or meanings. But, being confirmed in our belief of the testable applicability of the problem-solving

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process, we refuse to see the human person as impossible to disentangle from her or his discourse. The human knower cannot jump out of her or his formulations to affirm the 'thing' directly. But a knower can match formulation with the data of experience (in the end, sense experience) and match them with the rules of good methodology. The latter, in the end, arise from an inescapable – though fallible – drive in search of correct statements that put us into contact with the reality which we encounter.

A knower who judges the effectiveness of contemplated action over against desired aims will completely by-pass the trap that Derridans have set themselves through their assumptions. The subject will refer to his or her aims, as a benchmark, a point of reference or comparison. But Derridans do not permit any reference to the author's intentions in a discourse. Given that Derridans rightly discover meanings to be internally and interactively imperfect, and incomplete and defective as a self-consistent system, they have no recourse but to pull the rug from under any claimed knowledge. But the refusal to have recourse to a knower who is basically or 'transcendentally' but effectively distinct, though impossible to fully disentangle, from his or her discourse, is what deprived them of this recourse. One is not discovering that there is not recourse, but one is simply taking upon oneself the consequences of a rejection of it that has no cognitive grounding, and turns out to contradict itself when applied, as any valid epistemology should be, to itself.

The imperfect nature of formulations is the end of the road for the deconstructionist. For the critical realist it is a part in a jigsaw forming a whole process that is bigger than its parts. The pieces that form it are a knower, a reality that is, in the end, independent of the knower and the knowing, but also a spontaneous drive in the knower to ask questions, to understand and to affirm critically adopted formulations

So if social policy is to have anything to say in reply to the unavowed epistemology brought into mainstream studies by the Derridans, it cannot shy away from admitting the deep, often 'post-modern-friendly' implications of the 'relativities'. But neither must it shy away from viewing knowledge through a theory that has an explicit critical

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epistemology, while being also realist, in that it accepts basis in sense experience as a necessary level or stage though, by itself, not the whole story. Neither can it shy away from values and meanings as part and parcel of its essential fabric, besides being part and parcel of its object of study. Its knowledge must be both technical and functional, aiming to intervene to change reality, and, equally important, communicative of values, feelings, experiences, stances and personal options.

The upshot of this section can be put in a nutshell as: give free rein to your desire to know, follow its demands for good method, formulate your aim and do your action in line with your accepted formulations. Of course, subjectivity lurks in all your formulations. You can spot errors and often correct them, but you are not infallible and your formulations are tentative, probably many of them very approximative, others erroneous.

Of course, there is no answer to the 'brain in a bucket' objection. This refers to a modern version – more fully expressed in the Heythrop College, London, website of the objection put forward by Descartes that our knowledge processes are vitiated by a demon who has control of our mind. The Heythrop website asks if ours might not be a brain in a bucket connected to a computer that controls our thinking. Of course, that cannot be fully excluded. But can one exclude apathy, in pursuing better knowledge and 'a better world'? This time it becomes a question of stance or personal choice.

This dissertation is based on a pre-ideological stance in favour of people in need, especially those who are poorer and more vulnerable. It also appeals to its readers to embrace such values. The stance is taken in full knowledge that both writer and reader will imperfectly pursue it, but a desire for deep commitment to it is expressed (and felt). A reminder of this stance is very important when trying to see how our explorations into grounding in the end influence our formulation of need. The previous section explored the values of productive commitment to intellectually honest knowledge and action consistent with it for the sake of effectiveness. One can embrace this in tandem with many a stance regarding values and interests. A type of social Darwinist would

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formulate different needs from a proponent of the social model of disability. A pro-choice feminist would not include the same 'people' in her purview of vulnerable persons meriting help from a pro-life feminist, and define needs differently; as would a Taleban activist when compared with a politician radically led by 'American interests'.

The despair of relativists often springs from their giving up on the tall order of having to be 'all things for all people'. To hope to run after all the relativities together is like, as the French say, a hunter trying to pursue more than one hare simultaneously. We shall therefore try to spell out how needs would be defined by a person adhering to the value stance in favour of the poor. As a respector of diversity, a person led by this stance might, however, be often called to formulate values emanating from a diverse stance.

Implications on mental health need

Some related issues can be raised as to mental health community care need. The first is that of 'needs-led services'.

