

ISSN: 1747-4973 (Online)



WORKING PAPER SERIES

No. 3 (August 2005)

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Counselling and Care in the Community

Introduction

Sir Roy Griffith (Department of Health, 1989) stated ‘families, friends, neighbours and other local people provide the majority of local care and will continue to be the primary means by which people are enabled to live normal lives in a community setting’.

The main argument in this paper is that ‘care in the community’ did not happen in 1990, that the notion of community¹ so liberally used in the above quotation does not reflect the today UK urban reality and that the problem of ‘care in the community’ encompasses more than ‘families, friends, neighbours and other local people’.

A brief historical account of the development of the welfare state will show that the problem of ‘care in the community’ is rooted in the *political* development of the arguments around the welfare state. This discussion will demonstrate how the informal carer and care receiver do not naturally (by their needs) belong to this structure, but are incorporated in the administration of the welfare state.

I will then turn to the statistical evidence of the life of carers, mainly relying on the General Household Survey (National Statistics, 2002). This will amplify the problem both in psychological terms and in the way the Treasury sees it.

On the basis of my empirical research I will discuss how ‘care in the community’ and its administrative structure contributes to the confusion, distorted image of carers’ and care receivers’ role. The existence of an interlocking dependency, that neither chose, often creates misery, resentment.

On the basis of the empirical evidence I will argue that counselling, at least in this context, should not be ‘another support’ provided by the welfare state or charitable organisations to the carer and care receiver, but effective means by which they can explore their interdependency and become aware of its effect on them as individuals, hence at least psychologically could become independent of the helping organisations. This, in turn, has major policy implications.

¹ Historically, the ‘community’ comprised of those within the home vicinity. This often coincided with backgrounds and workplace (accessibility), hence the community was not simply a geographic, but a social phenomenon. Today in urban UK the term ‘community’ became an arbitrary expression for ‘neighbourhood’.

The Politics of the State and its Effects on the Carer and the Care Receiver

Prior to the introduction of the welfare state, the prominent legislation governing welfare was the New Poor Law of 1834². Its remit was to provide welfare for the unemployed, the elderly, young children, the disabled, the mentally ill and the sick. During its existence it provided welfare in the form of ‘indoor’ and ‘outdoor’ relief and institutions (workhouses). In its final years, it extended itself to education and medical treatment (see Appendix 1). It was funded by the people of the parish, originally as a tax then as a rate charge.

The main purpose of the law was to gain popular confidence and maintain social order (in the storm of urbanisation, industrial revolution, economic recessions, severe weather conditions). However, these aims soon collided with the need of curbing expenditure and ideological assumptions of the deserving and undeserving poor. These contradictions and the ramshackle administration³ required complementary services provided by charities. In spite of the clear shortcomings of the system, the poor law remained the main form of welfare until its abolition of 1948.

Just as the Poor Law, the creation of the welfare state was brought about at a time of necessity. The effects of two world wars, the Great Depression of 1929-1933, the popular epidemics (tuberculosis, venereal diseases, parasites) and the radicalisation of great masses demanded a change in social policy. At its annual conference, the Attlee Labour Party of 1942 endorsed the document on welfare programme (Fraser, 1981), produced by Sir William Beveridge, Chairman of the Interdepartmental Committee on Social Insurance and Allied Services. Financing of these reforms was to be through a fairer distribution of income, direct and indirect taxation.

²The origins of this law go back to 1348, at the outbreak of ‘The Plague’ or ‘Black Death’. See Appendix 1 for a chronology of subsequent amendments from its inception in 1349 to 1934.

³ The Poor Law was originally administered by Poor Law Commissioners, Board of Guardians (the Sponsor Clubs had administrative roles in the Poor Law only until 1840) and it took almost a hundred years (1929) when the administration became the responsibility of county councils and metropolitan boroughs. Although the original variation of the administration (Frielander-Apte, 1974) until the Poor Law Officials were introduced both at national and local levels and by this uniformity was achieved, which in turn improved the quality of service (Fraser, 1981).

Beveridge's draft was passed as legislation under The National Health Services Act of 1946 and came into effect on 5th July, 1948 via the Attlee Government.

The hardest won of these reforms was the conversion of the British Medical Association to a nationalisation of hospitals and the need to introduce a National Health Service. General Practitioners were also to be included in this new administration structure. Its concept was to provide a comprehensive medical service irrespective of means (Brown, 1973). The commitment and vigour displayed by the then governing party, Labour, with the support and participation of the opposition in implementing such comprehensive reforms indicate the continuing philosophy of the Poor Law, i.e. measures for maintaining social peace. The welfare state was a result of compromise of various social forces, while power-relationships among these forces determined the spending on the services, as insurance contributions were insufficient to finance the commitments.

