

## **Chapter 2 (In 'Cabbage Syndrome': The social construction of dependence, Colin Barnes (1990) The Falmer Press, pp. 17-39)**

### **The Emergence of Day Centre Provision for the Younger Physically Impaired**

It is often said that in Britain we have a tradition of welfare policies which separate dependent minority groups such as the physically impaired into segregated institutions (Manning and Oliver, 1985). It is a tradition, which although evident in the Middle Ages, became more widespread as a result of the Poor Law reforms of the nineteenth century. This tradition remained unchanged until the 1950s when 'community care' emerged as an official policy objective in government statements. In the following decades a number of services, including day centres, were developed to achieve this end.

My primary objective in this chapter is to draw attention to the principal similarities and distinctions between two particular forms of provision for the physically impaired. They are the 'traditional' residential institutions and the modern day centres. To complete this task the rest of the chapter is divided into four separate sections. The first focuses on the origins of English social policy for this group of people. The second covers the rise of institutional segregation and the differentiation of 'disability' during the nineteenth century. The third outlines the shift toward 'community care' and the establishment of day services for adults. The fourth section chronicles the emergence of the day centre, identifies its principal types, and discusses the major criticisms levelled at these structures from the perspective of the perceived needs of the young physically, impaired. The chapter concludes with an assessment of day centres for the disabled in relation to previous forms of provision. It is contended that like that of their precursors, the residential institutions, their development can be best understood as a social and political response to the growth in the number of individuals who, because of impairment, are excluded from the world of work, though this increase is partly a result of the social construction of disability.

### **The Origin of Social Provision for the Disabled**

How a society treats individuals with impairments is closely related to the meanings it assigns the causes of those impairments (Miller and Gwynne, 1972).

In all societies the impaired, particularly the physically impaired because of their visibility, are perceived as abnormal in the purely statistical sense of belonging to a minority group. And although it may be argued that our attitudes to abnormality are coloured by deep-rooted psychological suspicion of the unknown, it is generally accepted that our perceptions of normality are partially if not wholly determined by others through the process of socialization and the transmission of ideology or culture. For Mary Douglas, culture

in the sense of the public, standardized values of the community, mediates the experience of individuals. It produces in advance some basic categories, a positive pattern in which ideas and values are fully ordered. And above all it has authority, since each is induced to assent because of the assent of others (Douglas, 1966, p. 39).

While it may be correct that individuals' perceptions of normality vary slightly, at the structural level cultural values are invariably more rigid.

Although there is evidence to suggest that in some non-occidental societies the meanings attached to the causes of impairment were arbitrary and those affected were fully integrated into the community (Hanks and Hanks, 1948), in the cultural and historical precursors to our own society there has been a consistent bias against impairment and disability. Examples are found in religion, Greek philosophy and European drama and art since well before the Renaissance. In the Old Testament, much of Leviticus is an articulation of the physical perfection deemed necessary for participation in Christian ritual (Douglas, 1966). While the ancient Greeks and the Romans placed a high precedent on the care of those disabled in battle, they were enthusiastic advocates of infanticide for deformed or sickly infants (Tooley, 1983). Shakespeare's depiction of Richard III clearly demonstrates the perceived association between physical deformity and evil. In the England of the Middle Ages, the impaired were viewed with a number of attitudes ranging from, at worst, fear and degradation to, at best, paternalism and pity. They were excluded from the mainstream of economic and social activity and were dependent on the benevolence of others.

Until the seventeenth century the impaired, along with such other dependent groups as the sick, the aged and the poor, relied almost exclusively on the haphazard, and often ineffectual, traditions of Christian charity and alms-giving for subsistence. Although disenfranchising them from religious ceremony, Christianity, like the other leading western

religions, has traditionally acknowledged responsibility for the care of the disabled. During this period, however, as in the rest of Europe, the authority of the English clergy was greatly diminished by a series of confrontations between the church and the monarchy. These led to a decisive subordination of the former to the latter, which reduced the church's role in civil society. Monastic land was seized and redistributed and in consequence its ability to provide for the indigent classes was radically reduced.

The responsibility for provision shifted toward the emerging class of landowning gentry whose power replaced that of the feudal lord and the ecclesiastical elite (Trevelyan, 1944). But neither the monasteries nor private individuals made any serious attempt to match aid with need, or to provide an organized response to specific areas of dependency. It was generally accepted that this form of calculated, measured response was alien to a society where the urge to give to others was subject to the individual's felt need to ingratiate her/himself with God and thus ensure salvation (Scull, 1984). Impaired people were rarely lumped together under one roof, notwithstanding the probability that the most severely disabled were admitted to one of the very small medieval hospitals in which were gathered the sick, the bedridden and other 'honest folk' who had fallen into poverty. The ethos of these establishments was ecclesiastical rather than medical. They were devoted to care rather than cure (Scull, 1984). Throughout this period, however, there was a general increase in the numbers of people cut off from 'normal' economic activity.

Between 1500 and 1700 England experienced a dramatic growth in the general population following a century and a half of stagnation and occasional depletion due to plagues. At the same time commercialization of agriculture and the spread of the enclosure system meant that employment opportunities in the countryside were diminishing. Successive poor harvests were also blamed for unemployment. As food prices went up, people had less to spend on manufactured goods and therefore jobs in the textile and manufacturing industries were reduced. There was also an influx of immigrants from Ireland and Wales. Wars, too, were cited for the increase in vagrancy, although accounts of the effect of war were often contradictory. Some theorists argue that a decline in local conflicts eliminated one of the principal social mechanisms for soaking up large numbers of restless males. Others suggest that too much war caused large numbers of injured and jobless soldiers to be released into the general population without financial support (Stone, 1985). All through the early Tudor period the fear of 'bands of sturdy beggars' preyed on the minds of

local magistrates (Trevelyan, 1944). This inevitably stimulated a political response from the central royal authority.

Prompted by the need to maintain order, secure allegiance, and establish a more secure foundation for the newly heightened monarchical power, the Tudor monarchs came under increasing pressure to make some sort of economic provision for the poor. The passage of the Poor Law Act of 1601 marks an initial official recognition of the need for state intervention in the affairs of the destitute and the disabled. Parishes were now empowered to levy taxes to provide funds for the relief of the poverty-stricken. And although it is clear that Section 1 of the Act makes explicit reference to providing special facilities for the lame, the infirm and the blind, it is generally accepted that little effort was made to separate and define the various classes of the needy considered deserving of aid (Stone, 1985). Provision was also hampered by bureaucratic constraints concerning eligibility. Notably, there was already an institutionalized suspicion of those claiming to be unable to work and seeking alms. This was legally expressed in the statute of 1388 which mandated local officials to discriminate between the legitimate recipients of charity and those suspected of feigning impotency to avoid work.