The call for need-led service is an interesting challenge to critical thinking. Social workers and case managers are told that it is a mistake to write in a needs assessment that the client 'needs admission to the Psychiatric Unit', or 'needs home helps', or 'needs to attend one of our day care centres'. If needs are defined in terms of services, then provision will be 'service-led'. Services must, instead, be *needs-led services*. So needs must be defined in terms of a problem – which is at once broader and more basic as well as more individualised, less stereotyped – rather than as a 'solution disguised as a problem'. 'Needs home help' can become 'needs help with housework' or even, more radically, 'his/her domestic needs are many and not met'. The issue is fundamentally one of respectful listening to the client's formulation of need, very often our surest bridge to the client's experience of need. But often other people come up with solutions to my problems that I did not think of. This gets us into the realm of normative need – experts

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might know better than the client. Besides, a third person, not necessarily an expert, might contribute to the formulation of the problem or need, or even to the solution of it. Most challengingly, some people might not know they have a need before they know of a service or solution. The interviewee that said she attends the mental health services 'for the pills' will one day say she does this for rehabilitation once this notion has entered her accessible universe. So 'needs-led' will be interpreted correctly when you interpret 'need' correctly, even at the cost of defining it largely in terms of a service or solution. In fact, 'solution-based therapy' is the name of a service model which, in a way, says the opposite of 'needs-led'. (Will the relativist gloat over this 'contradiction'? 'Contrary does not say contradictory', the open-minded critical realist will say).

A second implications issue is that of *imposed meanings and need definitions*. Of course, meanings can be imposed in terms of the First Relativity – which is basically another way of saying that people can be 'genuinely mistaken' or even 'inevitably approximative' in the way they define their own needs or those of others. One would not normally call a genuine mistake in assessment or diagnosis an 'imposition' – though it would be a case, in a very real way, of meaning imposed by 'power', even if it is the mistaken self-labelling of, for example, an anorexic. But 'incorrect' or 'unhelpful' meanings are more clearly a case of imposition if Relativities 2 to 5 are concerned. Other people can impose needs definitions on a person by imposing their own personal choices, as in the case where applicants for housing are treated on a 'beggars cannot be choosers' basis, implying that the choice of locality is purely the providers' or the caring team's choice. Persons with a minority sexual orientation, deluded person who 'like' their delusions, raise problems of respect for diversity that can be said to be located in their definition of need, which should be broad and individualised enough to facilitate a solution that respects their diversity. So would persons whose norm in life is to work without a work book (escaping employment regulation and the payment of National Insurance) or young girls with a behaviour problem who disagree with the way of life advocated in their hostel. Relativity to the interests of an interacting formulator can also be variously exemplified. A psychiatric social worker may be instructed to explain to relatives that

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ECT is needed, knowing that the real reason has more to do with staff shortage limiting the personal attention that can be given to a disturbed patient than to the patient's 'pure and obvious' need. Client choice to enter or leave a unit could possibly be determined more by staff convenience than by client need. But, of course, staff needs and system limitations too have to come into the transaction – transparently and disinterestedly where they belong, in an ethically advanced system.

10.4.4 How objective can constructs, rating scales, models and meta-narratives be?

Constructs, rating scales and models

Dr Joe Oliver was very particular (in various personal communications) not to create a construct representing 'global quality of life'. Touching upon Aristotle and the Utilitarians and other philosophers, he maintained that the concept is too abstract, variable and elusive to want to 'pin down' with any validity, within such an empirically testable construct as 'global quality of life'

The present writer was originally shocked on reading about rating scales that measure psychiatric morbidity, in which the weighting given to the various domains of symptomatology is made to vary according to the main diagnosis of the patient. He later realised that this was part and parcel with purposive nature of such a rating scale. Viewing it, again, under the problem-solving method one can see the appropriateness of seeing action-oriented problem solving and statements of fact – such as a diagnosis – not to be so different from one another after all. True, such a rating scale is there to yield a diagnosis. But it is there to detect change in severity or symptomatology. Since certain areas of symptomatology are more prominent in particular diagnoses, giving those areas

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greater weighting increases the rating scale's change sensitivity. This is a valid solution on the problem-solving level aimed at improving intervention.

This does not deny a great measure of objectivity in rating scales. What is affirmed is affirmed as objective, as 'being there prior to or independently of' our affirming it. On the other hand distinguishing and disentangling, within this rating scale and its results, what is objective and what is subjective, what is valid and what is relativistic, is a complex task which can only succeed at the cost of laborious analysis and still very partially and indicatively.