In the 1950s-1960s and early 1970s the welfare budget 'see-sawed' between expansion and restriction. This created expectation and dissatisfaction, compounding the belief of the work-shy scrounger and the stigmatised recipient refusing benefit. It also encouraged an imbalance between the individuals' rights and responsibilities vis-a-vis the community (Bornet, 1993). The welfare legislation as a combination of bureaucratic regulations and individualised provisions further weakened intermediary structures, notably the family.

By 1979, economic pressure and the ideology of the then Thatcher Government resulted in a policy of care in the community administered by local authority personnel. This care became a confused mixture of care by the community and private care whether domiciliary or institutional (Walker, 1993). In 1990, the National Health Service and Community Care Act came into force. Its declared objectives are (Department of Health, 1989):

- to provide services that respond flexibly and sensitively to the needs of individuals and their carers;
- services that intervene no more than necessary to foster independence;

- services that allow a range of options for consumers;
- services that concentrate on those with the greatest needs.

The new law represented a radical move from a precarious welfare system governed by economic expansion and contractions subject to pressures of campaign groups to an increasing use of private and informal care and residulisation of the social services saw the demise of the welfare state (Walker, 1993). The trumpeted vision of empowering the users that preceded the introduction of this Act has not materialised. Users and carers complain they have been disenfranchised. The protagonists of the move ignored the opportunity of consulting with users and carers. Consequently, what could have been a watershed in welfare policy became a cost cutting exercise. This relied heavily on the involuntary participation of the carers. As a result the user and carer disempowered rather than empowered.

The Carers

“The prospect of becoming dependant on others for basic needs is regarded with trepidation by most of us ... Supporting chronically ill, handicapped or frail aged people is a front-line of unpaid carers” (Braithwaite, 1990)

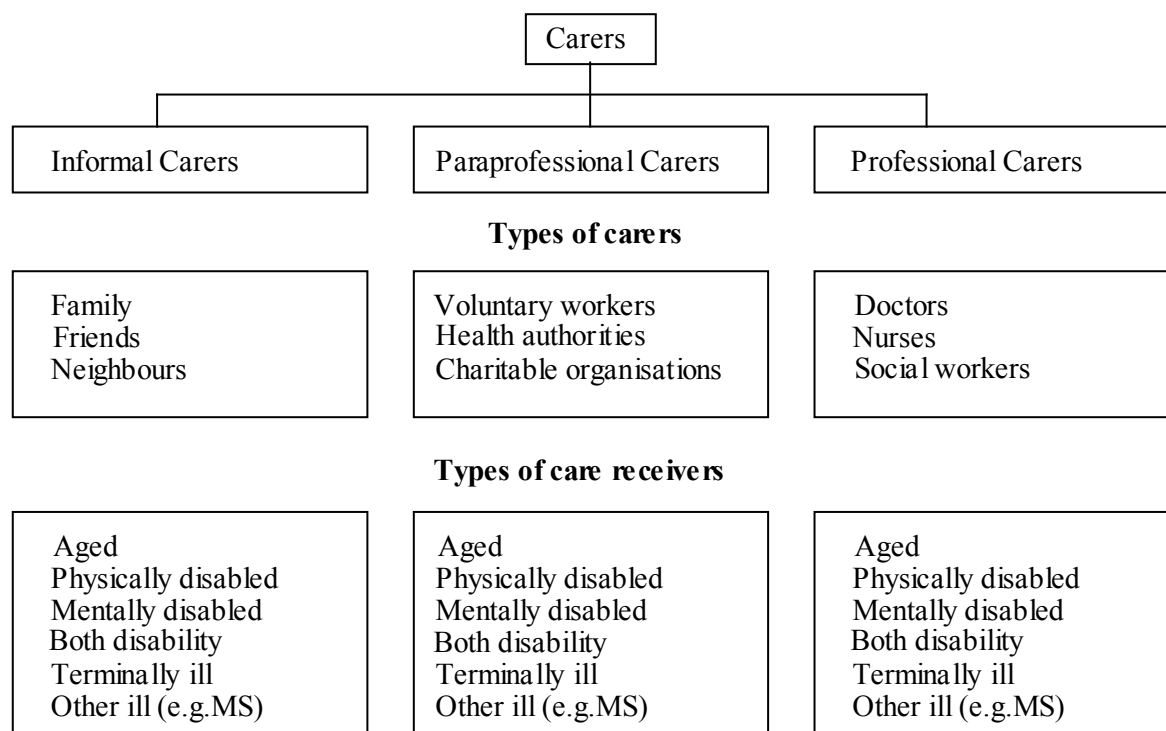
The term ‘carer’ is a very broad umbrella category, used in a rather loose and diverse manner. Hence, although classification introduces some rigidity in the analysis, as individuals may fall in different categories at the same time), the identification and description of the main categories of carers is necessary to analyse the potential (objective) needs of these groups for counselling.

