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SURVEY OF THE SOCIAL SERVICE SECTOR

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SURVEY OF THE SOCIAL SERVICE SECTOR

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ABSTRACT

From October 2017 to December 2018, IPS surveyed a sample of 107 out of the 463 Social Service Agencies (SSAs) listed with the National Council of Social Service (NCSS) to understand how they prioritised social needs, what their own organisational needs were, and to capture their views on key policy issues. The 107 sampled SSAs participated on a voluntary basis. In terms of representativeness, 53 per cent of the 107 sampled SSAs had 25 staff or less, and 23 per cent with more than 100 staff. About 81 per cent of the sampled 107 had annual revenues of $10 million or less, and 19 per cent had more than $10 million. In terms of outreach, 62 per cent of the sampled 107 had 50 to over 100 active volunteers, and 42 per cent served between 100 and 1,000 clients while another 30 per cent served 1,000 to 10,000 clients.

The sampled SSAs identified the greatest needs to be in the areas of the elderly, family and mental health. Service gaps from their perspective were in the areas of casework, financial assistance and advocacy/public education. In terms of organisational functions, they indicated that they required the most support in fundraising and IT. They also thought that they needed more tools and training for programme design and evaluation.

The 107 SSAs that were sampled had collaborated with typical partners (e.g., other SSAs, grassroots, corporates, government) and less so with community assets they were less familiar with (e.g., cooperatives or mutual benefit organisations). More than half also thought that turf issues prevented greater collaboration amongst SSAs. Their views on certain policy issues were quite split — on whether they were adequately consulted for policy decisions; on whether funding should go to fewer, more efficient organisations or supporting as many charities as possible.

To provide possible reasons and context to some of the survey results, social service professionals were invited to comment on the findings through three separate roundtables. Where relevant, the reflections of those who commented are documented here.

Executive Summary

EXECUTIVE SUMMARY

BACKGROUND: CHARACTERISING THE SOCIAL SERVICE SECTOR

- Greater central coordination and consolidation of social service sector.

- An SSA is a direct service provider that meets the basic welfare needs of vulnerable groups. In Singapore, statutory functions provide crises interventions for more acute social issues, so SSAs operate mainly in a remedial or recovery band of services, with fewer moving upstream to operate more preventive services or to achieve optimal functioning.

- The areas of focus for SSAs are concentrated on vulnerable children, youth, families, disability and mental health, and elderly.

- The approach to these issues is largely through service provision, which has become more professionalised over the years. Small pockets of SSAs engage in community development or advocacy to complement what is largely a sector dominated by individual level interventions like casework or counselling.

APPROACH

- The survey questions covered basic information about the SSA's social needs, organisational needs, and relationships with stakeholders. There were also questions that sought the respondents' views on key policy issues, which were identified through landscape scans and tracking developments of the sector.

- The survey was conducted from June 2017 to December 2018, sampling from the NCSS's list of members and based on a voluntary participation.

- The final sample size is 107, out of 463 SSAs that were listed with NCSS at the start of this project. The fieldwork was conducted by IPS researchers and administered via email or face-to-face based on respondent's choice.

FINDINGS

(A) Social Needs and Gaps

Prioritised Social Needs

1. Elderly	➢ Social Isolation ➢ Dementia ➢ Financial Independence
2. Family	➢ Divorce/ Reconstituted Families ➢ Single Parents ➢ Incarcerated Family Member
3. Mental Health	➢ Awareness & Acceptance ➢ Treatment & Rehabilitation ➢ Employment

(B) Service Gaps

Area of Service	Gap
Casework & Counselling	➢ Lack capacity to meet demand ➢ Ineffectiveness of current solutions
Financial Assistance	➢ Lack of accessibility to clients ➢ Ineffectiveness of current solutions
Advocacy & Public Education	➢ Ineffectiveness of current solutions ➢ Accessibility to client

(C) Organisational Needs

The top two corporate functions that SSAs indicated they needed external support in are fundraising and IT. This is followed closely by three other areas: Marketing/Communications, Community/Corporate Engagement, and Policy Advocacy/Research. They indicated the lack of funding and staff not having the requisite skills as reasons for need of support.

(D) Research Needs

Most of the sampled 107 SSAs conducted needs assessments, programme design and evaluation, and believed these are important forms of applied research. They indicated that more tools and training were required for programme design and evaluation.

(E) Partnerships and Collaborations

Prevalence of and satisfaction with collaboration: Opinion was split on whether there was much collaboration. Among SSAs, 48.1 per cent thought there were many collaborations happening in the social service sector while the others were neutral (35.8 per cent) or disagreed (16 per cent). In addition, 34 per cent were satisfied while 28 per cent were dissatisfied with the level of collaborations between SSAs, with the rest expressing neutrality.

Types of collaboration: The most common form of collaboration with other organisations tends to be in terms of sharing information, expertise or undertaking joint projects.

Common and uncommon partners: SSAs collaborate with "typical" partners of the sector, and less so with other community assets. Common collaborators of the SSAs are other SSAs, government, grassroots and corporates. Very few collaborated or even knew of mutual benefit organisations or cooperatives.

Desire for greater collaborations: Among SSAs, 44 per cent wanted to establish relationships with social cause consultancies; 35 per cent with researchers/universities; and 21 per cent with community service offices of schools.

Barriers to collaboration: Up to 56 per cent see turf issues as a barrier to collaborations between SSAs.

(F) Views on Policy

Engaging in commercial activity: Supplementing revenue through commercial activities was generally regarded as useful, but some recognised the danger of the SSA's mission being displaced.

Sharing data: SSAs were willing to share outcomes data more publicly for stakeholders to see, though some were cautious because of the sensitivity of the data.

Funding policy: Most wanted funding polices to be transparent and did not think that this would reduce the funder's ability to exercise useful discretion. Slightly more SSAs were dissatisfied with the level of transparency of funding policies (32.4 per cent) compared with those who were satisfied (22.9 per cent). SSAs were quite split on whether funding should go towards supporting fewer, more

efficient organisations (48.6 per cent) or towards supporting as many charities as possible (43.9 per cent).

Consultation and engagement: SSAs were split in terms of how adequately they were consulted for major policy decisions, where 39.3 per cent thought they were adequately consulted, 33.6 per cent thought they were not, and the rest were neutral. However, a higher proportion of SSAs (45.8 per cent) feel satisfied with government engagement compared with those who did not feel satisfied (26.2 per cent).

Chapter 1

Introduction

INTRODUCTION

This report analyses data from a survey conducted between October 2017 and December 2018 by the Institute of Policy Studies (IPS) among 107 social service agencies (SSAs). The study sought to understand how the SSAs prioritised social needs in Singapore, their relationships with other stakeholders, their organisational and research needs, and their views on key policy issues facing the sector.

DEFINING SOCIAL SERVICE AGENCIES

A non-profit organisation that provides welfare or social service to vulnerable or disadvantaged groups in Singapore was until recently, known as a Voluntary Welfare Organisation (VWO). A rebranding exercise by the National Council of Social Service (NCSS) led to them being renamed Social Service Organisations, and in 2019, Social Service Agencies (SSA). SSAs are members of NCSS, a statutory board under the Ministry of Social and Family Development (MSF). A VWO or SSA is therefore not a legal structure (they can be registered as societies or companies limited by guarantee), but a classificatory category used to describe a subset of voluntary organisations in the business of providing direct welfare services.

While MSF more broadly defines SSAs as organisations that provide services that "benefit the community at large" (MSF, 2020), SSAs' clients typically includes vulnerable or disadvantaged groups such as the elderly, vulnerable families and children, youth-at-risk, ex-offenders, and people with disabilities. These are relatively consistent categories that have been used in the directories of social services published by NCSS. Typical services include casework and counselling, homes, rehabilitative centres, drop-in centres and helplines, etc. There is also a typical professional profile of SSAs; they generally hire social workers, counsellors, psychologists and therapists as frontline staff.

SSAs that regularly provide social services as a primary function are largely funded by external sources of income such as donations and fundraising, and government grants, which can constitute anywhere from 65 per cent to over 90 per cent of an organisation's funding (Sim et al., 2015). Smaller charities[1] tend to depend much more on donations and fundraising, and have been relying less on government grants, though this

[1] Represented by lower total operating expenditures.

is the opposite for large charities[2] that depend on government grants for 40 to 45 per cent of their income. Manpower dominates SSAs' expenditure (Sim et. al., 2015, p. 30).[3] SSAs do not generate profits from their programmes, which are subsidised via external sources of income. In terms of assets, smaller charities tend to have a higher percentage in cash and cash equivalents; larger charities tend to have a higher proportion of non-current assets.[4]

Some non-governmental organisations (NGOs) are largely advocacy organisations, like MARUAH, AWARE, PinkDot, Disabled People's Association (DPA), but the boundaries are not always clear because some of these also provide direct services, e.g., AWARE's support group for divorced women. Incidentally, AWARE and Disabled People's Association are members of NCSS but not MARUAH or PinkDot, or even service providers such as Oogachaga, which provides counselling for the LGBT community.

There are also quasi-autonomous non-governmental organisations (QUANGOs)[5] that are a hybrid form of organisations that are set up by NGOs or sponsored by the government and are partly controlled and financed by them. The Agency for Integrated Care (AIC) was incorporated in 2009 to help the government plan and coordinate services to help Singapore's rapidly ageing population. SG Enable was set up in 2013 (its precursor was the Centre for Enabled Living) to create employment opportunities for people with disabilities.