In consequence of the traditions of restricting aid to people within the parish boundaries, a practice enforced by law in 1622, as many as 15,000 separate local administrations were involved in the management of the dependent (Scull, 1984). Although there was much scope for local discretion, there was a high degree of uniformity in the way the problems posed by impairment were dealt with at the local level. Every effort was made to keep the senile, the blind and the infirm within the community. The largest resources were directed toward 'household relief for individuals confined to the home. So intense were the pressures to achieve this objective, that funds were frequently provided to those willing to take on the responsibility for others unable to care for themselves. Major changes in this essentially non-institutional approach to the treatment of the impaired did not begin to be discussed or implemented until the nineteenth century.

### The Shift Toward Institutional Care

Throughout the eighteenth century the practice of segregating the most severely disabled members of the community into hospitals and similar establishments was gradually extended to other sections of the indigent classes, until there was a general tendency to segregate them all into institutional settings (Stone, 1985). Consequently there was an

unprecedented growth in the construction of institutions. Jones and Fowles have defined an institution as

Any long term provision of a highly organized kind on a residential basis with the expressed aims of 'care', 'treatment' or 'custody' (Jones and Fowles, 1984, p.297).

These included hospitals, asylums, workhouses and prisons.

One explanation for the incarceration of the disadvantaged links it to the breakdown of earlier forms of poor law relief in the face of urban industrialization and the huge problems of poverty that ensued (Mechanic, 1964). It has been shown, however, that the impetus to build institutions was not associated in time and place with the expansion of English cities. It invariably preceded it and was frequently most pronounced in rural communities (Ingelby, 1983). A variation on this theme is posited by others, who see the incarceration of the impaired as a direct result of the transition from traditional agriculture and/or cottage-based industries to the factory system.

The spread of factory work, the enforced discipline, the time keeping and the production norms, all these were a highly unfavourable change from the slower, more self determined and flexible methods of work into which many handicapped people had been integrated (Ryan and Thomas, 1980, p. 101).

These accounts tend to play down or ignore the general moral ambivalence concerning disability that existed before the industrial revolution. A more radical approach looks specifically to the relations of production, in particular the spread of wage labour. Firstly, a family dependent on wage earnings could not provide for its members in times of economic depression, so that large numbers of dependents were created by the new system. Secondly, the Elizabethan system of parochial relief was directly at odds with the ascending liberal market economy.

To provide aid to the able-bodied threatened to undermine in radical fashion and on many different levels the whole notion of a labour market (Scull, 1978, p. 37).

Wage labour made the distinction between the able-bodied and non-able-bodied poor crucially important, for parochial relief to the able-bodied

interfered with labour mobility. Segregating the poor into institutions had several advantages over domestic relief: it was efficient, it acted as a deterrent to the able-bodied malingerer, and it could actually create labour by instilling good work habits into the inmates (Ingelby, 1983). These considerations are reflected in the conclusions of the Report of the Poor Law Commission and the Poor Law Amendment Act of 1834 which succeeded it.

The 1834 Poor Law reforms introduced three new principles in welfare policy: national uniformity in welfare administration, denial of relief outside the workhouse, and deterrence as a basis for setting welfare benefit levels (Stone, 1985). However, these three principles were not implemented immediately and never fully.

At the beginning of the nineteenth century the administration of services varied radically at the local level. Centralization was, therefore, deemed necessary to discourage movement by workers in search of better welfare benefits or more generous treatment by Poor Law officials in other parishes. It was also believed that this policy would encourage labour mobility. Because aid was set at subsistence level only, and the treatment of the poor was to be universal, workers would go where the work was in search of higher wages. But Parliament set the minimum of guidelines and the policy was submitted to local officials by the Poor Law Commission through a series of circulars and orders. Consequently a high level of disparity between parishes continued.

As early as 1722 Parliament had granted local authorities the right to deny provision to anyone refusing to enter a workhouse, but the Amendment of 1834 went further by expressly prohibiting the provision of 'outdoor relief', or provision outside a workhouse. Stone (1985) has shown that this instruction was never strictly implemented. Until 1870 fewer than one-fifth of all adult able-bodied male paupers and *no* less than 15 per cent of all the destitute were on indoor relief, that is, confined to an institution.

Deterrence was evident in the principle of 'least eligibility', which stipulated that a pauper's situation should be less comfortable than that of an 'independent labourer of the lowest class' before relief could be granted. The workhouse was intended to be as unpleasant and unattractive as possible so that no one would enter it voluntarily. Families were broken up, inmates were made to wear special uniforms, there were no recreational facilities and socializing was strictly forbidden during working hours.

Routines were rigidly enforced and food was, limited to what was considered necessary for survival and work.

Stone (1985) has argued that these conditions were mitigated for certain groups since a number of regulations which succeeded the 1834 Act show there was a deliberate policy of exempting specific groups of the indigent from the principle of 'least eligibility'. Moreover, from the outset the Poor Law Commission suggested that workhouses should separate the incarcerated into four distinct groupings, namely, able-bodied males, able-bodied females, children and the 'aged and the infirm'. It was intended that the aged and infirm were to be housed in separate buildings and accorded separate care. In the following years these categories were refined still further, first, in order to determine who should be exempt from the prohibition against outdoor relief and, second, to establish separate facilities for different groups of paupers once they had entered the workhouse. The Poor Law officials developed five categories for dealing with those claiming aid. These were the sick, the insane, the aged and infirm, children, and the able-bodied. If an individual did not fall within one of the first four categories s/he was deemed able-bodied. There was some variation in the treatment of each group.

The term 'sick' was applied to those suffering from acute, temporary and infectious diseases. Chronic or permanent conditions were normally submerged within the category 'aged and infirm'. And although the position of the latter with regards to the granting of outdoor relief was often unclear, in terms of formal policy the rights of the acutely ill were quite specific. They automatically qualified for outdoor relief. Unfortunately there was much local variation of interpretation. In some areas the sick were granted medical aid, while in others they were subject to stringent means tests and forced to sell all their possessions before relief was provided. The central authority, however, encouraged local officials to provide aid in the home rather than in the workhouse. If admission was unavoidable separate facilities were to be provided, although here again conditions in different institutions and areas varied markedly.