Pitkeathley (1990) identified three main subcategories of carers: the informal carer (family, friends, neighbours), the paraprofessional carer (support workers, voluntary workers) and the professional carer (doctors, nurses, social workers). Figure 1 provides a more detailed classification of carers and care receivers.

The informal carer

There is no widely accepted definition of informal care⁴, empirical studies use different questions to identify carers. The 1990 General Household Survey (hereafter 1990 GHS) as well as the 2000 General Household Survey (hereafter 2000 GHS) that contained the widest nationally representative sample of approximately 13,250 in 1990 and approximately 14, 000 in 2000 living in private households in Britain, applied two screen questions for this purpose. From the questions it follows, that the Department of Health and Social Security defined informal carers as people who were looking after or providing regular service for a sick, disabled or aged person living in the same or in another household. Therefore, informal carers are family, friends, neighbours (Braithwaite, 1990).

Figure 1: Classification of carers and care receivers



Results of the 1990 GHS justified these descriptions and showed that informal care is highly prevalent in our society, involving 15% of the adult population (or 19% of households), which equals to about six million people. Compared to these figures, the

⁴ It partly derives from the self-identification of people as carers. The 1985 GHS found 0.3% of respondents whom the interviewers considered to be carers but who did not identify themselves as such (1985 GHS, p. 6).

result of the 2000 GHS did not show statistically significant change (16%), but even this small change meant that 800,000 more adults provided informal care in 2000 than in 1990 and now one in five households (21%) somebody is a carer. Both in 2000 and in 1990, most of the informal carers looked after care receivers in another household (11% and 12% respectively). About 8% of the adult population carried the main responsibility for looking after someone and 4% devoted at least 20 hours a week to caring in 2000 (3% in 1990). Most of these carers were between 45 and 64 years of age, thus 24% of this age group of Britain provided informal care in 2000. With this the trend of constant increase in this category stopped – between 1985 and 1990 the the increase in the number of carers occurred almost entirely in this category, particularly those looking after their parent(s) or parent(s)-in-law (4% increase).

Prevalence of informal care was independent of social groups and educational qualification in 1985, but information on these subjects were not included in the 1990 and 2000 GHS, thus, with the significant changes in the distribution of wealth, legislation and social norms, social factors might have become more prevalent.

Although the proportion of carers among men and women was not significantly different (14% and 18% in 2000, 13% and 17% in 1990, due to the larger proportion of women in the whole population, the burden on sexes was very different in absolute terms (3.5 million women compared with 2.5 million men in 1985 and 3.9 million women and 2.9 million men in 1990). Women were more likely to carry out informal care outside of the household and the main responsibility for caring. In the most prevalent age group of carers, the weight of women is strongly marked: 24% of women and 16% of men were carers. While the difference between proportion of carers among men and women increased by 1% between 1985 and 1990, it reduced in the concerned age group by 1% (women: 27%, men 20%). The proportions of devoting at least 20 hours were approximately the same in both sexes (5% of women and 3% of men) in 2000 (a slight increase among women since 1990). The most dominant form of caring is looking after children, then spouse, parents in the household, another child in another household, parent-in-law in the same household, friend in the same household. As early as 1990 Parker claimed that about 1.3 million people were significantly involved in providing heavy physical and personal care and a further two million people provided physical, but

not personal care. In addition a huge number of informal carers were offering help to neighbours and friends.

Informal carers perceived their caring as a natural duty and yet their experiences as carers is, stressful and involves considerable sacrifices (Braithwaite, 1990). This is clearly reflected by their own perception of their health needs⁵ and strained relationship often with the cared⁶.

Paraprofessional carers

Paraprofessional carers are those people and organisations whose caring activity is not a statutory one. Paraprofessional carers are, therefore, a mixture of employed, voluntary, charitable organisations and self-help groups. They provide care under different circumstances and a legal framework.