EVOLVING STATE-SSA RELATIONS: GREATER CENTRALISED COORDINATION

The "Many Helping Hands" Approach

In the early years, the government focused on providing services that SSAs could not. Ahmad Mattar, then Acting Minister for Social Affairs said in a conference on the social services in 1982 (emphasis authors' own):

> "In those early years of the existence of the Social Welfare Department, there was a clear understanding of the respective roles of the Government and the voluntary organisations in the

[2] Represented by higher total operating expenditures.

[3] In FY2013, the figure was between 46 and 58 per cent of total expenditure.

[4] Examples of long-term assets include land, trademarks, and long-term investments.

[5] These are sometimes called government-organised non-governmental organisation (GONGOs).

> field of social welfare. The Social Welfare Department, it was clearly understood, *entered the field only to operate such residual institutions or services as are not, or cannot conveniently be, established and maintained by voluntary effort alone*"
>
> — Dr Ahmad Mattar at the 1982 Voluntary Social Services in Singapore: Pre-University Seminar

In other words, the government mainly took on key responsibilities when the problem became too large for the voluntary sector to take on by themselves. For example, the Family Planning Association (FPA) was established in 1949 by a group of housewives and had great support from the government. They were pioneers in a controversial issue at the time — family planning and the use of contraceptives. By 1965, the government had realised the importance of population control and the Family Planning and Population Board was established. FPA subsequently handed over major responsibilities to the government and moved on to family life education. This was the same for the Singapore Anti Tuberculosis Association (SATA), which provided treatment from 1947 until the government took over the management of the disease (Neo, 1982).

This policy position towards welfare provision has been christened the "Many Helping Hands" approach, which sees many different players in society coming forward to help the disadvantaged in society. It has been articulated this way:

> "We should keep [the spirit of *gotong royong*[6]] alive, and we should avoid bringing in the State. Because when the State steps in, it brings in bureaucracy, it brings in rigid rules, and the support becomes depersonalised. You have to do according to what the book says. You cannot do according to what you, as a community leader on the spot, know needs to be done, which cannot necessarily be justified in dollars and cents according to exact formulas and procedures. As a result, the support misses those who needed most, and goes instead to those who are less in need"
>
> — BG Lee Hsien Loong at the 7th Parliament of Singapore [7]

Capability Building and Coordinating the Many Helping Hands

[6] *Gotong royong* means cooperation or collaboration in Bahasa Indonesia.

[7] This was the earliest recorded mention of the "Many Helping Hands" approach, made in 1991 by Lee Hsien Loong, Deputy Prime Minister and Minister for Trade and Industry, during a parliamentary debate on a motion to accept a White Paper on "Shared Values" (Lee, 1991).

While the government understood the benefit of sharing welfare responsibilities, they were also aware of the need for coordination across diverse organisations providing different services to address different social needs. Dr Woon Wah Siang, then Director of the Social Welfare Department under the Ministry of Labour and Welfare, was instrumental in establishing the Singapore Council of Social Service (SCSS) in 1958 for this purpose, now called the National Council of Social Service, or NCSS (Vasoo, 1983).

The Community Chest (ComChest) was established in 1983 by SCSS President Dr Ee Peng Liang to raise funds for the many social services organisations, "relieving them of the burden of fundraising so they can focus on their primary responsibility of caring for and serving the needy" (Community Chest, 2005, p. 3). This was modelled after the United Way, a federated form of fundraising that evolved from the earlier Community Chests in America. Centralising fundraising was touted to be beneficial to charities, and had been driven by businesspeople and wealthy donors because it would relieve the pressure on a small circle of givers, and also eliminate "the general sense of harassment" by solicitations (Morris, 2015, p. 111).

With federated fundraising, a system of allocating funds had to be developed. The Ministry of Social and Family Development (MSF), NCSS and Tote Board — which collects gaming revenue in Singapore — provide the main sources of funding for many organisations, and the resource allocation policies and funding priorities of these government bodies have tremendous influence on how these organisations operate.

In more recent years, MSF has rolled out Social Service Offices (SSOs) to do local planning and coordinate services. MSF has also created a case management system called Social Service Net (SSNet) that SSOs and SSA-run Family Service Centres (FSCs) have to use, giving MSF an important overview of client information across the nation. In order to ensure quality of services, NCSS had created the Programme Evaluation System (PES) in 2001 to monitor the performance of funded programmes. By 2003, every one of the social service programmes administered by NCSS had implemented PES in order to qualify for funding (Community Chess, 2005). This has since been refined to pay attention to outcomes instead of only outputs.[8] These funding models and performance management regimes matter because they structure the relationship between the state and the non-profit sector. The allocation policies of MSF

[8] Now known as the Enhanced Performance Evaluation System (EPES), by taking on an "outcome management" framework.

and NCSS shape the attention of the sector to selected social causes or disadvantaged groups.

By 2003, NCSS had launched its training arm, the Social Service Training Institute (SSTI) to provide continuing professional education for the social service workforce. It has become an approved continuing education and training (CET) centre recognised by the Workforce Development Authority (WDA). SSTI has since grown to take on broader manpower development roles and was renamed the Social Service Institute to recognise this expanded scope. Together with MSF, NCSS plans manpower to ensure adequate supply of people for the sector. They have created a competency roadmap for social work training and salary benchmarks for SSAs in an attempt to raise wages across the sector. However, the benefits of centralisation for the social service sector are uneven and perhaps too early to assess. For example, SSI has started a centralised hiring scheme — the Sun Ray programme — where NCSS hires and deploys staff to various SSAs to counter labour shortage and the inability of SSAs to attract talent. Centralised hiring and deployment presumably also create more career progression opportunities, which would otherwise be impossible if left solely to individual smaller SSAs. However, one possible concern is whether a master employer arrangement brings about challenges with regard to the organisational allegiance of these employees, who have to straddle NCSS and SSA work.

Fewer, Stronger Hands?

Unlike the early days, the government has increasingly taken the lead in many aspects of social welfare provision and sector development. Much of the response to problems of the sector has been to create more consolidation and control. Where there were fundraising challenges by individual SSAs, federated fundraising was created. Where there were insufficient skills and capabilities, a training institute was set up. When there was manpower shortage, centralised manpower planning and even centralised hiring was instituted. Where there was a need to catalyse innovation and productivity, an innovation lab in NCSS was created. Furthermore, with the creation of SSOs and the rolling out of SSNet with FSCs as close partners, the government is now able to get better administrative data directly from the ground.

The social service sector has also seen an emergence of medium-to-large sized charities that are well resourced and provide a wide range of services. This reflects a “push towards professionalism and consolidation measures” (Tan, 2019, para. 7). Large charities such as Thye Hua Kwan Moral Charities, AMKFSC Community Services and Fei Yue Community Services have grown to run anything from early intervention programmes

for children with disabilities to numerous FSCs and senior activity centres. AMKFSC Community Services has doubled its manpower count to 250 and increased the number of centre staff from 10 to 25 in the last five financial years. MSF too has effectively halved the number of agencies serving at-risk and offending youth. Such consolidation has been touted as necessary for "better coordination, less duplication of services, and families being able to get help in a more holistic manner" (Tan, 2019, para. 19), though this might be at the expense of specialised services serving niche communities. Also, while centralisation might be more efficient in terms of service delivery, it could be at the expense of community participation (Ang, 2015). As a result, the "many helping hands" philosophy might apply more to SSAs serving like *community-located* agencies that run programmes in accordance with centralised, government funding priorities, and less to SSAs run by the voluntary sector to serve their niche communities and which receive less centralised funding.

CHARACTERISING THE SOCIAL SERVICE SECTOR

Priorities of the Sector: What Social Causes, and Whose Needs?

What are the main social causes and population groups that are of concern to the government and SSAs in the social service sector? This is an important consideration because it determines whose needs and what type of needs deserve the support of the government and the voluntary sector. As social policy expert Jonathan Bradshaw put it: "The history of the social services is the story of the recognition of social needs and the organisation of society to meet them" (Bradshaw, 1972, p. 71).

Social welfare is subject to the politics and negotiation of what social causes, what groups, and what type of needs of those groups warrant statutory action or voluntary sector support. The determination of what counts as "basic needs" is also a way of prioritising what services should be provided, compared with those that address personal autonomy, optimal functioning or other such "higher needs".

While the boundaries are never so clear, it is possible to sketch and characterise the key types of social causes that matter to the social service sector at large, a result of collective definition of social needs negotiated by civil society and the government. In general, the social

service sector in Singapore serves the *basic needs* of the *vulnerable and disadvantaged.*[9] In Singapore, the groups considered vulnerable are:

- **Elderly.** This typically includes those who are low-income, socially isolated and frail (suffering from health or chronic conditions and therefore cannot live independently), but has sometimes been extended to include "active agers".

- **People with disabilities and mental health issues.** The definitions of "disability" and "mental health" are highly medicalised and have acquired a semblance of objectivity. However, what kind of functional impairments count as a "disability" and their "level of severity" will continue to evolve with social and technological developments.[10]

- **Vulnerable children and youth at risk.** This includes children who live in unhealthy family environments and who may require support. For youth, this typically means those "not in education, employment or training". The social services are designed to keep them in school, or if not, then at least in some form of employment or preparation for employment.