Whether this group was to be subject to the principle of least eligibility and deterrence was never fully resolved. Some officials felt the sick 'were not proper objects' for such a system. Others took the opposite view, on the grounds that if the sick were exempt, it could discourage self-reliance or making provision for this type of misfortune through membership of friendly societies and insurance schemes. Official policy vacillated between the two. Eligibility for outdoor relief on the basis of acute illness was frequently,

and increasingly as the nineteenth century progressed, left to the discretion of the local medical officer in conjunction with Poor Law administrators. If paupers were admitted to the workhouse as a result of sickness they were normally the responsibility of the medical officer. Doctors were generally considered by both inmates and administrators as more lenient than Poor Law officials (Stone, 1985).

Insanity was singled out for particular attention earlier than any other group. Despite the growth of public policy in this area during this period, insanity was never formally defined in official documents. The terms used varied from idiots, lunatics, the mad and the mentally infirm to 'persons suffering from diseases of the brain' (Stone, 1985). Consensus as to their meaning was not evident in the newly established psychiatric profession. For every treatise published on the subject claiming to set specific criteria for definition, another appeared rejecting it. As Scull (1978) observed, the definition of insanity involved a subtlety more easily accomplished in books than in practice.

There was, however, a universal recognition of the problems posed by mental illness, and there were two major strategies for dealing with it. The individual so labelled could be admitted to an asylum or other institution or boarded out on contract to families willing to be responsible for them. Several private asylums had been established during the seventeenth century. But public outcries over the atrocious conditions in many establishments; brought to light by a number of energetic and compassionate Benthamite and evangelical reformers, prompted the implementation of a public system in 1845, although the cruelty meted out to the insane in some institutions was often no worse than that afforded them in the community (see, for example, Roth and Kroll, 1986).

In terms of Poor Law policy the insane were exempt from the prohibition against outdoor relief. If admitted to a workhouse their special category status disappeared. Unlike other inmates they were subject to the jurisdiction of another body, the Lunacy Commission, whose influence in the workhouse was minimal. A further difference concerned the civil rights of the insane. Until 1871, Poor Law Officials had no authority to detain citizens within an institution against their will. But this did not apply to those labelled mad. During the seventeenth and eighteenth centuries the certification of insanity was the duty of the local lay officials, but after the 1845 Lunacy Legislation confirmation of mental illness was only valid if a doctor was involved. This has been attributed to the medical profession's successful struggle for control within private and public asylums, the

general acceptance that mental illness was physiologically based and the view that it was responsive to medical treatment (Scull, 1984). Once defined as insane, an individual could be detained by both doctors and Poor Law officials, and transferred from one institution to another against her / his consent.

The term 'defectives' was used to describe those suffering from sensory deficiencies such as blindness, deafness or the inability to speak. This category later included the lame, the deformed and, after 1903, epileptics and mental defectives. This last label referred to children considered mentally subnormal. Like the above, members of this group were not prohibited from relief outside institutions but were singled out for special provision concerning vocational training and education. Although there is evidence of segregated structures providing these facilities, notably in the voluntary sector, their treatment within the workhouse was no different to that of other inmates. This was also true for the oldest of the categories used in Poor Law legislation to denote all those with serious incapacities, the aged and infirm.

Little controversy raged over their eligibility for aid in the community or in hospitals but once committed to the workhouse, their treatment, like that of the sick, posed problems. The provision of separate and better facilities within these structures conflicted with the principle of deterrence. The idea of the workhouse, or institutions generally, as a 'paupers' palace' was seen as giving little incentive for the young and healthy to plan for the future. As the nineteenth century progressed the pressures to commit more and more people to these establishments increased,

In 1871 welfare policies were tightened when Parliament disbanded the Poor Law Board and transferred its duties to a newly created Board of Local Government with the status of a Cabinet department. This new authority set about implementing the principles of the 1834 Amendment Act with renewed vigour. Particular attention was directed to a campaign against outdoor relief. The demand for welfare cutbacks followed a lengthy period of economic depression, rising unemployment and a rise in welfare expenditure. The severe winter of 1860-61 and the rise in unemployment due to the cotton shortage because of the American civil war meant that many more people were claiming aid (Stone, 1985). In an effort to reduce costs the Local Government Board officials decided on a more stringent and universal application of workhouse confinement, even to those hitherto recognised as exempt, the physically and cognitively impaired.

The campaign against outdoor relief was more eagerly supported by the employees of the new department than it was by the central authority. Despite recommendations to the contrary by Local Government Boards, official policy concerning exemptions never changed. But pressure on local officials to reduce the numbers of claimants was exerted in a number of ways. For example, information concerning the ratio of paupers to the general population, and the ratios of people on both indoor and outdoor relief in each local area were regularly published and circulated in order to embarrass local dignitaries in parishes with large numbers of claimants. Because these lists contained no data showing the different categories of paupers, their publication placed implicit pressure on local authorities to reduce aid across the board. Much emphasis was made by the inspectorate on applying the 'workhouse test' to all claimants in order to separate the incapacitated from the indolent. Hitherto there had been little pressure to validate eligibility for those classified under one or other of the categories of exemption. Even after 1885 when the initial fervour of the new regime died down and a more humanitarian approach was adopted, local officials were still instructed to scrutinize carefully those seeking aid, so that help should only be given to those of 'good character'. The net result of these policies was to further separate the impaired from the rest of the community.

The limited data available show that the numbers of people consigned to the workhouse did begin to fall and continued to do so until the turn of the century. Also the numbers of individuals receiving outdoor relief declined markedly after the implementation of these policies. The numbers of people claiming aid was lower in 1878/9 than at any other time since 1841. It is impossible, however, to say which group of recipients bore the brunt of this reduction, as the figures available do not differentiate among the pauper population. But there was an expansion of separate facilities for the non-able-bodied poor during this period due to a number of public scandals and subsequent government enquiries exposing the extreme conditions in some workhouses. These

created pressure on local governments to establish separate schools for pauper children or board them out to local families. Similarly separate infirmaries for the sick and separate sick pavilions attached to workhouses became more common (Stone, 1985, pp. 51-52).