The district health authority, sometimes in conjunction with the local authority, have the responsibility to provide health services related to care. This can vary from authority to authority. There are, however, certain 'core' services provided, such as health visitors, social workers and district nurses. Depending on the policies of the local authority, further services may be provided such as home helps, meals on wheels, sitting and minding service, free laundry service. The carers providing these services do so in an employed capacity, meeting the fundamental needs of the informal and professional carers and care receivers, thus these services fell into paraprofessional caring.

The activity of these organisations is budget dependent, thus, unsurprisingly, the number of informal carers who did not receive regular visitors from the health authorities increased between 1985 and 1990⁷.

⁵ Carers experienced back problems from lifting, stress related illnesses (high blood pressure, irritable bowel syndrome), isolation, feelings of inadequacy, grief, loss for someone who may have changed, loss of sleep, fatigue. The document stated that these feelings could lead to physical problems, such as breathlessness and headaches (North West Regional Health Authority, 1994).

⁶ Informal carers found relationships strained and some experienced violence and abuse both from and towards the person they were caring for (North West Regional Health Authority, 1994).

⁷ While in 1985 68% of carers living in the same household as the care receiver did not have regular visitor from the local health authorities, the proportion increased to 75% by 1990 (figures for care receivers living in another household than the carer are 51% and 53% respectively). In 1985, 8% of carers living in the same household as the care receiver were benefited by those services provided by the local health

In Britain there is a plethora of voluntary and charitable organisations, that are non-profit organisations, usually funded by donations. Extra funding may sometimes be given by health authority, local authority or the government. They may have some paid employees, but are mostly run by volunteers. The services they provide are extensive. They give information, advice and publish literature on what the carer and care receiver may be entitled to. This ranges from welfare benefits advice, illness and conditions. Without attempting to give an exhaustive list of facilities, they provide care assistance in the home⁸, aids equipment, transport, respite car. In cases financial assistance is available. These organisations play a major role in the field of social care as providers of information, service and mutual support (Connelly, 1990).

Self-help groups tend to arise as a consequence of personal circumstances. They aim to provide support to people in similar situation with like experiences, alleviate stress by providing help in the home, arrange sessions and activities and often act as lobby groups.

With the introduction of the Community Care Legislation (1990) these types of paraprofessional carers have been brought in under the umbrella of 'Care in the Community' and hence entitled to be consulted when drafting policies on funding distribution and care facilities.

The professionals

The category of 'professional carer' includes, among others, doctors (GPs), nurses (district, psychiatric), social workers, health visitors, therapists (special, occupational physiotherapist).

Doctors (GPs) provide treatment for ill-health be a means to organising and arranging for the patient the services available in the area. Nurses, health visitors, therapists provide a network of help support and assistance, predominantly in the home. These professionals provide a link between carers and care receivers and the GP. They help

authorities that fall under paraprofessional caring. This proportion fell by 1% by 1990 (figures for care receivers living in another household than the carer are 40% and 38% respectively).

⁸As the 1985 GHS and the 1990 GHS show, in 1985 4% of care receivers and carers had voluntary visitors, while in 1990 the proportion fell to 3%.

with practical tasks such as changing dressing, washing and lifting. Therapists remit extends to providing specialise care. Social workers advise a 'wide range' of problems from practical to financial specialisation areas. They handle are the disabled, mentally ill elderly.

The professionals have expertise and skill to offer the carer and care receiver. As 'gate keepers' they have a responsibility to provide good health care.

Assumptions

The three types of carers perform different functions in the 'care in the community'. Professionals, at least in the current administrative set-up are not part of the community, they 'fly in' when the timetable dictates and allows and in case of urgent need. Their relationship to the care receiver is that of an authority. They play the role of the absent father of an abstract and extreme middle-class Victorian family.

Paraprofessional carers are provided when there are resources available and when the care receiver deserves it (as the service can be withdrawn). While, without the slightest doubt, they provide invaluable services to care receiver, it depends on their goodwill and priorities whether the service is delivered or not – the care receiver has no control on this. Thus following the previous analogy, the paraprofessional carers play the role of the good aunt of that abstract and extreme middle-class Victorian family.

The informal carer is tied to the care receiver by emotional, blood and often financial ties. They are under various pressures (internal and external) to deliver the service. The focus of the research is the informal carer – without them the good aunt and the absent father cannot provide the care and they cannot sufficiently substitute the missing informal carer.