- **Vulnerable families.** This includes low-income families, or those with abusive or neglectful parents due to a range of issues such as problem gambling, drug use or incarceration. However, vulnerable families are also typically defined as falling short of the ideal family type, which in Singapore means the nuclear family. In other words, single-parent households and reconstituted families

[9] These are relative terms — who is vulnerable and what are the basic needs? Nevertheless, MSF and NCSS are able to define the focal causes that set the parameters for the sector at large. A simple scan of policies, publications and departments allow us to get a sketch of the issues and social causes that MSF and NCSS care about. MSF publications have covered child abuse, student care, disabilities, divorce, elderly and active ageing, family life, family violence, foster parenting, problem gambling, low income, intergenerational relationships, and work-life harmony. The NCSS's service planning and development group has the following departments: children, youth and family; disability; eldercare; mental health services; and standards and impact. There are minor variations — such as the inclusion of "recreational services" for children and youth in the 1985 NCSS Directory of Social Services, which now sounds anachronistic as a kind of social or welfare service — but these categories have remained relatively stable. NCSS has also recently taken on mental health as a cause while MSF has not, leaving it within the jurisdiction of the Ministry of Health and the Institute of Mental Health.

[10] For example, due to the pervasiveness of the optical and eyewear industry, and the negligible need for social accommodation, short-sightedness is not thought of as a "visual impairment", and therefore a status that requires special protection.

are also considered to be at risk. More recently transnational families have been included, but only of the low-income type.

- **Caregivers.** A new group to receive increasing attention, this includes those who provide care and assistance with medical tasks and activities of daily living (ADLs) for family members, the elderly, persons with disabilities and persons with mental health issues. Caregivers are usually the parents of those receiving care, but they may also be the spouses or other loved ones. Typically, caregivers do not refer to professional staff working with institutions but informal unpaid caregivers outside of those settings. It should be noted that this group does not include foreign domestic workers or parents taking care of children without disabilities nor mental health issues.[11]

A categorisation of the types of social services provided across different areas of need is provided in Annex B.[12]

There are many questions one could raise as to whether and how these groups should be supported by the social services. If the sector at large and ministerial direction were to focus mainly on vulnerable groups and their basic needs, then the debate might be about whether such groups are actually vulnerable, or how basic are these needs.[13]

Causes and groups that are *not* included might become an important matter for consideration and public deliberation.[14] There are also many

[11] See details at https://www.moh.gov.sg/caregiver-support and https://www.ncss.gov.sg/GatewayPages/Social-Services/Caregivers

[12] From the table in Annex B, we can see that the more basic needs (second row) and more urgent crisis intervention services (rightmost column) are typically statutory functions. In Singapore, some higher-level needs such as preventive measures for health and community strengthening have government agencies overseeing them (i.e., the Health Promotion Board and the People's Association, respectively).

[13] Or we can take a more expansive definition of welfare, as in the 1967 United Nations definition, but risk losing clarity and focus: "Social welfare as an organised function is regarded as a body of activities designed to enable individuals, families, groups and communities to cope with the social problems of changing conditions. But in addition to and extending beyond the range of its responsibilities for specific services, social welfare has a further function within the broad area of a country's social development. In this larger sense, social welfare should play a major role in contributing to the effective mobilization and deployment of human and material resources of the country to deal successfully with the social requirements of change, thereby participating in nation-building".

[14] Depending on one's analysis of social trends, one might argue this is "not yet included" or "will never be included".

possible smaller-scale debates about what qualifies for support or funding. For example, “recreational” activities for people with disabilities are typically considered to be “social services” because they contribute to social integration, but not recreational activities for youth in general (now considered to be under MCCY and National Youth Council’s purview). Another possible question is whether an “active ager” should be served by this sector, since this segment could well be middle-class retirees who are financially independent and healthy.

With greater affluence and social development, it is understandable that there will be seepage in service coverage to address higher-level needs or groups that are less vulnerable. Although we have taken on a relatively narrow focus in the social service sector (perhaps rightly so due to our context and state of development), perhaps the time will come for a broader definition of social welfare and social services, so that other causes and types of needs become included or excluded as part of the continual readjustment of focus.

Approach of the Social Service Sector

In tandem with Singapore’s state of development, the social services also seem to have moved from crisis-based and remedial forms of intervention to relatively preventive services, and those that focus on optimal functioning. The social work curriculum itself has evolved to meet the sector’s demands, with the earlier emphasis on interpersonal practice and counselling displaced by the later focus on community development, and in more recent times, research and policy.

This was how a veteran summarised the evolution of social work training in Singapore (emphasis our own):

> “The emphasis of social work training in the late 60s and early 70s was *on interpersonal practice and counselling practice*…focus was to prepare them to work in social work arena, the government and voluntary sectors…
>
> “In the 1980s, the department was oriented towards *community development* work and *work with groups.* The curriculum of social work training was revised to accommodate a generic emphasis. This was deemed necessary as social work graduates were sought in areas outside the traditional social work field. The unconventional career paths of social work graduates thus necessitated a generic approach to the training of social work students…

> "Social work training in the 1990s is geared towards *prevention*. While a high level of emphasis of social work training is still given to clinical expertise, human service management, support networks and community development are now increasingly given more emphasis…" (Sapa'at, 1992, p. 39).

If community development is the process of bringing the community together to take collective action to determine its own needs and how they should be met (Ife, 2016; Ledwith, 2016), towards building a shared identity and facilitating human agency (Bhattacharyya, 2004), it should be noted that not many SSAs actively engage in it.[15] This may be an unintended consequence of the historically state-led nature of grassroots activities in Singapore,[16] and because the delivery of direct services has been historically tied to more secure funding policies.[17] The same can be said for research and advocacy; most SSAs do not engage in this unless they can afford to. Research may not contribute to direct service improvements — bar programme evaluation, which has been imagined as a way to prove the efficacy of a SSA's services and programmes.

Chapter 2

Methodology

[15] Beyond Social Services distinguishes itself from other similar SSAs in that it actively builds shared identity in the communities that it serves.

[16] Seah Chee Meow argued that through the People's Association (PA), the state created a controlled form of mobilisation and community participation through a wide network of government-sponsored grassroots organisations, which had the unintended consequence of displacing community organisations and non-profits in playing a larger role in community development. As he observed, "Generally, it would appear that the role of the people in development is of a supportive character. The citizens comply rather than innovate; they receive and adapt rather than suggest and modify. This situation has been facilitated partly because important grassroots leaders are generally attuned to the objectives of the government while the people (as a result of effective communication) have been kept aware of the government's various measures" (Seah, 1978, p. 19).

[17] Early examples of American-style community organising were considered to be abrasive and confrontational, and did not receive support compared with more collaborative approaches (Vasoo et al., 1983, 3). While social service providers are welcomed, supported and even generously funded by the state, more activist or advocacy organisations are held at arm's length due to their propensity to challenge government policies.

METHODOLOGY

The sampling frame for the survey is derived from the list of SSAs that are members of the NCSS. At the point when the survey was conducted, there were 463 such agencies.[1] The interview process was conducted from October 2017 to December 2018. In total, 107 organisations agreed to participate and completed the survey.

SSAs in the sampling frame were contacted via email where their heads or senior management were invited to participate in the study or nominate a management staff to complete the survey from October 2017 to December 2018. Upon agreement, the participants had the opportunity to complete the survey on their own via email — the soft-copy of the survey was sent and picked up via email — or face to face, in which an interviewer would record their responses on a hard copy of the survey in a face-to-face meeting. In the latter case, no personal identifiers were collected.

Data collected was self-reported, anonymous and kept confidential. The results were then compiled and analysed. The participants were remunerated with a $20 shopping voucher as a token for their participation.

The survey questionnaire is appended in Annex A.

[1] NCSS maintains a member list here: https://www.ncss.gov.sg/GatewayPages/Social-Service-Organisations/Membership/List-of-NCSS-Members

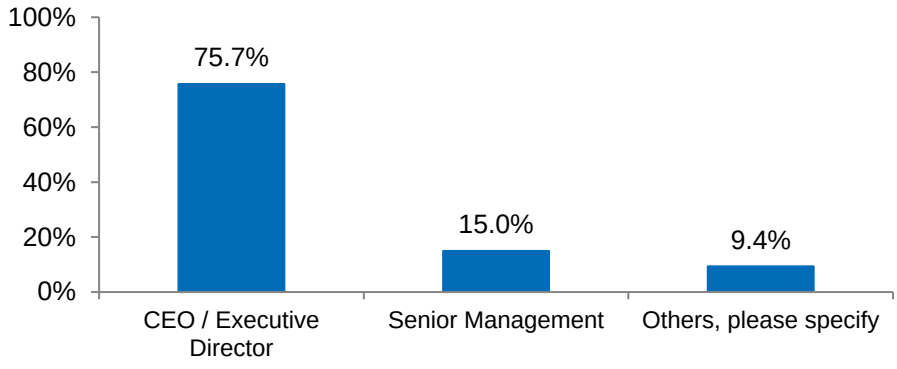
Chapter 3

Demographics

DEMOGRAPHICS

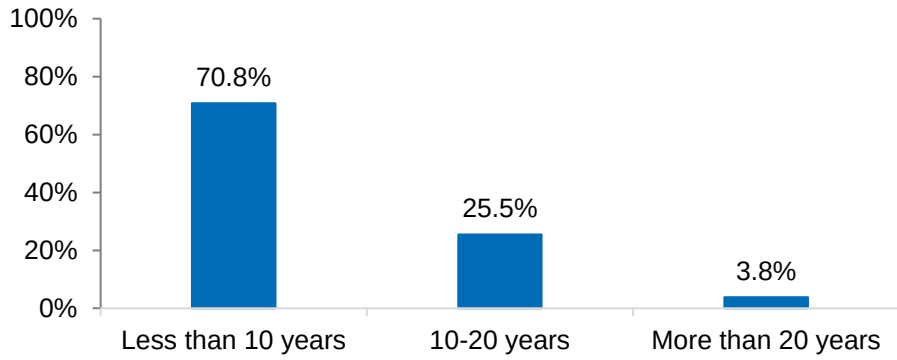
More than three quarters of respondents were CEOs or Executive Directors in their respective organisations. About 15 per cent comprised other senior management staff, with the remainder identifying as board members or senior members of staff designated to complete the survey.