It is highly probable, therefore, that the decline in the provision of relief is partly due to the fact that an increasing number of paupers with disabilities

were directed toward specialist institutions rather than the workhouse. For while it is true that the numbers entering the workhouse declined this was not the case for other institutions. There followed a general shift toward institutional care for the disabled, which only began to recede in the 1950s (Schull, 1984). The welfare policies of the nineteenth century established a pattern of provision for individuals with impairments which increasingly moved toward categorization and segregation from the rest of the community. In many respects this pattern remained unchanged until the emergence of the modern welfare state and the advent of the community care movement. These developments are the subject of the next section.

## The Return to the Community and the Arrival of the Day Centre

Although community care did not become official policy until the 1950s a number of similar measures had previously been introduced \ In the general area of disability there were limited efforts to provide facilities' outside institutions from the 1870s onwards. For example, the Town and Country Association for Teaching the Blind in the Homes was founded in 1879 (Blaxter, 1981). A number of welfare schemes were also set up to provide training facilities, sheltered and home employment for their blind, the deaf and disabled ex-servicemen before, and during the 1914-18 war. As a result of the serious shortage of labour and the moral obligation felt toward the war casualties, the Tomlinson Committee Report of 1941 recommended that a national interim and post-war scheme of rehabilitation and resettlement should be provided for individuals suffering from any type of disablement, whether congenital or acquired (Schlesinger and Whelan, 1979).

In the field of mental impairments, the Mental Deficiency Act of 1913 contained provision for voluntary and statutory supervision of the mentally handicapped within the community. The Mental Treatment Act of 1930 recognised a growing movement for the provision of out-patient clinics. And although the National Health Service Act of 1946 accepted that hospitalization was the principal form of treatment, it acknowledged the need for policies which were geared for what was termed 'aftercare' and 'pre-care' Jones *et al.*, 1983).

The official origins of the use of the phrase 'community care' can be traced back to the report of the Royal Commission on Mental Illness and Mental Deficiency of 1954-57, which considered in detail the problems arising from outdated mental hospitals and the considerable stigma attached to in-patient treatment. And although there was no precise definition given, subsequent government documents and statements concerning welfare policies for disabled people increasingly used the term, though the phrase has different meanings for different groups of people Jones *et al.*, 1983).

Parker (1981) has identified three key components inherent to the concept of care in the context of community care. They are: (a) physical tending, with the most intimate kind of care relating to such physical needs of dependent people as toileting and bathing, (b) material and psychological support not involving physical contact, of which counselling is a good example, and (c) more generalized concern for others which mayor may not lead to the other two types of help. Contributions to charity are a good

example of this type of concern. To provide these three elements within the community, provision must invariably involve a combination of formal and informal, statutory and non-statutory services. Walker (1981) has suggested that the principles underlying community care include support by a dependent person's own family, friends and neighbours, an emphasis on care in non-institutional settings, the presence of support in the home from statutory services and preventative measures to prevent re-admission to an institution.

The move toward community care as a policy objective took a more prominent turn in 1961 when the British government announced its intention to halve the number of mental hospital beds. Titmus questioned the motives behind this announcement, arguing that they were primarily economic. It was his belief that while hospital facilities would be reduced, little would take their place. He maintained that patients would be transferred from the care of the trained to the care of the untrained (Jones *et al.*, 1983). Although Titmus challenged the government to refute his contentions, there was no official reply. The economic rationality of the policy was later reiterated by Jones who drew attention to the cost of maintaining large institutions.

Many of our hospitals had been built in the mid Victorian period when an expanding empire meant expanding exports. The same degree of capital outlay could not be envisaged in the 1960s - particularly by a government dedicated to cutting public expenditure (Jones *et al.*, 1983, p. 105).

Some writers maintain that this new policy was based on a series of spurious statistics and an apparent blind faith in the positive effects of psychotropic drugs, recently developed during and after the 1939-45 war. The benefits of this form of treatment have been seriously challenged by several observers and psychiatrists themselves are divided as to their value (Jones and Sidebotham, 1962).

In 1962 the Ministry of Health published 'A Hospital Plan'. This was followed one year later by 'Health and Welfare, the Development of Community Care', generally referred to as the 'Community Care Blue Book'. Between them these two documents provided a sketchy outline of plans for care in the community including proposals for increases in the numbers of general practitioners, home helps, district nurses and health visitors, sheltered housing and sheltered workshops. Provision was intended for four specific groups, namely, mothers and children, the elderly,

the mentally disordered and the physically handicapped. Services were to be

so organized and administered as to meet more precisely the varying needs of special groups and even of different individuals (Jones, 1982, p. 73).

A major difficulty in implementation resulted from the fact that local authorities were autonomous from central government with regard to how they spent their resources. At the local level there was no consensus as to what was required or what it would be possible to provide. Consequently as with previous policies there was a disparity between central policy and local implementation.

Around this time there emerged a plethora of investigations into institutional life by a number of social scientists, nearly all of them condemnatory. The definitive study was Goffman's (1961) analysis of the 'total institution', which described the dehumanizing effects of life inside such organizations. Relatively cut off from the outside world, these structures were said to create pathological conditions for the inmates. Through the use of concepts such as 'binary management' (the division between staff and inmates), 'batch living' and the 'institutional perspective' (whereby the aims of the institution take precedence over those of the individuals it was designed to serve), Goffman developed an ideal type model and a theoretically universal framework which was applicable to all forms of institution ranging from mental hospitals to army barracks. A principal weakness of his study, however, is that while drawing attention to the similarities in these structures, it neglects the differences (Jones and Fowles, 1984).

There followed a number of investigations which corroborated Goffman's findings in various residential settings. For example, Barton (1959) suggested that mental patients in long-stay hospitals developed a secondary illness due to their incarceration which he termed 'institutional neurosis'. Townsend (1967) utilized Goffman's approach for his study of old people's homes. Pauline and Terence Morris (.1962) elaborated the personal and social deterioration experienced by prisoners in Pentonville) jail. King, Raynes and Tizard (1971) studied the administration of homes for mentally handicapped children and developed the concept of 'normalization'. They showed that given the same individual care and attention accorded' normal children' , mentally handicapped children in

residential homes improved in individual and social capacity as opposed to those kept in an institutional environment.

With regard to analyses specifically concerned with institutional care for the physically impaired, researchers have tended to view the effects of institutional care on residents in less negative terms than Goffman. On the basis of his study of life inside a residential home run by the Leonard Cheshire Foundation 2 Musgrove (1977) concluded that the conditions therein bore little resemblance to those of the total institution. The home was not a closed system, regimentation was minimal and residents were able to retain their individuality.