It has, interestingly, been suggested (Priebe et al., ed., 1999) that rating scales about quality of life could also profitably undergo such a differentiated weighting among its domains. The suggestion, however, was not motivated by a desire to impose, but rather a contrary one: to increase respect for diversity. Respondents could be invited to state themselves what weighting to give to each domain in terms of, for example, the different weight they would give to their housing, family, religion, health, money etc. as contributors to their overall quality of life.

Max Marshall's Autoneed also goes a long way in respecting the diversity of experiences and decisions of client and carer. A need is registered if either the client expresses a problem and a wish for help, or carer points out that it causes her or him stress. A more normative criterion for need is also introduced: whether there are indicators that client is dangerous to self or others or carer feels that the problem elicited threatens client's ability to sustain of the his or her desired living placement.

Grainne Fadden's Family Impact Questionnaire⁵ raises an interesting issue. She later dropped this lengthy questionnaire in favour of briefer and crisper ones, and her articles

⁵ This more acceptable renaming is introduced to refer to the rating scale originally named 'Family Burden Questionnaire'.

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tend to go in the more 'scientific' direction of finding correlations between family burden or impact and particular types of morbidity and situations. However, the original lengthier questionnaire affords a better 'human' or 'empathic' understanding of the family's living situation. The latter illustrates 'understanding' as 'the work of life' as opposed to 'understanding as the work of reason' which set Garfinkel, for example, at loggerheads with Popper. But it only serves to illustrate that, in the end, we have to triangulate among quantitative and qualitative, functional and meaningful, empathic and 'standing back' approaches.

With the help of qualitative, ethnomethodological, grounded theory or hermeneutic approaches one hopes to be able to respect diversity and minimise the imposition that comes from simplistic overgeneralisation. These approaches are, in fact, the enemy of certain 'models', but not others. As one moves from the medical to the rehabilitation to the strengths or social model of mental health care the direction is definitely one that is more humanistic, liberating and congruent with our pre-ideological stance in favour of the vulnerable. This raises two questions: (a) what make a model more or less objective; and (b) what makes a model involve less imposition?

What makes grand theory grand? What is the antidote?

The criterion of objectivity is, basically, 'correctness with which questions are answered'. Moving from the medical through the rehabilitation to the strengths and social models, objectivity is improved if the questions are broad (such as, 'what is happening?', 'what is determinant?' or 'what helps the client?' or 'what brings about effective improvement in quality of life?'). But objectivity is not influenced if the questions put are model bound (such as, 'what is happening medically?' moving through 'what is happening from a rehabilitation point of view?' to 'what is happening from a strengths or social point of view?'). *But if objectivity is to be seen in the light of the ethical concerns that come from a humanistic stance, effectiveness becomes a key realm in the criterion of objectivity.* It is seen in terms of the 'humanistic' ideals that are espoused by a

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combination of a responsible stance and a responsible elaboration of the meanings it incorporates

What is curious is that the 'later' models have found the earlier ones 'deficient', but have not thrown out the idea of having a model, but come up with a new one. Curiously too, each subsequent model is more holistic, open to the combination of more viewpoints (in such a way that each incorporates the previous within a broader set of complementary viewpoints) and, simultaneously, perceived as more humane and liberating. *This seems to contradict the post-modern/ post-modernist contention that could be framed as, 'the grander the theory, the more it is an imposition'.* In fact, the contrary happens.

The answer to this must be that this post-modern/ post-modernist contention is mistaken. Models and meta-narratives are not more 'imposed' or alienating the *grander* they are, but the more *reductionism* they are. The medical model was 'imposed' because, while it claimed that it was for their good, it determined people's lives by rules and criteria that were operative and beneficial only when one was dealing with purely medical problems. This reductionist approach, in effect, told people that it was good for them to live in institutions modelled on acute hospitals, where patient passivity and batch treatment were conducive, as a rule, to more effective or, at least, feasibly efficient, treatment. The strength of this view of reality comes home more forcibly when a schizophrenic living at home cannot think of any other reason for attending MOP than to 'get the pills'.

What is equally intriguing is that the 'grander' the model, out of the ones we are considering, the more it is client-centred - which contradicts the post-modern/ist contention about meta-narratives. It is perhaps right here to distinguish various criteria of 'grandness', seeing them in relation to their expected imposed or alienating qualities.

1. 'Grand' meaning *having a broad application* does not necessarily mean more 'imposed'.
2. 'Grand' meaning *complex*: The social model, by incorporating and broadening the two previous models, is richer in ideas and, as such, more complex. However, it

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curiously can, in real ways, reduce 'complications' in a person's life and therefore less 'imposed'..