Figure 1: Distribution of respondents according to position held in organisation



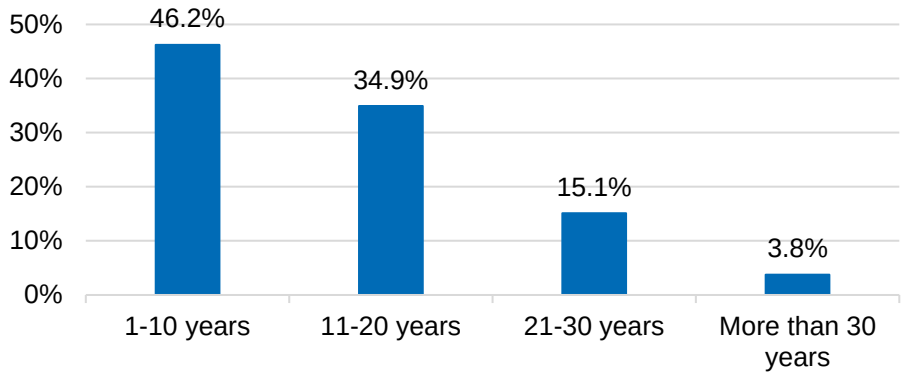
More than 70 per cent of respondents have held these positions for less than 10 years. This was 10 to 20 years for about 25 per cent of respondents. Only 3.8 per cent have spent 20 years or more in these senior positions.

Figure 2: Distribution of respondents according to duration spent in a senior position



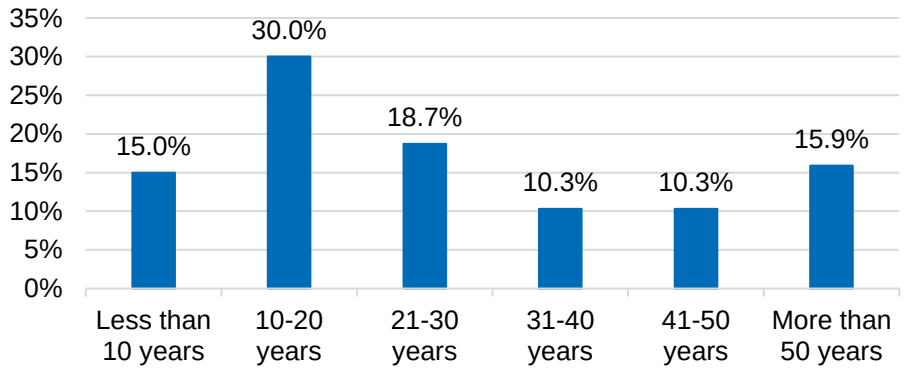
Most respondents (46 per cent of the sample) have worked in the social service sector for less than 10 years. Next, 35 per cent of respondents have worked in the sector for 11 to 20 years. The remaining 19 per cent have worked in the sector for more than 20 years.

Figure 3: Distribution of respondents according to years spent in the social service sector



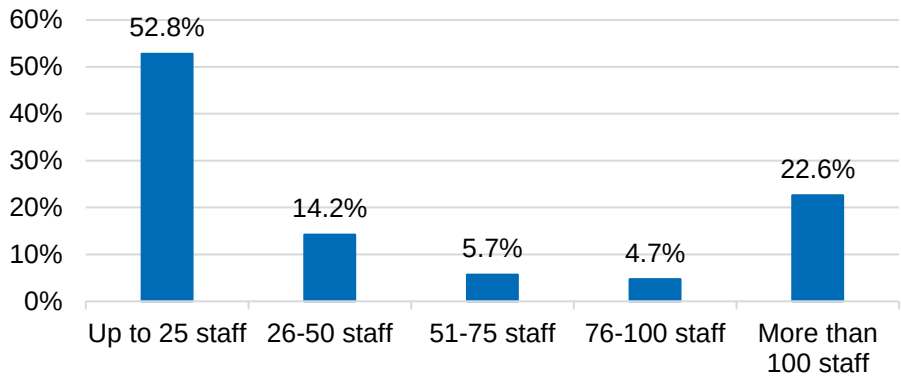
The respondents were from SSAs that were established for less than 10 years as well as SSAs that were more than 50 years old. The most common were SSAs that were established for 10 to 20 years (30 per cent of respondents were from such SSAs).

Figure 4: Distribution of respondents according to age of the SSA



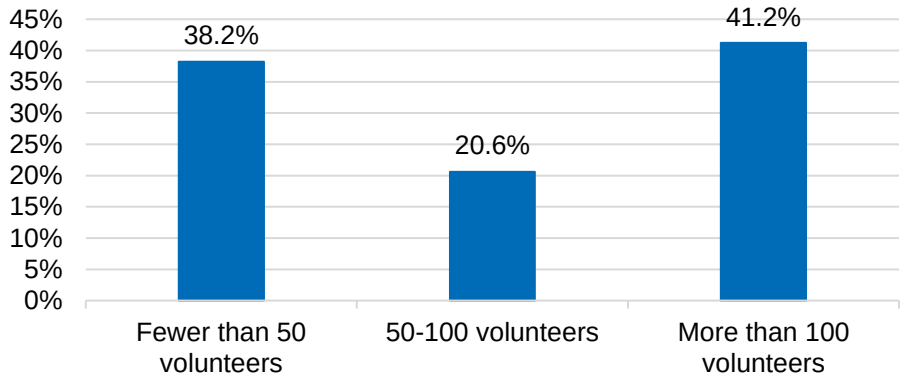
More than half of the respondents surveyed had 25 or fewer staff in their SSAs, while 22.6 per cent of the respondents surveyed had more than 100 staff in their SSAs.

Figure 5: Distribution of respondents according to staff count in the SSA



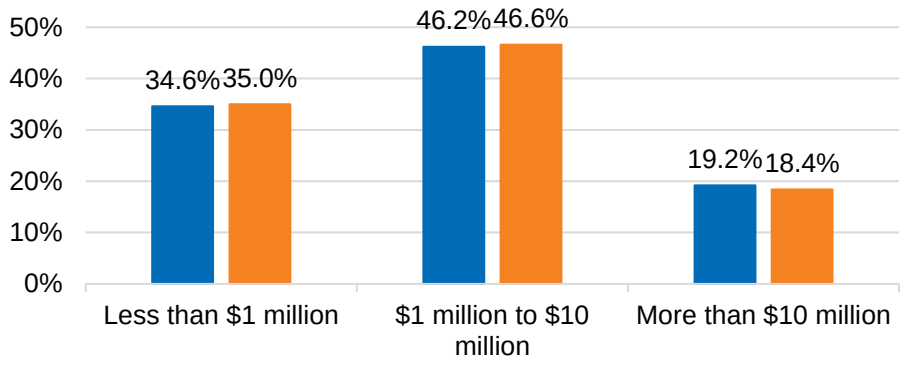
Among the respondents, 41.2 per cent were from SSAs that managed more than 100 active volunteers, and 38.2 per cent were from SSAs with fewer than 50 active volunteers. It should however be noted that the respondents might not have had the same definition of “active volunteers” in mind as we had not provided a standard for what counts as being active.

Figure 6: Distribution of respondents according to number of active volunteers in the SSA



Nearly 50 per cent of respondents indicated that their SSAs recorded annual revenues and expenditures of between $1 million and $10 million.

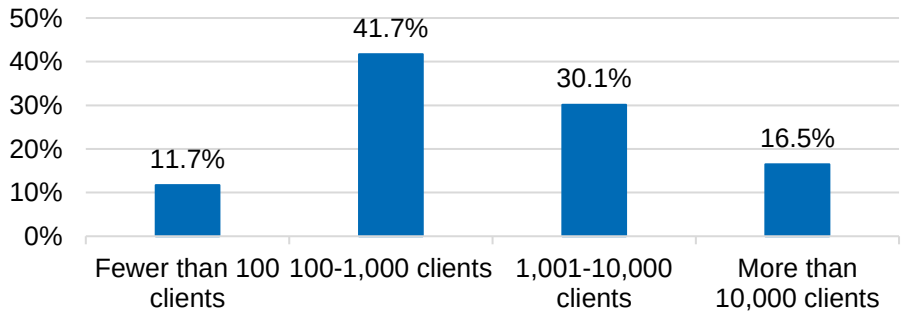
Figure 7: Distribution of respondents according to annual revenue and expenditure of the SSA



SSAs in our survey sample mostly served between 100 to 10,000 clients each year. Here, 41.7 per cent of the SSAs served between 100 and 1,000 clients, while 30.1 per cent of the SSAs served 1,000 to 10,000 clients.

It should be noted that this does not refer to *discrete* clients served; clients frequently utilise multiple services between and within organisations. In addition, SSAs that run public education programmes may reach out to high numbers of clients but their engagement with each client may be limited when compared with SSAs that offer more regular and consistent services to a smaller group of clients.

Figure 8: Distribution of respondents according to number of clients served by the SSA each year



In terms of legal status, 69.2 per cent of the SSAs surveyed indicated being a Registered Society and 29 per cent indicated being a Company Limited by Guarantee. One SSA reported that it was a charitable trust.