Because of the various pressures on the informal carer and the lack of intensive, non-bureaucratic interlinks with other carers, I expect significant psychological effects on both the carer and the care receiver.

In the case of the carer the simplest effect that could be expected is the diminished ability to manage priorities. It is likely that the emotional relationship and psychological pressure

to deliver the service and the welfare state that tries to buy their services in the forms of benefits forces the informal carer to become a fulltime, paid carer of a particular person (or a few people).

However, unlike job contracts, the informal carer is in an emotional tie with the care receiver that is incomparably stronger and deeper than a psychological contract between the employer and employee. The informal carer cannot leave his or her job until the care receiver needs the service or until the emotional tie is broken, which, in most cases, is likely to represent a very undesirable alternative.

The more the informal carer becomes a fulltime carer, the more likely that he or she becomes dependent on the caring relationship: his or her career has been interrupted, his social contacts diminished and may even become financially dependent on the maintenance of the caring.

From this it can be expected that anger, guilt and blaming would emerge in the relationship, and these feelings are stronger the longer and more demanding the caring situation is. This, in turn, would result in diminishing expectations, fear of change and uncertainty avoidance. If some other force does not intervene, it would likely result in low self esteem and eventually dependence on the care receiver.

If these expectations are verified, counselling could be helpful. The effectiveness of counselling then would depend on the ability of the counselling process of increasing awareness (both the carer and care receiver) and encouraging the carer to consciously make decisions. However, without a radical change in the structure and organisation of 'care in the community', in many cases counselling can only make the informal carer aware how he or she was misappropriated.

Methodology and the sample

To explore these issues, I carried out a survey (see Appendix 2 for the questionnaire). In order to obtain more illustrative evidence and to explore contextual factors a limited sample of people (12) were interviewed using a semi-structured interview schedule.

In the survey one hundred questionnaires were distributed in South East Liverpool, an urban area with about 100,000 inhabitants. The response rate was 73%. Of the returned questionnaires 32 people could be classified as informal carers, four as paraprofessional carers, five as professional carers and 32 non-careers.

The questionnaire, to address the problem of the diversity of respondents, consisted of three parts. Firstly, questions were put to the respondents that were dedicated to identify the socio-economic background of the respondents and whether they were carers or not⁹. The second section explored the activities and feelings of those respondents who were carers, while the third section asked those respondents who were non-carers to express their opinions about the same issues that were asked from carers (“In your opinion...”).

In the total sample women represented 82%, while among informal carers 75%. It means that 40% of responding women and 61.5% of responding men were carers. More than half of the respondents were aged between 30-44 years, but among informal carers their ratio was substantially higher (70%), probably because in this age-group it is the most likely that someone look after either elderly or young child. A quarter of the respondents did not answer the question related to their profession. Of the answers, the proportion of skilled manual and clerical workers was above 50% (44% among informal carers), while people above this, had a proportion of 31% (almost identical among informal carers), which is a significant over representation compared to the whole population (for more details on the sample, see Appendix 3).

Counselling and the care in the community

As I pointed out earlier, the political move of ‘returning care to its rightful place’, that is the community, was not new to the informal carer, only the welfare administration awarded them with the title of ‘informal carer’.

As these people got a title from the welfare bureaucracy, they are entitled to support too. 89% of informal carers of the sample said that they received support. Within this group, 100% of those lived with the care receiver got some support, while 18% of carers who

⁹ The relatively high ratio of carers in the sample was a result of quasi-targeted distribution of questionnaires.

looked after someone in another household did not receive support. Quite unexpectedly, the overwhelming majority of non-carers also felt that carers should get support to care. The main form of support is financial, especially for those carers who were living with the care receiver, but a quarter of those who looked after someone in another household received no financial support to care.

Most informal carers were aware of support provided by professional carers (72%) and more than half of them knew that voluntary organisations provide support to carers. However, less than half of informal carers knew support available from central government, which seems to be contradictory to the fact that more than 80% of them received financial support to care. The contradiction suggests that informal carers are either not aware that benefits are provided by the central government or they consider the benefits as their right rather than support. 60% of informal carers said that they were not aware of support by the community, which either means a problem with the question (i.e. definition problems) or indeed the assumption that the community is ready to support carers varies case by case.

Answers of non-carers to these questions showed some differences. While awareness of support by professionals was still the highest (78%), most of the respondents were aware of support by the community (67%). The difference between the answers of informal carers and non-carers to the latter question could either be an existing difference between the circumstances of the respondents or a reflection of illusions attached to the 'community'. The relatively low proportion of 'yes' answers to questions on the other two types of support is probably caused by the lack of knowledge, since these respondents did not have to seek (or being aware of) these kinds of support.