3. 'Grand' meaning *overpowering* (often combining imposition and 'tightness' or inflexibility): This type of 'grand' will inevitably be 'imposed', by definition. It also has the connotation of 'grand' in the sense of 'big headed' or 'grandiose', seeing oneself as bigger than one should. Flexible models are welcome, because they allow me to do things as I see best here and now. No one normally experiences as inflexible the problem-solving model or the need to breathe or the spontaneous drive to ask questions, because the exigency sounds appropriate and spontaneous when it emerges.
4. Grand meaning '*having a broad perspective*' meaning that, though many theoretical frameworks or theoretical components make it up, they leave room for satisfying choice in practice.

In other words, what is wrong with meat-narratives or grand theory or big models is not their 'size' or 'complexity' but their appropriateness – meaning, by our criteria, their correctness as an answer to demands of effectiveness *and* the meanings that assure effective intervention *because* they imply a correct understanding. In other words, though Germans in the nineteenth century were fond of very complex and, in many ways, very tight theories, like Hegeliansim and Marxism, and Anglo-Saxons and Anglicans and post-modern culture are fond of 'an empirical approach', 'a broad Church' or 'depthless culture' and 'a la carte identities', the best theory is the one that, using Plato's criterion, 'fits the facts'.

Meta-narratives and grand theory, in fact, offend not by saying too much, but by saying too little. Or rather, they say too much about too little but then go on saying it about everything. In other words they commit the double error of *reductionism* with *over-extension*. Thus, the medical model reduces its subject to its medical aspect, and then extends criteria, perspectives and rules of conduct appropriate to the medical aspect to the whole of the life of the client, his living space and his family. This becomes an exercise in imposition, that is, of unjustified power, when doctors abuse of their having the 'final

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say' as to danger and safety by wanting to have the 'final say' as to many other things as well unrelated to medical expertise. It is as if the engineer who had the last word as to whether the Titanic should travel insisted on having the last word about all the goings-on that took place on that ship! The same applies to Marxist, Social Darwinism and Right Wing dogma insofar as seen as inflexibly reducing all issues into one set of ideas appropriate only to a limited area of reality. But a stance in favour of the vulnerable puts imposition on its head. In exercising and driving 'strength in weakness' it can support theories about the world that can be quite wide-ranging in scope, yet humble and ever ready to listen and to see.

10.5 Questions of congruence: How far are they questions of evidence?

Validity and the notion of congruence

In this section we reflect on some validity issues related to the notion of congruence and that of cultural analysis. We propose congruence as the criterion to distinguish between appropriate and inappropriate policy transfer, model importation and service design 'adaptive adoption'. A service design will be appropriate if it integrates functionally and on a 'meanings' level with what there is in the adopting country.

Obviously, the criterion of congruence begs the question: what are the criteria of coherence? That is almost like saying that the question of congruence is more of a right question than a right answer. But if increased know-how is to improve the goodness of fit between policy design and context, it must capably and persuasively detect cases of good and bad fit, explain them, and direct us as to how to choose between fits that will work and those that will not. Here, what we are looking for is basically predictive validity.

Here, again, the challenge is not to overdo congruence. A system can be too coherent. The Soviet bloc collapsed because it was internally too coherent, in a way, isolated from outside feedback. The present Maltese socio-political settlement too at present risks being over-coherent, in that both major political parties very often collude with sources of

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resistance against necessary change, out of being too afraid to cause the tiny swing needed to tip the electoral balance. Longer-term economic sense and necessary change is interminably postponed. Like strategic planning, Active Remodelling for Congruence must proactively seek congruence with the actually and potentially operative context, but all this in the name of the valued goals proposed for the country.

Besides being overdone, congruence can be 'over-extended', like any model or component of a model. This is in the sense of attributing congruence, integration or coherence where there is none or, rather, there is no question of any. Congruence, thus, is an empirical question: it is through examination of actual cases that one discovers where it applies and where it does not. Thus, one can consider the question, 'Does negotiated contracting by purchaser fit better in a country with a Beveridge system than in one with a Bismarck health insurance system?' Because Britain pioneered the system and Bismarck countries as a rule have stayed with contract terms centralised by government, one could conclude that this is incongruent with the Bismarck system. However, Germany and the Netherlands have in fact introduced such discretionary contracting (Saltman et al. (1998), 168-170). Even if they did not, an examination of the inner logic of both adoptee model and adopting context would have anticipated such grafting to be 'recipient-friendly'. How it turns out in fact might be another matter. In other words, the best learning through conceptual examinations but by applying the latter to others' experiences. This whets one capacity to anticipate and assure a successful 'graft'.