Most SSAs surveyed indicated having Charity and Institution of Public Character status, at 88.8 per cent and 86 per cent, respectively.

Most SSAs surveyed served a range of client groups. Many of the SSAs surveyed served children (53 per cent of the sample) as well as youth, families and the elderly (47 to 50 per cent of the sample). In addition, 28 per cent operated in the mental health and disability spaces. SSAs serving caregivers constituted 23 per cent of our sample.

Around 22 per cent of the SSAs surveyed also reported serving other client groups beyond those listed in our survey, such as migrant workers, people living with HIV/AIDS or ex-offenders.

Table 1: Main client groups that SSAs serve

	Client Group	% of SSAs (n = 107)	Indicated Examples
Which are the main segments of society your SSA caters to? (Please check all that apply)	Children	53.3	Children from low-income families, pre-schoolers, children with disabilities or special needs, abused children
	Youth	49.5	Youth-at-risk, school drop-outs, juvenile delinquents, latchkey youth
	Families	48.6	Low income families, single parents, families of ex-offenders, families with domestic violence, divorcing couples
	Elderly	47.7	Isolated seniors, frail elderly
	Disability	28.0	Autism, intellectual disability, multiple disabilities
	Mental Health	28.0	Persons with depression, youths with mental health issues, seniors with dementia
	Caregivers	23.4	Caregivers of: ex-offender children, people with mental illnesses and dementia, special needs children, elderly
	Others	22.4	Migrant workers, people living with HIV/AIDS, ex-offenders and their families, foreign wives, homeless girls, problem gamblers, women

About half of SSAs surveyed (52.3 per cent) offered multiple types of social service programmes and did not specialise in one key service. Among the SSAs surveyed, 22.4 per cent offered other programmes such as pro bono TCM clinics, financial support, psychiatric rehabilitation,

advocacy and public education services and community development work.

Table 2: Programme types that SSAs offer

	Category	% of SSAs (n = 107)
What would best categorise your organisation? (Please pick one)	We run a wide variety of social service programmes	52.3
	Others, please specify (e.g., advocacy, membership body, self-help group)	22.4
	Residential home, hostel or temporary shelter	4.7
	Family Service Centre	4.7
	Counselling centre	4.7
	Home-based care (e.g., hospice home care, senior home care, home care for people with disabilities)	1.9
	Halfway house	1.9
	Day care, day activities centre or drop-in centres (e.g., senior activities centre, dementia day care, etc.)	1.9
	Crisis intervention (suicide, pregnancy, family violence)	1.9
	Caregiver support service	1.9
	Employment support service	0.9
	Addiction recovery / aftercare case management	0.9

Of the SSAs surveyed, 31.8 per cent expressed affiliation with a religious group (n = 34). Among these, support received by their affiliated religious group included manpower, finances, strategic direction, space, and support in-kind.

Table 3: Support received by SSAs affiliated with religious groups (n = 34) in the past two years

	Types of Support	Number of SSAs
Has your affiliated religious group provided any support in the past 2 years?	Personnel (administration, management, board)	22
	Finance (grants, loans, loss write-off, etc.)	22
	Strategic direction/vision	14
	Space (offices, storage, accommodations)	9
	In-kind (goods, material, transport, etc.)	8

Chapter 4

Social Needs and Gaps

SOCIAL NEEDS AND GAPS

This section looks at how SSAs perceived social needs in Singapore and which needs they perceived to be of priority. By taking reference from the range of social needs aligned with MSF and NCSS concerns, respondents were asked to choose and rank which should be of focus to Singapore in the future: children, families, youth, elderly, disability and mental health.[1] Respondents were then asked to rank the top three areas of social need, with "1" indicating the most important social need to prioritise.

To delve deeper into why SSAs believed a social need should be prioritised, respondents were asked to pick specific issues that they perceived to be important. For example, under the social need of "children", specific issues of concern included "abuse or neglect", "lack of foster families", and "early childhood interventions". Respondents were also asked to indicate where the gaps lay, such as if there were inadequate service provision or policy/legislation, and if they observed rising trends relating to such issues.

Apart from social needs, respondents were also surveyed on the types of services their SSAs provide. Among those provided, respondents had to rank the top three services that required more government support, then select the most important gap within each of the three services. Finally, they had to indicate all applicable reasons for the gap specified in those services, such as the adequacy of funding, capability of practitioners or relevance to clients.

KEY SOCIAL PRIORITIES REGARDED BY SOCIAL SERVICE AGENCIES: ELDERLY, FAMILY AND MENTAL HEALTH ISSUES

Out of 107 respondents, most indicated elderly, families and mental health to be the top priorities for social needs. Among the respondents, 64.5 per cent ranked the elderly among the top three social needs, followed by 62.6 per cent for families, and 45.8 per cent for mental health.

Table 4: Social needs prioritised by respondents

[1] As of November 2019, this typology has been adjusted to "seniors", "children & youth with special needs", "adult with disabilities", "children and youth", "family", "persons with mental health conditions" — but more importantly, now includes "caregivers". See details here: https://www.ncss.gov.sg/GatewayPages/Social-Service-Assistance.aspx

In the next few years, what social needs should Singapore prioritise?	Number of Respondents			
	Ranked 1st	Ranked 2nd	Ranked 3rd	Total who ranked this social need among the Top 3 (% out of 107)
Children	13	14	11	38 (35.8%)
Families	23	20	24	67 (62.6%)
Youth	6	15	15	36 (33.6%)
Elderly	38	18	13	69 (64.5%)
Disability	6	11	9	26 (24.3%)
Mental Health	10	20	19	49 (45.8%)
Others	4	1	7	12 (11.2%)

We also wanted to test whether respondents whose organisations served particular social needs, would rank the same social needs as among the top social needs that Singapore should prioritise, thereby potentially reflecting their own organisational preferences. For example, would SSAs that serve the elderly also indicate “elderly” as a top social need for Singapore?

Given that elderly, families and mental health were the top three priorities, chi-square tests were carried out to examine the relationship between the type of clients currently served and social needs prioritised by organisations.

SSAs that catered to the elderly were significantly associated with prioritising the elderly among the top three social needs ($\chi^2 = 13.583$, $p < .001$). The association was similarly significant for SSAs serving clients with mental health conditions, and prioritising mental health as a need ($\chi^2 = 12.737$, $p < .001$). However, it was not significant with SSAs that served families prioritising families as a social need ($\chi^2 = 3.150$, $p < .1$).

The Elderly: Rising Incidence of Social Isolation and Dementia, Inadequate Service Provision

Of the 69 respondents who prioritised the elderly as a social need, the most salient issues raised were social isolation, dementia and financial independence. Nearly half of the respondents who chose social isolation and dementia as relevant issues for the elderly indicated inadequate service provision as a reason for those issues. Fewer respondents believed that inadequate policy or legislation was the problem.

Fewer respondents, albeit still a substantial number, also indicated end-of life matters as a concern for the elderly, mainly due to inadequate service provision. During the roundtables, social sector leaders cited Singapore's "Asian culture" and taboos surrounding death as barriers to service uptake, even if services were made available. At the level of service provision, the barriers that were identified include difficulties in identifying moments to engage individuals and their families before life-threatening diagnoses; imprecision over an individual's actual life expectancy which hinders effective conversations; as well as inadequate funding arrangements surrounding home and day care for individuals at the end of life. More also needs to be done to increase awareness and understanding of palliative care among Singaporeans.

Table 5: Perception of specific issues & gaps among respondents that prioritised elderly as a need

Elderly* (n = 69) *51 SSAs reported serving the elderly as a client group	Pick all relevant issues		Why is this a problem? (You may choose more than one)		
			Rising incidence / trend	Inadequate service provision	Inadequate policy or legislation
	Social Isolation	66	47	29	12
	Dementia	56	50	26	8
	Financial Independence	49	36	19	13
	End of Life	37	17	23	11

Families: Rising Incidence of Divorce/ Reconstituted Families and Single Parents

Of the 67 respondents who prioritised the family as a social need, most cited the rising incidence of divorce, reconstituted or step-families as well as single-parent families.[2] Another significant issue raised was the inadequate service provision for families with an incarcerated member.

Table 6: Perception of specific issues & gaps among respondents that prioritised families as a need

Families* (n = 67) *52 SSAs reported serving families as a client group	Pick all relevant issues		Why is this a problem? (You may choose more than one)		
			Rising incidence / trend	Inadequate service provision	Inadequate policy or legislation
	Divorced, reconstituted or step-families	49	43	20	9
	Single parent	42	32	18	15
	Incarcerated family member	32	15	22	9

Mental Health: Public Awareness and Acceptance as the Top Issue

Of the 49 respondents who prioritised mental health, 45 cited public awareness and acceptance as the top issue of concern, with nearly half of the latter citing inadequate service provision or inadequate policy or legislation.

A significant number of respondents (over 65 per cent who prioritised Mental Health as a social need) were also concerned about the treatment and rehabilitation as well as the employment of persons with mental health conditions. Most of these respondents identified the problem to be inadequate service provision.