Turning to the questions on the potential help from counselling¹⁰ clearly demonstrated that although informal carers see themselves as doing what they had to do, they also suffer psychological problems. Respondents to the survey stated that they had the following feelings in order of preponderance:

¹⁰ The findings from this part of the survey has to be treated with caution, as only a small proportion of carers actually received help by a counsellor, thus they often expressed expectations rather than experience or knowledge. The pattern that emerged from the interviews, however, reinforced the evidence from the survey.

- less time for themselves
- stress concerning finances
- feelings of inadequacies
- loneliness
- involvement of strangers in family business
- feelings of guilt

Considering the close contact between the carer and the care receiver, it is not surprising that the care receivers had similar feelings although created by completely different factors. The care receivers recognise that the carer may be their only lifeline for assistance, thus compounding their situation of dependency and inadequacy and this often results loss of dignity when the carer is required to see to all of their needs.

As a result both the carer and the care receiver often feel the extremities of isolation whilst in each others' company. This isolation then, paradoxically could result in a psychological dependency - two emotionally crippled people or family propping each other up. Table 1 summarises these contradictory feelings in the carers and care receivers. The illustrative statements are taken from the interviews carried out in this research.

Carers have stated they are not provided with the knowledge and support from professionals, such as general practitioners, social workers and psychologists, which corresponds to Braithwaite's (1990) findings. When contact was made almost the only support offered was medication for anxiety and depression. While tranquillisers and other types of medications have their own benefits and role, the important in this is that pills do not exhaust the skills that professionals can offer – very few of the respondents were advised of the availability and potential benefits of counselling.

Those carers who received counselling approached it with varied expectations. Some expected advice and answers to his or her problems. There was a significant proportion in the sample for whom 'another authority' suggested counselling and they clearly approached counselling with apprehension as they, at least to a degree, perceived this

recommendation as a comment on their ability to care. This feeling was stronger among those respondents who looked after a relative and those who have been carers for a long time. Although it is difficult to ascertain from the limited sample, it appears that many of these carers developed a strong feeling of anger as they felt that they have discarded a 'real job' career, friends and social interactions. In cases when these feelings led to low self-esteem, some of the carers used their caring role as an excuse and portrayed themselves as a 'victim of society' (cf. Webb-Tossell, 1991).

Table 1: Paradoxical feelings between carers and care receivers

Carer	Care receiver
Feeling Guilt	
I cannot provide everything I cannot cope with all the responsibilities I cannot leave her here and look after my things	How can I repay you What could I do without you You sacrificed you life for me
Feeling: Anger	
I could have become... I could have gone... I could have stayed... I could have had more joy It would be better if you were not here	Why weren't you here? The tea was cold (and the nurse told you...) When you went out to enjoy yourself, the electricity went out and it was dark and cold It would be better to die When I die you will see...

This problem was especially acute in those respondents who came from a background in which there was a strong work ethos as these people did not perceive caring as a real job and they were also to receive welfare benefits, thus they, although not manifestly, considered themselves as dependent on the state. For these people the care in the community is meaningless or even an insulting term as they are locked into an ever decreasing community of themselves, the care receiver and the visiting paraprofessionals and professionals.

Counselling, in spite of the initial apprehension, was beneficial to these people as they could explore their feelings, could rationalise them and develop 'alternative coping strategies' (cf. Skidmore, 1994). The opportunity afforded to talk about their suppressed feelings that cannot be shared with family, nor even their 'nearest and dearest' (this may be the receiver), brought support and focus to the majority of the respondents. This, as Braithwaite (1990) expressed, helped them to recognise the amount of personal control they have in the care-giving situation instead of feeling trapped because they have so little control.

By clarifying their position and hence reducing the temptation to blame, counselling helped carers in the sample to identify the roles of various actors in the caring situation, including the care receivers, other family members, paraprofessionals and professionals. By understanding these roles, a few carers claimed that they were able to utilise the contribution of these 'others' better in the care.

Satir (1967) states in her work with families that two messages are conveyed. One about the pain or trouble they observed in the patient (read care receiver) and one about the pain and trouble in himself (read carer). When carer and care receiver are given access to a facility to express their feelings without fear of being judged, consoled, when they are listened to aware that the counsellor 'does not want to make it better' can be refreshing and enlightening. Permission can be given to express feelings, allowing a 'suffocating relationship' to be better utilised, in which growth can ensue.