All this leads to some relevant reflections. First, need of congruence in policy is not to be taken for granted. Inspection is needed to find out if it actually exists, and also if it is desirable. Second, congruence is a matter of purposive problems solving, of finding the best model for an espoused aim. We can say that when Thatcher's government designed the contractual system, she was indulging in adaptive policy transfer – an Active Remodelling for Congruence - while importing a policy idea largely from the US. Having decided to retain the Beveridge system, it proceeded to *adapt* within it the NHS structure to make out of it an instance of wise (or adaptive) policy adoption. In turn,

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Germany and the Netherlands imported the idea pioneered by the British. In both, an adaptive ingredient was decentralisation. Countrywide contract terms were replaced by ones made on a lower administrative level and negotiated with particular providers or sets of providers. Providers could also improve their competitive edge by providing features that were arguably better than those of their competitors'. It is worth adding, in parenthesis, that the new concepts and adaptations to a foreign context became, in their turn, interesting enough for 'Lessons from the British Experience' (Light, 1997) to be garnered by an American observer. Perhaps Maltese 'adaptive adoptions', too, will yield lessons to the models' 'natural parents'!

Third, the fact of decentralisation is interesting. Decentralisation can be said to be an antidote to over-congruence or, more correctly, *over-tight congruence*. Decentralisation is a deliberate exercise in increasing flexibility. It is a movement that is very germane with post-modern fragmentation. Tom Peters glorified it in his *Thriving on Chaos* (1989) as a characteristic of effective management. Perhaps nothing illustrates better the challenges of tackling diversity than management, public administration and social policy as they optimise flexibility through decentralisation. In promoting flexibility with control they introduce decentralisation but with increased attention to centralised accountability and control. It seems to admirably parallel the discarding of tight and over-arching systems of thinking. We nowadays need systems of thinking that allow for variety of what we fit into them according to our particularised needs and perceptions 'from the ground'. Peters overstates the fragmentation by calling it 'chaos', reflecting the overstatement that is enshrined in the very name of chaos theory which is more about emerging order than about actual chaos. But that is the fashion now, and that is part of what seems like an adolescent's reaction to 'overbearing', imposed, overextended and over-tight systems. Perhaps, taking a leaf from decentralisation practice in management, what we need now is not the absence of any systems of thinking and organisation, but their replacement by looser and leaner ones but still, in the end, rational ones.

This almost boils down to taking up the same advice as that given by post-modernity against grand theory. But it is over-extended theory (and, as such, 'over-grand') theory

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that should be proscribed, not rational theory or the use of reason as such. Still, there is gain to be obtained from taking a more pro-rational (critical realist) view. Though we follow the same advice against certain uses of Marxism, Hegelianism, psychoanalysis, etc., we do not contradict our theory by what we do: in the way we develop our knowledge, active or reactive. We can remain consistent with our method all through.

Unfortunately, the theories of Limited Rationality and Mixed Scanning realistically tell us that, whatever we do, we can never get out of cutting *some* corners – and probably often *many*. Any theory worth having is basically about doing. In the end, theoretical cutting of corners raises questions of power, in the form of the question, ‘*Whose* corners will be cut?’

10.6: Myth, Grand Theory, Cultural Resilience and Weak Meta-narratives

Proponents of qualitative analysis in social policy taunt the pro-quantitative camp with ‘physics envy’. But social policy would be shooting itself in the head if it found no place for history and myth, metaphors and even ‘metaphysical entities’. In social policy one has to come to terms with all these, foreign bodies though they are in the modernist view of physics. In some way or other, we have brushed against every single one of them in this present research project. We shall discuss some issues related to their validity, which throw light on the significance of our findings, including contextual ones. The discussion will inevitably only ‘brush against’ this deep subject, but will tackle aspects closely related to the research project.

This discussion addresses some aspects of cultural change that underlie the development of social policy, with Malta as focus. History and myth, metaphysical entities and meta-narratives, will be the issues we shall use to address relevant ‘cultural’ themes, such as family, community and civil society; religion and patriotism; outside cultural influence and a culture’s ‘health’; and, finally, empowerment and related value stances.

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This discussion also draws this chapter to a close. In so doing it has been found necessary to connect it to what the writer has discovered to be, for him, the deep underlying issues. As in other junctures in the writing of this dissertation, the putting together of the subject 'took place' first, and the effort to discover what attracted it together became clear only later. This being so, beside 'cultural', I am see this conclusion also as 'personal'.