Miller and Gwynne (1972) studied both voluntary and local authority institutions and drew attention to the 'warehouse' and 'horticultural' models of institutional care.<sup>3</sup> The former refers to those structures in which the impaired individual is simply put away in storage. The function of these establishments is to perpetuate the distance between 'social death', the point when the individual enters the institution, and physical death as long as possible. The 'horticultural model' emphasizes the unique qualities of each inmate and the importance of subjective responsibility, and seeks to cultivate unfulfilled ambitions and capacities. The latter is not without its problems, however. The authors themselves expressed concern over the overvaluing of independence, the denial of disabilities and the general tendency toward the distortion of staff / resident interactions, where the realities of impairments are played down or ignored (see Chapter Four).

Studies of institutional care for the physically impaired have not been restricted to voluntary or local authority provision. In a national survey of long- term hospital services, Bloomfield (1976) stated that although many inmates of Young Chronically Sick Units require extensive help with personal care, hospitals were not the appropriate environment for this service. She contends that,

by focusing on the one aspect of the inmate's requirements, the younger chronic sick units systematically robs the individual of the opportunity for achieving satisfaction and purpose in the life remaining to him. The unavoidable emphasis on his physical dependence on authoritative personnel frequently leads all but the strongest individuals to an accepting apathetic state with little interest in life and even less initiative (Bloomfield, 1976, quoted in Oliver, 1983a, p. 89).

Similar views were expressed by Battye (1966) after spending a large portion of his life in a chronic sick unit and a residential home run by the Cheshire Foundation.

Organizations claiming to represent the young physically impaired have also been vociferous in their critique of residential care. For example, the Union of Physically Impaired Against Segregation (UPIAS) have consistently called for the abolition of all segregated and segregative institutions, their ultimate objective being the complete integration of all impaired people into the community. This would necessarily involve the gradual phasing out of all institutional provision whether run by voluntary agencies or the state. And although to date they have not demanded the immediate shutdown of all existing structures they have opposed the construction of new ones (UPIAS, 1981).

It remains the case that for many there is little choice whether or not to opt for residential care in an institution, since there are relatively few alternatives available, such as sheltered housing. Although official figures in this area are much disputed, Topliss (1979) has shown that during the 1970s there were approximately 343,000 people with disabilities in residential institutions, 76,000 of whom were under the age of 65. Of these, 55,000 were accommodated in hospitals for the mentally ill and around 20,000 resided in institutions for the physically impaired. The most common reason for entry into residential care is family breakdown or the refusal of the principal carer to continue with her/his 'responsibilities'. A summary of the extensive literature detailing the economic, physical and emotional pressures on informal carers can be found in the work of Parker (1985). This underpins Goffman's assertion that institutions do not exist solely for the benefit of the inmates.

If all the institutions in a given region were emptied and closed down today, tomorrow parents, relatives, police, judges, doctors and social workers would raise a clamour for new ones; and here the true clients of the institution would demand new institutions to satisfy their needs (Goffman, 1961, p. 334).

At a general level the arguments against institutions became more intense in the late 1960s and early 1970s when there was a spate of sensational public expositions of cruelty and harsh conditions manifest in some institutions for the elderly and the mentally ill. In 1967 the findings of an investigation by the Association for the Elderly in Government Institutions (AEGIS), into the treatment of old people in a London hospital was published and constituted a powerful indictment of institutional provision

(Robb, 1967). There followed several publications and newspaper articles directing similar accusations toward a number of hospitals for the mentally handicapped. All were subsequently investigated and in at least one case, the Ely enquiry, the charges proved accurate and criminal proceedings against some hospital personnel ensued (Jones *et al.*, 1983).

As a result of these enquiries, public, and in some cases professional, confidence in the services provided by long-stay hospitals and similar establishments was seriously undermined. Local authority services, on the other hand, remained relatively unscathed. Consequently the pressure to reduce the numbers of patients in large institutions, generally hospitals run by the health service, intensified while local authorities were encouraged to expand their facilities.

There was little agreement as to what services should be provided or where the money to fund the expansion should come from. Extensive variation characterized provision at the local level and budgets were already stretched due to two main factors. The first was the heightened expectations of the general public since the inception of the welfare state, and the second, a steady increase of dependent groups after the 1939-45 war. These included children, the elderly and the disabled.

Published estimates of the numbers of people with impairments in the general population taken during the last three decades vary between just over 3.1 million (Harris, 1971), 9.9 million (Townsend, 1979) and 6.2 million (Martin, Meltzer and Elliot, 1988). This disparity is due to the different definitions of disability used by the researchers. The Harris and Martin studies were sponsored by central government and both used functional evaluations of disability based on a series of questions regarding people's ability to care for themselves, for example, to wash, dress and use the toilet. The differential between the two estimates, according to Martin *et al.* (1988), are explained by the fact that the 1988 study, unlike its predecessor, included people who were mentally ill and / or handicapped and those whose disability was judged 'marginally less severe'. The Townsend (1979) study used a broader-based assessment covering individuals' capacity to care for themselves, share relationships and fulfil social roles analogous to those of others of a similar age range.

The available data show there are more disabled women than men, although within the age structure there is considerable variation. Up to the age of 50, both in numbers and prevalence, more men are impaired than women. Two likely explanations for this are (a) that more men work and

risk disablement through accidents and work based illnesses, and (b) that more males indulge in dangerous sports and leisure activities. Hence these estimates reflect the sexual divisions in society and the fact that both work and leisure are dominated by men. After the age of 50 there are more disabled women but their prevalence in the population is also greater (Oliver, 1983a). This is a reflection of the fact that women live longer than men, coupled with the fact that the incidence of a significant number of disabling conditions increases with ageing.

At the other end of the age range the figures are less precise. The two government surveys did not take account of children and Townsend collected information only about children aged 10 or over. No data showing the prevalence of children with impairments among the general population have yet been published.<sup>4</sup> Estimates based on the work of the National Children's Bureau, Family Fund's records of children with severe disabilities, the Isle of Wight study and information from the 1974 General Household Survey indicate numbers of children with severe impairment ranging between 89,000 and 126,000, with a prevalence rate of approximately 6.2 children per thousand population. All indications are that the population of children with impairments has increased as more have survived infancy in consequence of medical advances in technology, but it is not clear whether this increase will continue due to developments in pre-natal screening etc. (Parker, 1985).