Table 7: Perception of specific issues & gaps among respondents that prioritised mental health as a need

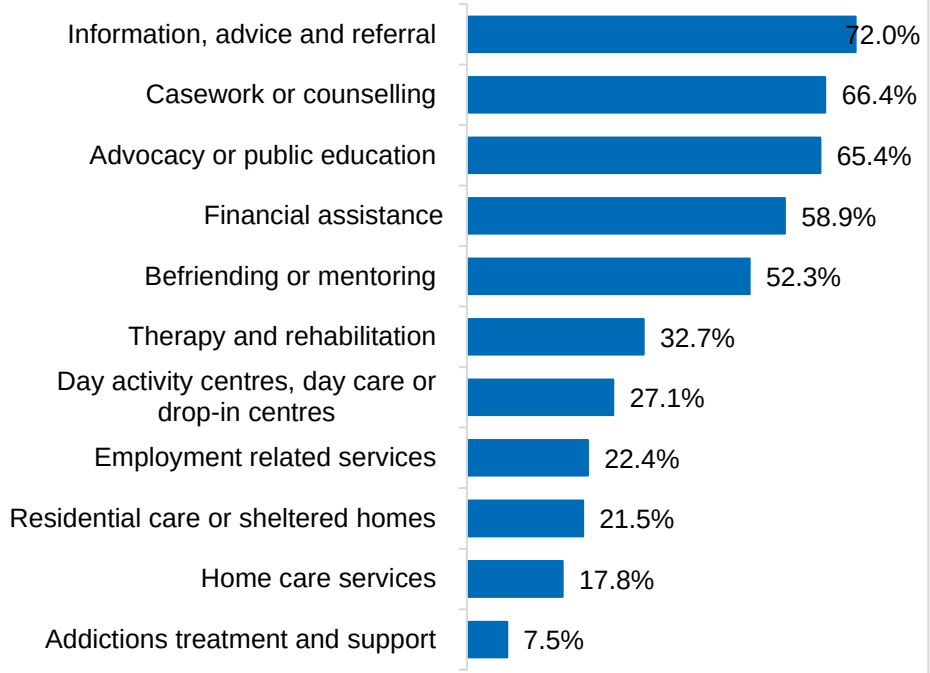
[2] When respondents indicate that these are areas of need, it does not necessarily mean they think that divorce in itself or reconstituted families are problematic, but that these become catalysts for relational and adaptive issues faced by families.

Mental Health* (n = 49) *30 SSAs reported serving people with mental health conditions as a client group	Pick all relevant issues		Why is this a problem? (You may choose more than one)		
			Rising incidence / trend	Inadequate service provision	Inadequate policy or legislation
	Public awareness and acceptance	45	25	19	19
	Treatment and rehabilitation	39	18	31	11
	Employment	32	14	24	10

SERVICES PROVIDED BY SOCIAL SERVICE AGENCIES AND SERVICES THAT REQUIRE MORE GOVERNMENT SUPPORT

Most of the SSAs surveyed provided information, advice and referral services (72 per cent). Majority of them also performed casework or counselling (66 per cent), advocacy or public education (65 per cent) as well as financial assistance (60 per cent).

Figure 9: Distribution of respondents according to services provided



The top three services that respondents believed required more government support are casework or counselling services, advocacy or public education programmes, and financial assistance. Approximately half of the surveyed respondents who provided these services within their organisations desired more government support.

Table 8: Services provided and services needing government support

Services	Number of respondents whose organisation provided this service (% of n = 107)	Number of respondents who believed this service required more government support			
		Ranked 1st	Ranked 2nd	Ranked 3rd	Total who ranked this service among the Top 3
Casework or counselling	71 (66.4%)	15	11	14	40
Advocacy or public education	70 (65.4%)	11	15	12	38
Financial assistance	63 (58.9%)	17	4	9	30
Information, advice and referral	77 (72.0%)	8	8	6	22
Befriending or mentoring	56 (52.3%)	1	13	2	16
Therapy and rehabilitation	35 (32.7%)	3	6	7	16
Employment related services	24 (22.4%)	5	3	5	13
Residential care or sheltered homes	23 (21.5%)	8	5	4	17
Day activity centres, day care or drop-in centres	29 (27.1%)	2	9	6	17
Home care services	19 (17.8%)	6	1	1	8
Addictions treatment and support	8 (7.5%)	3	2	1	6

We further asked respondents to indicate gaps in the services that required more government support, and the reasons for the service gaps.

For respondents who wanted greater government support in casework and counselling, the gaps most commonly identified were the lack of capacity to meet demand (due to inadequate funding) and the ineffectiveness of current solutions (due to low capability of practitioners).

For respondents who wanted greater government support in financial assistance, the gaps most commonly identified were their clients' lack of accessibility to current financial assistance schemes and the ineffectiveness of current solutions, as a result of inadequate funding and various funding restrictions.

For respondents who wanted greater government support in advocacy and public education programmes, the gaps most commonly identified were the ineffectiveness of current solutions (for various reasons), and clients' lack of accessibility to these programmes (due to inadequate funding)

Table 9: Top three service gaps indicated and their reasons

Number of respondents who indicate service gap	Service Gap (pick one most important gap)								
	Capacity to meet demand			Effectiveness of solution			Accessibility to client (cost, physical distance, lack of information)		
	n	Reasons for service gap		n	Reasons for service gap		n	Reasons for service gap	
Casework or counselling (n = 40)[1]	19	Adequacy of funding	11	16	Adequacy of funding	5	10	Adequacy of funding	7
		Capability of practitioners	8		Capability of practitioners	9		Capability of practitioners	3
		Relevance to client	3		Relevance to client	6		Relevance to client	1
		Other reasons	5		Other reasons	3		Other reasons	4
Financial assistance (n = 30)[2]	8	Adequacy of funding	7	10	Adequacy of funding	4	12	Adequacy of funding	7
		Capability of practitioners	1		Capability of practitioners	1		Capability of practitioners	3
		Relevance to client	1		Relevance to client	1		Relevance to client	1

[1] Forty respondents out of a total of 71 who provided casework and counselling.

[2] Thirty respondents out of a total of 63 who provided financial assistance.

		Other reasons	2		Other reasons	7[3]		Other reasons	4
Advocacy or public education (n = 38)[4]	5	Adequacy of funding	4	18	Adequacy of funding	6	16	Adequacy of funding	9
		Capability of practitioners	3		Capability of practitioners	8		Capability of practitioners	3
		Relevance to client	0		Relevance to client	6		Relevance to client	3
		Other reasons	1		Other reasons	11[5]		Other reasons	6

[3] The reasons were heterogeneous and there were no discernible response clusters.

[4] Thirty-eight respondents out of a total of 70 who performed advocacy/ public education.

[5] The reasons were heterogeneous and there were no discernible response clusters. There was general disinterest in the associated social issue (5), policy/ legislation issues (3).

Chapter 5

Organisational Needs

ORGANISATIONAL NEEDS

This section looks at the corporate functions and organisational needs of the SSAs surveyed. In the survey, respondents were asked to indicate the corporate functions their SSAs possessed and to perform a ranking of the top three functions that they believed required more external support, with "1" indicating the function most needing external support. Unlike the previous section on services provided, respondents could rank functions that their organisation did not yet possess, and indicate that they would like to build it as a function in future. Respondents were also asked to indicate reasons for the capability gaps in the corporate functions requiring external support, including the lack of funding, inability to retain staff or staff not having requisite skills.

With technological developments slowly gaining traction in the sector — as innovation is increasingly encouraged to ease labour constraints in the social service sector (Rashith, 2019) — respondents were also asked which organisational functions they believed technology could have the most impact on. Similarly, they had to choose three functions and rank them in order, with "1" indicating the highest potential impact as a result of technological input.

CORPORATE FUNCTIONS IN SOCIAL SERVICE AGENCIES THAT MOST NEED EXTERNAL SUPPORT

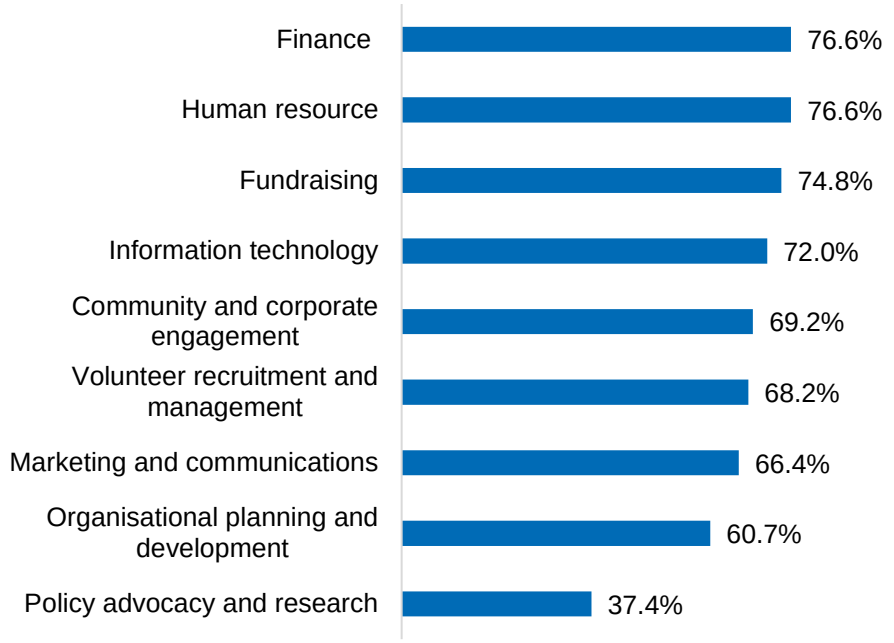
When asked to rank the top three areas where their SSAs most needed external support, most respondents chose fundraising, information technology, and marketing and communications. Community and corporate engagement as well as policy advocacy and research were also important areas that required external support, with approximately 30 per cent of respondents indicating these in their top three choices.