History and myth

'Family, community and civil society', with religion thrown in as part of the set, was a division of the 'User World' Level which forcefully asserted itself on this research and split that level into two (see Table 10. 4: 'Bifurcation' of the User World Level that took place during the conceptualisation of the research). It got separated from the rest of that level, identifiable as 'Need Assessment, Quality of Life, Empowerment'. Both clusters have a strong value dimension. What is striking is that 'family, community, civil society and religion' are quite easy prey to myth making, which can misread their real nature or history. With respect to family and community we have found out that though the Maltese family and community are emotionally and practically helpful, their help is strictly bound within traditional stereotypes. If community care were to be strongly developed, very decisive work would have to be done to draw the Maltese family and community to giving the widespread and finely tuned support needed to avoid overspending on institutions while still safeguarding a good quality of life for dependent persons in the community. Rather far from the myth, the strength of the Maltese community and family are more of a potential that good, well operationalised and well-audited policy can draw out in observable, tangible and life-changing ways.

One issue that could easily draw myths onto it is that of Maltese identity and its link with surrounding cultures. In *The Risorgimento and the Unification of Italy*, Derek Beales (1971) questions the dominant interpretation of the link between the Italian national movement, the Risorgimento, and the actual unification of Italy that took place in 1859-60. Other historians who write about it were usually Italians, inspired by patriotism while

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holding, at the same time, an idealistic view of history. He writes from a different point of view: neutral as regards Italian patriotism, and more Anglo-Saxon focus on pragmatic and empirical historical explanation.

Key level⁶	Code	Core Theme	User level Divisions
U/V	11	Need Assessment	U1-Level: Quality of Life and Empowerment
U/V	12	Quality of Life	
U/V	13	Empowerment	
U	21	Family (& Community)	U2-Level: Family, Community and Civil Society
U	22	Community	
U	23	Religion	
C	51	Civil Society	

Table 10. 4: 'Bifurcation' of the User World Level that took place during the conceptualisation of the research

Our account of the context of Maltese community care looked at history linked popular expectations regarding welfare to events as far back as the Knights. Openness to the outside world was seen from the viewpoint of issues of policy importation, mainly but not exclusively from the models of British community care. The link with Atlantic Britain took shape against the question of how to safeguard the cultural links with Malta's culture, with historical elements from both the Mediterranean and European, especially Southern European links. How can one talk of cross-cultural and historical influences without tottering into the creation of myth?

The meta-narratives of Hegel and Marx can sound like sacred texts written by authors who claim to penetrate beyond the frames of reference of us mortals, and see a guaranteed flow of events on assured causality processes which we, down here, find

⁶ Though each theme may belong more to one of the levels, each of them unfolds validly across the levels.

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impossible to verify empirically. Yet, other types of historical and cultural studies have developed which do not claim guaranteed processes but describe processes of identity development of countries that are near enough to processes that we can observe in individuals and small groups to be connectable to causality processes that are largely verified empirically. Thus, Cassar's account of the historical development of Maltese identity is largely anthropological. Interestingly, it views Maltese identity as gelling around the creation of myth around three historical personages: St Paul, who was shipwrecked in Malta (Acts of the Apostles, Chapters 27 and 28), Count Roger the Norman, who 'saved the Christian Maltese from the clutches of the Moslem infidel' in 1090 and then gave us the Maltese flag, and La Valette, the Grand Master who led Malta to victory against the Turks in the Great Siege of 1565. 'Once "said"... myth becomes apodictic truth', as Houtart (1974, p. 486) quotes Eliade (1961, pp. 96-7), within an interesting discussion of the national function of myth. Cassar sees these myths as more or less deliberately cultivated by such Maltese influentials as historian Gian Frangisk Abela for the express purpose of gaining for the Maltese, in their own eyes and those of the proud aristocratic and foreign Knights, the respect as a heroic, Christian and European people. Here, the validity criterion for such a myth is not so much how far it is true, as how far it is an effective gel for a people's identity. Any counsellor of adolescents would tell you that that makes a lot of sense and has an empowering – and predictive – validity.