There is substantial literature available documenting the extensive material disadvantage suffered by people with disabilities. Townsend's (1979) study, for example, paints a picture of low pay, longer working hours, worse working conditions and poor housing, coupled with a higher likelihood of unemployment. A more recent government study found that people with impairments tend to be badly off financially and that three-quarters are reliant on state benefits for their main source of income (Martin and White, 1988). The problem of unemployment is particularly acute amongst young physically impaired adults (Parker, 1984).

In an effort to develop and rationalize provision at the local level the government set up a committee of enquiry which published its findings in 1968.

The Seebohm Report is generally considered a watershed in the development of services in and by the community for physically handicapped people.<sup>5</sup> Among its principal recommendations was that local authorities should accumulate data relating to the size and nature of the

problems resulting from physical impairment, develop and/or expand existing services including day centres, and acknowledge the need for specific services for young people.

Substantial development is particularly required in the services for handicapped school leavers, and more thought and experiment is required to determine the best timing and method of giving guidance on careers to physically handicapped children and young people (Seebohm, 1968).

Based on the Seebohm Report, the Local Authority Social Services Act 1970 established social services departments in their present form. The committee's recommendations on provision for people with physical impairments were incorporated into the Chronically Sick and Disabled Persons Act of 1970. But for a variety of reasons including the fact that legislation was passed at a time of organizational upheaval at local government level, the pressure of demands by other client groups, and inadequate resources, the new departments were never able to provide all the services envisaged. Moreover, any optimism regarding finances for expansion were dashed in 1973 because of the effects of the global oil crisis on the national economy. Despite this there was an unprecedented growth in the provision of day centres for adults throughout the country. What form they took and how they have been perceived in relation to the needs of young people with physical impairments is dealt with in the next section.

#### Day Centres for the Younger Physically Impaired

On the basis of data from the National Survey of Day Services conducted between 1974 and 1978, Carter (1981) estimated that in 1959 there were just over 200 day centres in England and Wales. In the following ten years, which Gough (1979) termed the 'golden age' of the welfare state', the number increased fourfold. Carter contends that in 1976 there were 2,600 day units operating each week up and down the country. In order to find out who provides which services, she selected thirteen areas in England and Wales at random for investigation and found that local authority social services departments provided 47 per cent. Area health authorities were the second most important, combining to support 26 per cent, voluntary agencies such as Age Concern or MIND (The National Association for Mental Health) provide 23 per cent of the total and there is a residual group of units, approximately 4 per cent, supported by other statutory bodies such as the probation service or education departments.

Carter (1981) found that most day centres were situated outside city centres in suburbia and that four out of every ten were located in the grounds of residential institutions, usually hospitals, residential homes or long-stay hospitals. A number of critics have drawn attention to the stigma attached to this practice, particularly when the buildings normally used fall into one of two types, either large gymnasium-type structures, or the modern purpose-built variety. Both are accused of advertising their difference from the rest of the community (Durrant, 1983). When considered with the fact that most units cater exclusively for relatively, and often overtly, disadvantaged minorities, this adds further weight to the assertion that day centres are inherently segregative.

Most units are like schools and hospitals in that they are part of a larger bureaucracy, but are fairly small in comparison with most contemporary organizations. An average day centre has forty-eight places with a staff/user ratio averaging one to eight (Carter, 1981). Day centres are not governed by one unitary body and different units have differing objectives, meet in a variety of buildings and provide a range of services for various groups of people. They are subject to a variety of management structures although common strands are detectable in most if not all. Despite the obligation by central government to provide day services for disabled people and their families at the national level as specified in the Seebohm Report, day centres have generally been opened in response to locally perceived need. Hence there is much variation in provision from area to area (Kent *et al.*, 1984). There is no subsequent evidence of a comprehensive or coherent national policy on the development of day centres or what roles they should perform.

These considerations make the problem of definition somewhat difficult. Carter defined a day centre as

A non-profit making personal service which offers communal care and which has care givers present in a non-domicilliary and non-residential setting for ,at least three days a week and which is open at least four or five hours a day (Carter, 1981, p. 5).

Her analysis included day centres, sheltered workshops, adult training centres, drop-in centres, and family and community centres covering a variety of user groups. Table 2 shows Carter's estimates of the categories of users of day centres in England and Wales.

*Table 2 Categories of Day Centre Users in England and Wales*

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The Elderly	39%
The Mentally Handicapped	19%
The Physically Handicapped	19%
The Mentally Ill	14%
The Elderly Confused	4%
Mixed	2%
Families	2%
Offenders	1%

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*Source: Carter, 1981*

It is highly probable that although only 19 per cent of these units were designated for use by the physically impaired, there were considerable numbers of people with physical disabilities in centres for the elderly since the likelihood of impairment increases with age. Carter reported that there were slightly more women users than men than would be expected in relation to the general population and that more people who lived alone used these facilities. The percentage of those aged between 36 and 64 corresponded roughly to the numbers in the general population. But those in the 16 to 19 age range and those past retirement (60 for women and 65 for men) were proportionately over-represented.

Most day centre users were at the unskilled or unqualified end of the employment market. Half, excluding the elderly, had left school at 14 or before. And 79 per cent had no qualifications of any type or any marketable skills whatsoever. Carter also claimed that only 4 per cent of day centre users had any kind of work to return to, if and when they left the centres. She stated that

users of day centres start at the bottom of the skill pile. Given that most have a disability, by reason of a labelled mental disorder or extant bodily infirmity, the combination of lack of skills plus disability leaves many day centre users as a difficult employment prospective (Carter, 1981, p. 5).

Since the Carter study there is evidence to suggest that there has been a growth in 'mixed' centres catering for different user groups at the same

time. The Community Care Centre in West Wiltshire provides a good example of this type of establishment. It can accommodate twenty elderly, fifty psychiatrically ill, thirty impaired users and a playgroup and creche for twenty children daily (Foreshaw *et al.*, 1981). Of the 291 centres Carter studied only 6 were mixed. In a slightly later survey of 65 centres, Symonds (1982) found that 18 had adopted this policy. Commenting on this practice Tuckey and Tuckey pointed out that

While it may be that helping or working alongside the mentally ill, the mentally handicapped or the socially inadequate would be beneficial to some disabled people it is not likely that the majority of disabled people, any more than the majority of non-disabled people would choose to spend their time in this way, even if paid to do so (Tuckey and Tuckey, 1981, p. 48).