Table 10: Corporate functions among SSAs and those needing external support

Corporate Functions	Number of respondents whose SSA had this corporate function (% of n = 107)	Number of respondents who indicated their SSA needed external support for this corporate function			
		Ranked 1st	Ranked 2nd	Ranked 3rd	Total who ranked this function among the Top 3
Fundraising	80 (74.8%)	31	17	11	59
Information technology	77 (72.0%)	22	10	9	41
Marketing and communications	71 (66.4%)	11	13	11	35
Community and corporate engagement	74 (69.2%)	3	15	15	33
Policy advocacy and research	40 (37.4%)	10	11	12	33
Human resource	82 (76.6%)	4	9	9	22
Volunteer recruitment and management	73 (68.2%)	5	7	10	22
Organisational planning and development	65 (60.7%)	3	8	8	19
Finance	82 (76.6%)	7	4	4	15

Approximately 70 per cent of the respondents indicated that these corporate functions that most required external support already existed within their SSAs, except for policy advocacy and research which existed in less than 40 per cent of the SSAs surveyed. During the roundtables, participants discussed that advocacy was often seen as a “good-to-have” as opposed to services that were “need-to-have”, and that advocacy presented certain risks in Singapore’s context.

Figure 10: Distribution of respondents according to existing corporate functions



Most respondents indicated that the reasons for capability gaps in these five functions were the lack of funding as well as the lack of staff with requisite skills.

Table 11: Top five functions requiring external support, and reasons for capability gaps

Corporate Functions	Number of respondents who indicated these reasons for capability gap		
	Lack of funding for the function	Unable to retain staff	Staff did not have requisite skills
Fundraising	40	9	35
Information technology	30	7	31
Marketing and communications	25	4	27
Community and corporate engagement	18	3	11

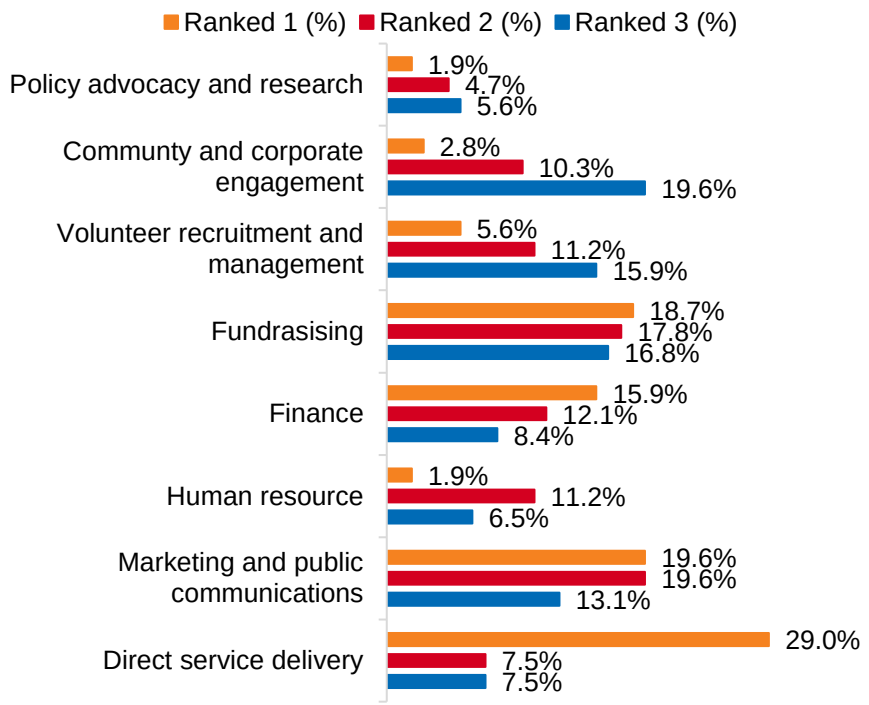
Policy advocacy and research	24	2	15

TECHNOLOGY'S IMPACT ON CORPORATE FUNCTIONS

The corporate functions that respondents most commonly chose as their top three areas where technology could have the most impact were fundraising (53 per cent); marketing and public communications (52 per cent); and direct service delivery (44 per cent).

The corporate functions that the least number of respondents reported as a top area in which technology could have an impact were human resources as well as policy advocacy and research.

Figure 11: Respondents' perception of the impact of technology on corporate functions



Chapter 6

Research Needs

RESEARCH NEEDS

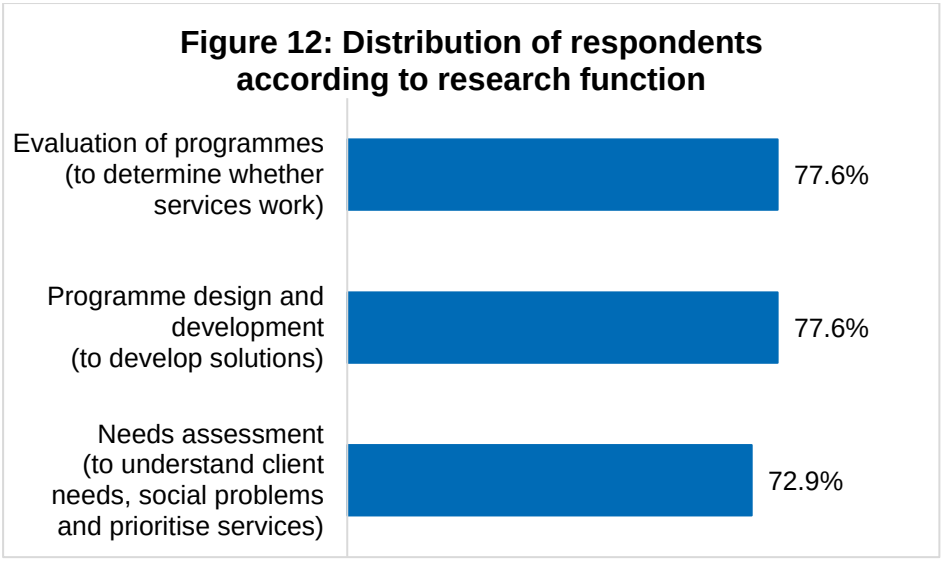
The objective of this section was to ascertain how SSAs thought about research functions as well as support. Organisations were surveyed on three research functions: needs assessment, programme design and development, and programme evaluation.

For each research function, respondents were asked if their organisation engaged in any in the last two years, how important it was perceived to be, as well as the support they required, including funding, training, tools and frameworks, and staff buy-in.

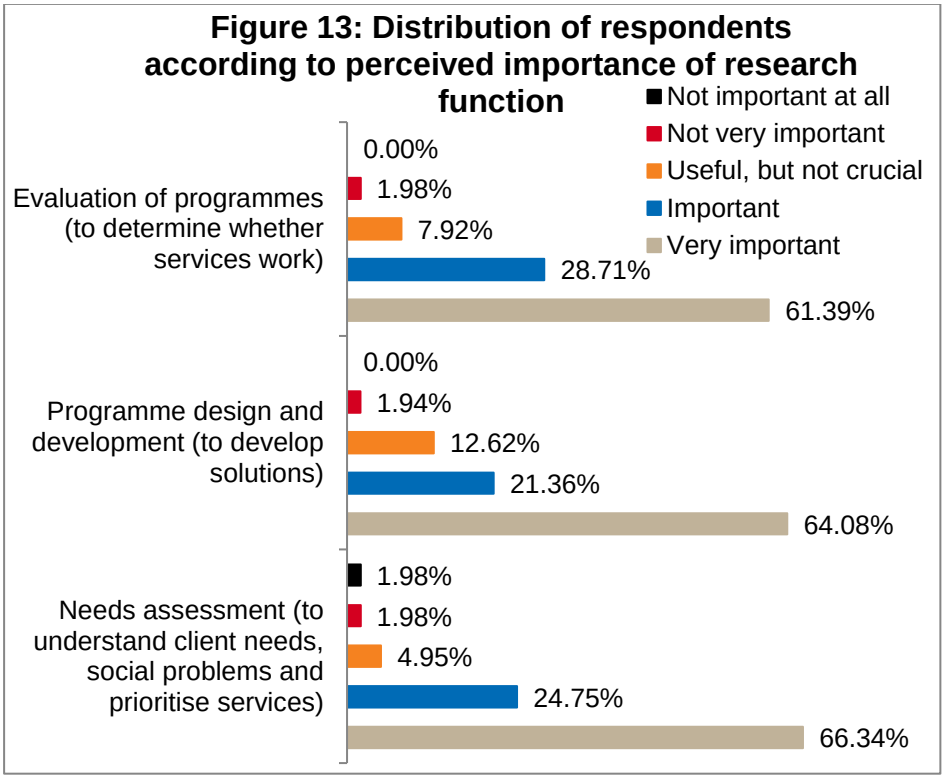
RESEARCH FUNCTIONS THAT SOCIAL SERVICE AGENCIES CONDUCT AND THEIR PERCEIVED IMPORTANCE

More than 70 per cent of the respondents reported that their SSAs had conducted some form of needs assessment, programme design and development, and programme evaluation in the past two years.

However, SSAs may have different understanding of and standards for doing research. During the roundtable discussions, the participants discussed the importance of clarifying the definitions and kinds of programme evaluations carried out by SSAs. For instance, while funders and organisations seeking to scale up a programme or seek additional funding would often look out for quantitative measures of the impact and outcomes achieved in SSAs' programmes, some programmes may not have a statistically significant sample size to provide such data. More awareness of the appropriateness and limitations of different evaluation methods is necessary.