Metaphor, 'metaphysical entities' and a culture's health

Barth, Barthelma and Pynchon are singled out as 'the figures usually associated with postmodernism ...in fiction' (Sarup 1993, p. 129). Pynchon wrote 'V', a novel that takes place prominently in Malta and in which Malta and its intercultural identity is a central theme around which important features of the story revolve. Pynchon sees Malta, and the Maltese like his character Fausto Majistral, as caught up in a culture where the European

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and the Semitic identity, with their deeply different concepts of time and history, co-exist side by side. Just as much as Maltese is Arabic in structure and basic words but European in much of its vocabulary, so is the fossilised ancient Arabic culture there in the present. Majstral comes face to face with this when he tries in vain to write a love letter in Maltese to his wife, finding no words to express emotional and mental entities which his European languages make him familiar with.

In spite of an enthusiastic welcome of this attention on Malta by Maltese authors (Bianchi et al, 1995), the empirical question arises whether Maltese culture, while being indubitably the meeting place of diverse cultural cross-currents, is really as unintegrated as that. 'With their talent for syncretism', the dissident voice of Blondy (1997, here translated from the French) remarks, speaking in a different context regarding Baroque, '(as well as, I would say, for phagocytosis) [the Maltese] have given this foreign language [here referring to this style architecture] a specific identity of mode to the point that they use Baroque as a trade mark for themselves'. The question of the integrated or fragmented character of Maltese culture is an empirical one. However, to think of the Semitic and European roots of Maltese as being so separate is like thinking of the Anglo-Saxon and the Norman/Romance side of English as separate, and as representing cultural systems that have a big chasm between them within the very language, and therefore within the personality of English speakers.

Pynchon is a postmodernist novelist in moving away from rationalistic explanations. He often uses metaphors and recourse to what positivists would call 'unverifiable metaphysical entities' to explain historical happenings. Thus Mara, a woman representing, in a way, 'entropy' – as in the Third Law of Thermodynamics – is presented as the triggering cause of the Maltese disturbances of June 7, 1919. Curiously, he is moving in the diametrically opposite direction from Derrida. Derrida throws out grand theory as being, in the end, approximative and metaphorical, and the Cartesian self, transcending the ideas formulated, as being impossible to disentangle from discourse. Pynchon is equally postmodernist in fully embracing myth and metaphor and 'metaphysical entities' as being essential to explanation and, implicitly, a redemption

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from modernist reductionism. The lesson seems to be that interventive social science like social policy must be post-modern in the sense of having a 'broad Church' that accepts ideas on many levels. This it can do (without undermining validity) by having a critical realist epistemology, which accepts the knower as distinct, at a transcendental level, from his or her formulations, able to exert values and decisions. Metaphorical expression can be a way of exploring new formulations. It wriggles out of the limits imposed by dominant explanatory systems. Again, it can be an attempt to break free from modernism but, again, not in the direction of an irrationality. It seeks the sort of temporary suspension of completed rationality that is the mark of de Bono's lateral thinking and brainstorming. de Bono says brainstorming is incomplete in itself. A subsequent 'checking for congruence of formulation and fact' would be needed at a later stage. But, even when exercising myth and metaphor, social policy must remain appropriately and ultimately empirical, even though in areas of innovation the completion of rationality and intelligibility may have to be postponed.

On the question of the integrity and wholeness of Maltese culture, Cassar's approach is more empirical than Pynchon's. Cassar speaks of the advent of the knights, aristocrats from all European nationalities, with the equally international sailors, soldiers and merchants that they brought with them, as having very deeply penetrated the life of Valletta and the Three Cities flanking the harbour area. Birgu, one of the cities, sounds like a Singapore, with its everyday use of many languages. This stands in deep contrast with Sicily as classically described by Lampedusa (1991,1999), as a region also ruled by foreigners, but whose influence its inhabitants resisted, creating a place where 'time stood still', out of this resistance to the foreigner. Pynchon fails to appreciate the smoothness and imperceptibility of the to and for movement from Semitic to European concepts that occurs in Maltese. It is no different from the continual moving between Germanic and Romance meanings in English. However, looking at contrasts between Arabic and Anglo-Saxon (North American) ways of communicating (as in Zaharna, 1995) a Maltese

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would see to what extent Malta harbours diverse modes of self-expression, running from Arabic, through Mediterranean, through Latin, to European to Anglo-Saxon.