Conclusions

The roles of carers and care receivers are rooted in history and these roles have long been utilised in the welfare system. Their prevalence in policy discussions and the invention of names are only spotlights on their appropriateness as means and excuse for the reduction of funding the welfare budget (Department of Health, 1989). The aura of 'care in the community' breeds a mentality and society that perceives that the care of the elderly, ill, disabled and mentally ill falls predominantly to family, friends and neighbours making them the sole caretakers. It is further endorsed by a fundamental characteristic of the British welfare state, deriving from its historical origins and political purpose, its paternalism and sanctimonious approach plainly visible in the form of financial assistance (pensions and benefits).

While people have looked after their dependents (although it varied in time and communities), the current 'care in the community' approach was imposed on them. The welfare state made no attempt to tailor it to people's needs – thus people have to adapt. In addition, for the welfare state and for the tabloids the carer and care receiver become part of that 'lumping society', while caring and expecting care from the community is an obligation and non-compliance is penalised by the same welfare state and by the same tabloids.

The 'care in the community' is plain political manipulation, while care in the community (without quotation marks) is a reality. The community includes doctors, nurses, members of Parliament, the government. To take one group, the carers and the care receivers, and isolate it from the rest is a corruption of the notion community. As a result of the isolation of this group means that the carer and care receiver are left alone to deal with the real terrors of existence, while they expect to look at the professionals (who for some reason in the 'care in the community' are outsiders) for their opinion or admonishment. This reliance on externals then deters them from looking to their own evaluation. It reduces their capability to function as an individual (Lash, 1991).

Advocating the harnessing of care and support for receivers to family, friends and neighbours as a cost-effective meaning has to become obsolete, only then will correct and more humanistic procedures of basic management techniques, family therapy and resolution strategies become the 'reality' for informal carers and care receivers.

APPENDIX 1

Evolution of the Welfare State

- 1348: The 'original' Poor Law.
- 1349: Statute of Labourers - Edward III urged by the landed gentry because of a shortage of labour and rise in wages, ordered able-bodied labourers to accept any employment from any master willing to hire him and forbade him to leave his parish.
- 1531: Lawful Begging legislation - the first recognition of public responsibility. Benevolent groups disappear.
- 1536: Residency Law - had to reside in place for three years to obtain relief.
- 1536: Parish to maintain impotent 'poor'. Able-bodied beggars forced to work. Idle children 5-14 indentured.
- 1562: Statute of Artificers. Vagrants forced to hard labour as work become scarce and food prices increased. Number of unemployed swelled by redundant priests and nuns.
- 1563: Households compelled to make tax contribution.
- 1572: Elizabeth I introduces a general tax to fund the poor with an overseer to administer.
- 1597: Churchwardens and certain households appointed as overseers. Alms House erected.
- 1601: Codification of the Poor Law.
- 1662: The Settlement Act
- 1696: The Workhouse Act
- 1722: Overseers to agree contracts with private contractors to employ poor.
- 1782: Above abolished. Salaried Guardians of Poor appointed. Principle of outdoor relief reversed. People maintained in their home.
- 1793: (To 1815) War with France increased cost of living. Disabled war veterans refused workhouse and demanded relief in their homes. 1795 Relief measured on price of bread standard of living fell. No maintaining in the home.
- 1799: Combination Laws - prohibited trade unions.
- 1824: Above legislation replaced

- 1830: Chartists' Movement
- 1848: Plans to 'improve' the working class through education (Working Men's Colleges set up by Benevolent Benefactors).
- 1905: The Poor Law Commission and the Unemployment Act
- 1906: Meal Act
- 1907: Education Act
- 1908: Old Aged Pensions Act
- 1909: Labour Exchange Act
- 1911: National Insurance Act
- 1918: Representation of People's Act (Abolished disenfranchisement of recipients of relief)
- 1919: Ministry of Health replaced Local Government Board
- 1925: Widows, Orphans and Old Age Contributory Pensions
- 1929: Local Government Act. Abolished Poor Law Unions and Boards of Guardians. Introduction of county councils and metropolitan boroughs.
- 1931: National Economy Act Unemployed and Assistance
- 1933: Children and Young Persons Act
- 1934: Unemployment Act
- 1940: Old Age Pensioners Act

Source: Friedlander, W. A. - Apte, R. Z. (1974): Introduction to Social Welfare. Prentice Hall Inc.