It is clear from the Carter study and the few that have succeeded it that there is little, if any, provision specifically available for young adults with physical impairments. In general they are mixed with others considerably older. However, there is limited but conclusive evidence to show that many younger individuals with impairments do not wish to spend their time with those substantially older than themselves and that they would prefer centres which cater for those nearer their own age (see, for example, Anderson and Clarke, 1982; Jowett, 1982; and Kent *et al.*, 1984).

While there is some information relating to those individuals who already use these services, there is hardly any concerning those who, for whatever reason, choose not to. One of the few studies that addressed this issue clearly indicates that many young impaired people do not use day services because they would have to mix with the elderly (London Borough of Hammersmith, 1979). Kent *et al.* (1984) maintain that this point is hidden from policy-makers due to the high demand for day centre services generally. Until recently, within social services departments as in health authorities, individuals were classified as young if they were below the statutory retirement age. Since only 9.8 per cent of impaired people are less than 45, a terminological amendment has been made to the most recent literature with those previously termed 'young' being renamed 'younger' (Abberley, 1987).

The internal organization and staffing of day centres depends on the type of unit and the services it offers. At the general level Carter found that while day centres bear witness to the lack of jobs available for users, their very existence was a clear indication of the expansion of employment in the

service sector during the 1960s and 1970s. Her analysis revealed that nearly a quarter of day centre personnel represented people who had transferred from blue collar and manual trades occupations. Many of the staff were as unqualified as the users. Half had left school at the age of 15 or before. A higher proportion of women than men were employed in day centres and the middle age group was over-represented in relation to the general population (Carter, 1981). This situation has prompted some observers to argue that there is an urgent need for higher levels of training for day centre staff, in accordance with the recommendations of the CCETSW (Central Council for the Education and Training of Social Workers) report of 1974 which looked in depth at this issue.

In their report on day services for the young physically impaired Kent *et al.* (1984) defined day centres as

A place where physically disabled people under the age of retirement meet on two or more days a week and where care is available and activities are arranged by or for the users. A day centre caters primarily for those who are permanently excluded, by reason of disability from the formal employment market (Kent *et al.*, 1984, p. 9).

The principal functions of day centres for people with physical impairments below retirement age can be understood with reference to the four models of care identified by Dartington, Miller and Gwynne (1981). Although these models were originally discussed with regard to institutional care they are equally applicable here. They are the 'warehouse', the 'horticultural', the 'enlightened guardian', and the 'disabled action' constructs. They were developed ten years after Miller and Gwynne's (1972) study of residential care which included the 'warehouse' and 'horticultural' models mentioned earlier.

The 'warehouse' construct corresponds with the traditional negative views of impairment. Subjective limitations are translated into total dependence. The 'horticultural' model is rooted in the liberal view that disability is relative. Professional energy is directed toward the denial of difference and rehabilitation. The 'enlightened guardian' construct recognizes the inadequacies of both the former and incorporates elements of each. Thus a model emerges which explicitly provides for both sets of needs -the dependent and the independent. The final paradigm disregards the others on the grounds that they are each based on able-bodied assumptions of

impairment which are considered inappropriate, the first, because it encourages apathy and passivity in the impaired individual, the second, because it is seen as unrealistic and the third, because it allows the professional to vacillate between the assumptions of both the former. Disabled action refers to the situation in which the disabled themselves control or at least participate fully in the policy and decision-making processes of services which concern them. The theoretical basis on which these models were developed is discussed in Chapter Four.

The declared aim of many day centres is simply to provide a facility which enables people with impairments to leave their homes for a few hours a day once or twice a week. This is an extremely important function for both the impaired individual and her/his relatives or carers. It is one of the few instances where to date the state welfare system has provided assistance for the growing army of informal carers. And there is ample evidence to show that these services are wanted by the general public. For example, a study by West *et al.* (1984) showed that the most preferred care arrangements were community-based services, particularly day units. The danger is, however, that many centres see providing relief for carers as their primary task. This is evident in the general tendency to refer to day centres as day 'care' centres, emphasizing the caring role. Hence this type of centre is in keeping with the 'warehouse' model. It is generally accepted that care alone is not acceptable for the young physically impaired, especially those now termed younger.<sup>6</sup> 'Tea and sympathy' achieves little in terms of promoting young people's control over their own lives or their participation in ordinary adult activity. These units provide little or no stimulation and induce passivity and dependence (Kent *et al.*, 1984).

The 'horticultural' model finds expression in centres where rehabilitation takes precedence, notwithstanding that for the congenitally impaired the term 'habilitation' may be more appropriate. The services offered can be divided into two distinct but frequently related areas of activity, namely, social rehabilitation and vocational/ employment preparation. The former relates to the situation where the impaired individual may be taught to look after her/himself with respect, for example, to washing, bathing and social competence. The philosophy on which such programmes are based is summed up by the concept 'self- determination' (Henshall, 1985).

Elaborating on principles of common sense, Henshall argues that it is wise to avoid skin breakdown, becoming overweight and the weariness of living in a muddle. Social rehabilitation therefore involves an introduction to

optimum hygiene routines, suitable eating habits and an orderly way of life. It addresses

the function of a disabled person as it is carried out within the usual environment and lifestyle of the individual. It is concerned with very basic life skills without which everyday tasks become a burden to the disabled person. Independence in personal tasks, management of household chores and achieving mobility with ease are important to all (Hensall, 1985, p. 8).

Exponents of this approach acknowledge that personal independence in the normal sense is not possible for all impaired people. But it is claimed that this impasse can be overcome through mutual consultation between the impaired individual, her/his family (if s/he has one) and the rehabilitation personnel. Clearly here there is the potential for conflict over whose opinion should take precedence as to what is achievable. The danger for professionals to be over- paternalistic is a very real one.

The second type of rehabilitation concerns attempts to prepare for or return impaired individuals to employment. Day centres are seen as training centres preparing people for sheltered or open employment. There is evidence to show this does occur to a limited degree in adult training centres for the mentally impaired, notwithstanding that the data concerned is relatively old, collected before the recent employment crisis. But there is little to support the notion that rehabilitation occurs in centres for the physically impaired. The present employment situation prompted one service provider in a study of services for impaired young adults to state

Give training for what? You cannot go on training until the client is 65 years old (Brimblecomb *et al.*, 1985, p. 86).