The resilience of a culture amid contact with the outside world is an important issue of health. Big sizes as well as a deeply rooted historical consciousness are predictors of better preservation of countries' cultural traditions. (Jilek 1998). If Malta does not score highly in the first criterion, Cassar suggests that a European historical consciousness took firm root in Malta at least by the time the knights came. But perhaps the best counter-evidence against Pynchon's interpretation of Maltese culture can be found in an article by Janusz Maslowski (1986), to whose preparation the present author made a minor contribution. Maslowski shows that the psychopathology of Maltese schizophrenics clearly follows the European pattern. This is characterised by more positive symptoms and a longer time to heal, in contrast with the distinct patterns among non-European ethnic groups. It seems that Westernisation is quite deeply rooted in the Maltese mind, with its concomitant pressures that seem to aggravate the prognosis of schizophrenia, which Jilek lists as:

Family nuclearization with concomitant abrogation of obligations toward the extended kinship and therefore lack of support for its mentally ill members; covert rejection, social isolation and sick-role typing of the mentally ill; a general expectation of chronicity of all mental disorders; emphasis on the rationalistic-positivistic interpretation of all subjective experiences; personal accountability for ideas and behaviour assumed to be irrational and therefore evidence of insanity; unclear and contradictory social role expectations.

Curiously, Jilek notes that this 'westernised' aggravation of schizophrenia tends to reverse in societies where westernisation has been temporary and has retreated, but a deeply western pattern of chronicity is assumed 'once the process of Westernising acculturation-deculturation has become irreversible' (citing Sizaret et al. 1987). Alien culture can also cause 'anomic depression', of the type suffered by North American aboriginal experiencing anomisation and marginalisation under imposed Westernisation. He also expects extended family to reduce morbidity.

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In a globalising and post-modern world, the above discussion has great relevance. In many important ways, there are aspects of the questions of culture that are too important to allow to become the preserve of metaphor or 'pure myth'. Globalisation will introduce new inundations of cultural and organisational forms from outside. Being able to preserve one's identity through all this will become a necessity, if a population is to avoid anomie or anomic illness. The stabilities that had created an eco-system that somehow worked will now be undermined. A deep historic consciousness seems to be a protective factor. Myth creation and preservation seem to be an essential ingredient of this process. Myth that gives a clear and strong identity to a country can be like small group processes in a big organisation: they promote identity and belonging, and are essential to the 'health' and effectiveness of a country too. The myth creation that is congruence-based and evidence-based enough with respect to local realities will mobilise local energy and sustain the society's health. Mistaken self-understanding can do the opposite.

Small states may be particularly vulnerable, not only on the cultural but also on the organisational level. Big (and rich) countries, for example, dictate what interpretation of the free market is 'good for us'. The free market is in a way a flexible ideology. 'Exceptions' are made to it, in the direction of central control, in the name of free competition with the same dedication as are proclaimed its general principles. It claims, in many ways, to be the ultimate 'look no hands' approach conducive to the post-modern dream in which everybody does his own thing, yet everything works out.

But it is difficult, for one thing, to see if this 'ecologically tested' model, that worked in big 'imposing' countries, works in smaller ones, and the extent to which these smaller countries have the capability of identifying early enough what adaptations this would require for their particular needs. Malta is the second densest population in Europe, second only to Monaco, and fifth densest in the world. The free market has resulted in house prices that are already at the level of outer London. People in outer London not only earn three times what Maltese people earn, but also can move out to the British hinterland, where land is less pricey. The Maltese have only the Mediterranean to retreat

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to, and they are now very close to the limit of what they could imaginably afford. Yet, till now, Maltese are seeing the rise in prices as a natural result of living free in a free market in a small island (See Pace, 2001b). That the monies do not improve the product, but take more and more years of a couple's doing two or three jobs only to improve the assets of a third person or group of persons is not seen as raising questions of justification. The avidity of land speculators to see the small economy's natural ceiling to pricing broken down by moving away from Maltese to foreign buyers is not seen as plainly unacceptable. The consequences of an 'invaded' culture can affect health in many ways, both on the meanings and on the functional level.

A national identity, a well-managed national culture and 'wise' policy adoption and adaptation can protect a country from debilitating 'invasion'. Myths need not be threatening or overbearing. We need myths that liberate an empowering identity. We also need a vision of our world that is broad enough to allow us to co-ordinate what we do in its various domains to avoid process conflict and ineffectiveness. We need meta-narratives that are broad and overarching. But they should avoid the quality of being overextended and ineffective, overbearing and imposed. This they can do by respecting both the safeguards needed for objectivity and the diversity of needs. The option in favour of the poor, which we embraced initially, can be the criterion on which to continually and decisively test them against being overbearing and debilitating. Subjected to such a check, remodelling will bring more than a smooth running that comes from congruence, and will help us open up and widen the access to more and a better life.

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