APPENDIX 2

The questionnaire applied in research and its quantitative analysis

Questionnaire

(This questionnaire serves research purpose only to help identifying in which areas counselling may benefit carers and care receivers.)

A.1) Are you

Female Male

A.2) Your age is

..... years

A.3) Which of the following do you belong to

White Caribbean Indian
African Chinese

Other, please specify

A4) Are you employed?

Yes

No

A5) If yes, is it full-time employment?

Yes

No

A.6) Your profession is

A.7) Are you the

Owner of the house you live in

Tenant of a council owned house

Private tenant

Non householder

A.8) Which town or village do you live?

A.9) Do you live with someone who requires special or constant care?

Yes

No

If yes, please turn to section B!

A.10) Do you provide somebody with special or constant care you do not live with?

Yes

No

If yes, please turn to section B!

If no, please turn to section E!

Section B

B.1) Do you receive any support for this care?

Yes

No

B.2) If you receive support for this care, who gives it?

B.3) Do you receive *financial* support for this care?

Yes

No

B.4) Are you aware of the following possibilities of receiving various kinds of support for this care?

support from voluntary organisations

Yes , e.g.

No

support from the community

Yes , e.g.

No

support from doctors and nurses

Yes , e.g.

No

support from the central government

Yes , e.g.

No

B.5) Does the care cause (or caused) a constraint to your employment (e.g. working time, overtime, training, promotion, transfer, taking a new job, etc.)?

B.6) If you are unemployed or a part-time employee does it relate to your having to care for someone?

B.7) Does this care cause acute stress (especially in other fields of your everyday life) to you?

Yes

No

B.8) If yes, could you specify these fields and their importance?

B.9) If counselling was or is available, do you consider it would help in avoiding the stress?

Yes

No

B.10) If counselling was or is available, do you consider it would help in reducing the stress?

Yes

No

Section E

E.1) Do you think care should be provided (by other than the family) to those who need it?

Yes

No

E.2) Do you think *financial* support should also be part of this care?

Yes

No

E.3) Could you mention some situations in which this care should be provided?

E.4) Are you aware of the following possibilities of receiving various kinds of support for this care?

support from voluntary organisations

Yes , e.g.

No

support from the community

Yes , e.g.

No

support from doctors and nurses

Yes , e.g.

No

support from the central government

Yes , e.g.

No

E.5) Do you think people who need special care are stressed by their situation?

Yes

No

E.6) If yes, could you mention examples?

E.7) Do you think providing care causes stress to carers?

Yes

No

E.8) If yes, could you mention examples?

E.9) If counselling was or is available, do you consider it would help in avoiding the stress of carers?

Yes

No

E.10) If counselling was or is available, do you consider it would help in reducing the stress of carers?

Yes

No

E.11) If counselling was or is available, do you consider it would help in avoiding the stress of care receivers?

Yes

No

E.12) If counselling was or is available, do you consider it would help in reducing the stress of care receivers?

Yes

No

Appendix 3

Tables generated from questioners (figures are percentages, respondents = 100)

Table 1: Respondents by sex, age, profession

Carers	Informal carers	Paraprofessional carers	Professional carers	Non-carers	Total
<i>By sex</i>					
Male	75	75	80	91	82
Female	25	25	20	9	18
<i>By age</i>					
0-29	3	50	0	9	8
30-44	70	25	2	50	56
45-64	27	25	3	41	35
65-	0	0	0	0	0
no answer	6	0	0	0	5
<i>By profession</i>					
unskilled	4				2
semi-skilled	5				12
Skilled	11				55
Above	8				31
no answer	7				25

Table 2: Knowledge of informal carers of types of support available to care

	Informal carers	Total
<i>Support by voluntary organisations</i>		
Knows	55	58
Does not know	45	42
No answer	9	7
<i>Support by the community</i>		
Knows	39	49
Does not know	61	51
No answer	13	10
<i>Support by professional carers</i>		
Knows	72	79
Does not know	28	21
No answer	9	7
<i>Support by central government</i>		
Knows	45	53
Does not know	55	47
No answer	9	7

Table 3: Carers' opinion whether counselling helps avoiding or reducing stress caused by care

	Informal carers	Paraprofessional carers	Professional carers	Total
<i>If counselling helps avoiding stress</i>				
Yes	78	67	60	74
No	22	33	40	26
No answer	28	20	0	24
<i>If counselling helps reducing stress</i>				
Yes	81	67	60	76
No	19	33	40	24
No answer	34	20	0	29

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