Nonetheless in the pursuit of this aim some units offer light industrial contract work, usually unskilled boring jobs, such as packing Christmas cards or rubber washers. Contract work for its own sake is deemed inappropriate since there is no satisfactory outcome in terms of either skill acquisition or financial reward. Day centre workers are only allowed to receive 85.00 per week. Any surplus is claimed by the agency running the operation. A few units have developed schemes where any profit is shared out amongst the users in kind so as not to encroach on their social security entitlement (Gordan, 1986). But such practices are seen as demeaning and exploitative (Tuckey and Tuckey, 1981). Arguably the most damning criticism levelled at such establishments is that the precedent afforded the

work ethic overshadows equally important functions such as social rehabilitation (Oliver, 1983a).

The third model, 'enlightened guardian', is applied to centres which allow users to extend not only their social and cultural activities but also their vocational skills. The unit becomes a focal point for social and recreational activity as well as a kind of college of further education. In offering users the opportunity to play and/or to learn, these units combine both 'warehousing' and 'horticulturalism'. It is worth noting that although the Warnock Report on Education for Special Needs (1978) had little to say on the subject of day centres, it did express concern about the general lack of educational input in these establishments and recommended both that there should be specifically educational element in every centre and that the education department should be responsible for its provision. But these recommendations, like so many in the report, did not become universal practice. Moreover, since there is rarely any obligation placed on users with regard to rehabilitation in these units, it may be said that they have adopted a policy of what Warnock termed 'significant living without work'. Such a position tends to ignore the social, psychological and economic precedent our society places on work. Therefore, centres which adopt this philosophy are open to the accusation that they reinforce the perceived differences between the impaired and the non-impaired, since this provision is not generally available to the latter. In addition, these units are usually organized and run by the non-impaired who are themselves in work. Consequently, in the long term at least, it is likely that they also reinforce dependence.

As noted earlier, the idea that the impaired should remain passive recipients of services provided by others is being increasingly challenged. Hence the term 'disabled action' refers to those units where users participate fully in or control the organization and provision of services. One of the most celebrated and successful examples of this type of centre is the Primus Club in Stockport, where users have successfully controlled the budget and employed the staff for the past decade (Carter, 1981; Kent *et al*, 1984). Since higher levels of user participation and control are now considered important by many people with impairments as well as some professionals in the caring industry, these units are often seen as the most appropriate. However, if they are exclusive to this section of the community, then like the others discussed they are socially divisive and do little to eliminate the deleterious historical divisions between the impaired and the non-impaired. 7

It is important to remember that these illustrations are presented in ideal typical form. None of these options are mutually exclusive and some day units may incorporate some or all of the principal features identified here. But they do provide a useful means of broadly distinguishing different types of services.

## Conclusion

It is clear that a cultural bias against individuals with physical and/or mental impairments was well established in Britain long before the transition to a modern industrial society began and that the low social status and pattern of local provision for such people was well entrenched before state intervention in this area. State involvement in social welfare was prompted by the economic, political and social upheavals of the seventeenth century.

At the outset the central authority pursued policies similar to those of today, namely, keeping the impaired within the confines of the family home whenever possible. As the pace of industrial development intensified and this number increased, the tendency towards segregating the more severely impaired into institutional settings was gradually extended to other indigent minorities. A number of structures, such as the asylum and the workhouse, were developed for this express purpose. By the end of the nineteenth century this practice was almost universal. Throughout this period, however, the moral dilemma posed by the harsh treatment of those viewed as overtly dependent, both in and outside institutions, prompted the central authority to initiate further categorization and segregated provision. But although this development had obvious positive effects, it made the division between the impaired and the rest of the community more pronounced.

Since the late 1950s there has been a concerted attempt by central government to reverse these policies. The motives for this policy change were / are similar to those which prompted their implementation a century earlier, notably economic stringency and an increase in the 'dependent' population. In an attempt to achieve this end a number of services, including day centres, were developed to prevent admission to residential institutions for so-called dependent groups. Although, as with previous policies, there is much disparity in provision at the local level, there has been an unprecedented expansion of these facilities.

From the perspective of the physically impaired, these developments are undoubtedly a step in the right direction. But day centres, like residential institutions, are open to a number of criticisms. Four main types of day centre were identified. These comprised the 'warehouse', the 'horticultural', the 'enlightened guardian' and the 'disabled action' models. All were found wanting since at worst they are said to induce apathy and passivity and to disable their users further, and at best, to perpetuate the 'traditional'

divisions between the able and the non-able. In view of these considerations the emergence of day centres, like their precursors a hundred years earlier, can only be understood as a social and political response to the problems created by large numbers of people who, because of impairment, are excluded from the mainstream of economic and social activity. As a result they perpetuate discrimination and emphasize stigma.

## Notes

- 1 The terms 'institution' and 'residential' are used here to refer to the same phenomenon, although as Jones and Fowles have pointed out the former is frequently used pejoratively and the latter non-pejoratively (Jones and Fowles, 1984).
- 2 Established in 1948, the Leonard Cheshire Foundation is the largest British charity providing residential accommodation for people with impairments (Miller and Gwynne, 1972).
- 3 In Britain residential care for people with physical impairments is mainly funded from three sources, voluntary agencies, local authority social services departments and area health authorities (Oliver, 1983a).
- 4 A government report on children with disabilities was scheduled to be published in April 1989. It was not available at the time of writing.
- 5 The distinction between care in the community and care by the community was made by Bayley in 1971. The former includes statutory institutional type services. The latter denotes non-institutional provision and involves the receivers of care in the community itself (see Bulmer, 1987).
- 6 There is a growing awareness that this type of centre is no longer acceptable for other sections of the 'dependent' population, including the elderly (see, for example, Tester, 1989).
- 7 One notable attempt to avoid this problem was the 'community centre' approach favoured by Bob and Linda Tuckey at the Stonehouse in Corby. While concentrating on the needs of people with physical impairments, the centre adopted an open door policy to others in the community. Most users were under 45 years, and some were in their

late teens and early twenties (Tuckey and Tuckey, 1981). At the end of five years there were about a hundred people using the centre in the course of a week, of whom only sixty were disabled. As the centre became more well known, problems resulted from what Carr terms 'squatters rights' (Carr, 1987), with different user groups claiming time and territory with little cross-fertilization. In consequence, non-impaired user status is now restricted to 25 per cent of the total membership and only to those 'who have an interest in Stonehouse' (Stonehouse Association Constitution, December 1985; Carr, 1987). Although user participation in running the centre is reported to -be high (see Chapter Six) control of the centre's budget remains with Northamptonshire Social Services Department.