More than 80 per cent of the respondents regarded research for the three functions — evaluation of programmes, programme design and development, and needs assessment — as important or very important.



During the roundtables, it was acknowledged that although most SSAs valued the importance of research (in particular its relation to evidence-based services), few actually had the funding and capability to conduct research. SSAs tend to have limited dedicated headcount or budget for research because funders prefer to fund projects that deliver concrete outcomes rather than fund researchers to conduct studies that cannot guarantee tangible outputs. Many SSAs without sufficient research funding would rely on volunteers or interns on an ad-hoc basis to produce research for their projects.

SUPPORT NECESSARY FOR SOCIAL SERVICE AGENCIES UNDERTAKING RESEARCH

Approximately half of the respondents indicated that additional support was needed in the form of funding, training, tools and frameworks for the SSAs to be able to carry out all three research functions.

Table 12: Support necessary for specific research functions

What support is necessary to carry out research functions?	Research Function		
	Evaluation of programmes	Programme design and development	Needs assessment
Funding	52.3%	55.1%	57.9%
Training	58.9%	64.5%	49.5%
Tools and frameworks	61.7%	54.2%	59.8%
Buy-in from staff	19.6%	16.8%	15%

Chapter 7

Partnerships and Collaborations

PARTNERSHIPS AND COLLABORATIONS

The survey also sought to examine SSAs' relationships with different stakeholders: how close perceived collaborations were, and if SSAs wanted to establish working relationships with certain partners. Stakeholders included researchers, government agencies, social innovation labs, and other charities and non-profits. Respondents were also asked about their perception of the state of collaboration in the sector. Understanding the level of collaboration with different stakeholders sheds light on untapped resources and partnerships that might prove useful, and on the effectiveness of existing collaborative relationships.

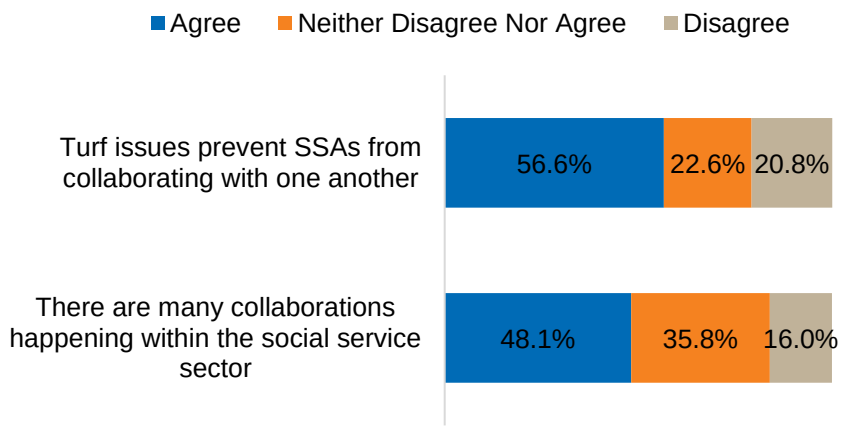
COLLABORATIONS COULD BE BETTER IN THE SECTOR

Respondents were asked for their opinions about the following statements regarding collaboration in the social service sector:

- "There are many collaborations happening within the social service sector."
- "Turf issues prevent SSAs from collaborating with one another."

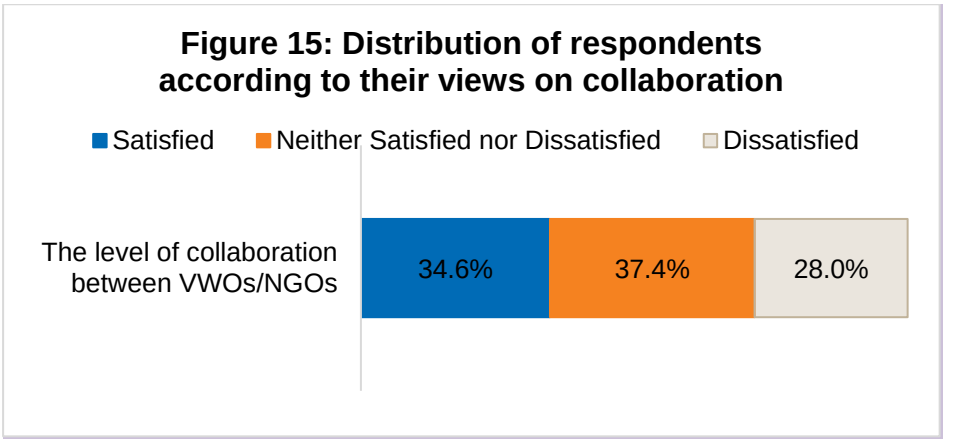
Close to half of the respondents agreed that there were many collaborations happening within the social service sector.

Figure 14: Distribution of respondents according to their views on collaboration



Only 34.6 per cent were satisfied with the level of collaboration between SSAs and NGOs.

Figure 15: Distribution of respondents according to their views on collaboration

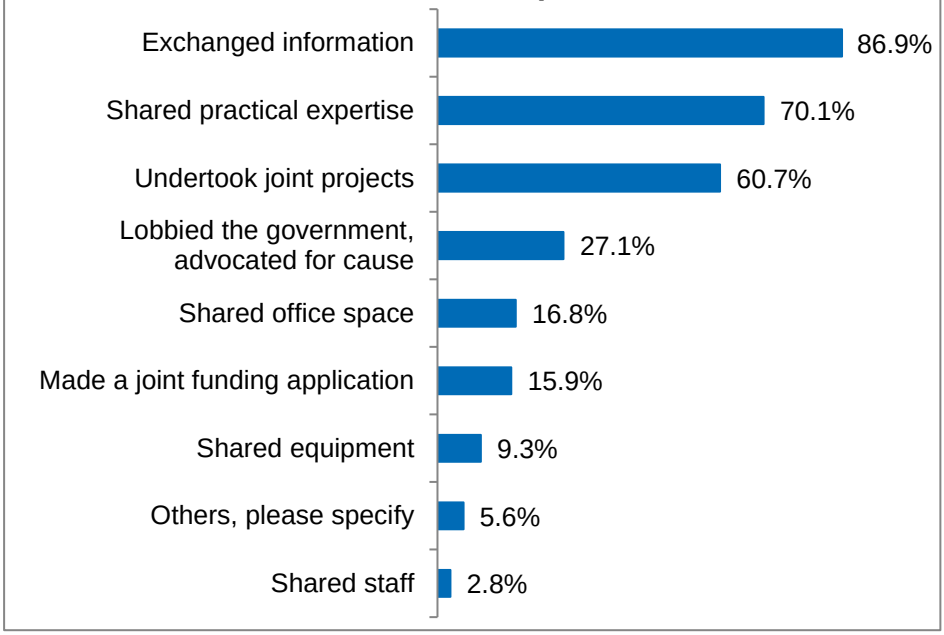


Almost 90 per cent of the respondents exchanged information with other charities and non-profits. Around 70 per cent of the respondents shared practical expertise, and 60 per cent undertook joint projects.

However, few SSAs had lobbied the government or advocated for a cause together with other agencies (27.1 per cent of respondents). Fewer have made joint funding applications (15.9 per cent of respondents).

Few SSAs also shared resources such as office space (16.8 per cent of respondents), equipment (9.3 per cent of respondents), or staff (2.8 per cent of respondents) with other charities or non-profits.

Figure 16: Distribution of respondents according to type of collaboration with other charities and non-profits



SOCIAL SERVICE AGENCIES DO COLLABORATE, BUT SEE TURF ISSUES

A majority, close to 90 per cent, of the respondents reported some working relationship and collaboration with other SSAs. However, almost 60 per cent of the respondents saw turf issues as preventing SSAs from collaborating with one another (refer to Figure 14 above).

At the roundtables, many sector leaders weighed in on this issue with different points of view:

- In addition to face-to-face meetings and networking sessions that were organised for social service agencies, truly successful collaborations were based on trust and organic development of relationships, which took time to cultivate.

- There was a lack of opportunities for all social service agencies to get together, get to know one another, and to discuss in-depth issues that everyone faced, partly because agencies were focused on their daily operational needs.

- Service agencies operated more as contractors who were beholden to funders for the provision of social services in accordance with specific causes. This exacerbated the problem of already limited funding, and vested collaborations with the expectation of success (e.g., higher efficiency, optimisation of resources) even though this was not always achieved. There needs to be more latitude in the ecosystem for agencies to try their hand at collaboration, with room for constructive failure.

- There was interest in the interface between the "health" and "social" dimensions of care and for like-minded agencies on both sides to collaborate. However, barriers included different protocols and funding policies, vocabularies, and geographical boundaries carved by healthcare and social service agencies.

- Attempts at collaboration could fall through because of service overlaps, existing boundaries that had been agreed-upon as well as different philosophies to service provision. Collaboration among agencies on different turfs might see greater success.

- One idea to encourage collaborations was to provide stories of successful collaborations and the best practices that made such collaborations work.

Most SSAs reported some working relationship and collaboration with policy makers or government agencies (85 per cent of respondents); grassroots organisations (75 per cent of respondents); and corporates (70 per cent of respondents).

SOME DESIRE GREATER STAKEHOLDER COLLABORATION BUT FEW EXIST

Less than 20 per cent of the respondents collaborated closely with researchers and universities, grant-makers and social enterprises, even though approximately 40 per cent had some working relationships with these stakeholders. A sizeable number of SSAs, close to one-third of the respondents, wanted to establish relationships with these stakeholders.

Even fewer SSAs had collaborated with or knew about mutual benefit organisations, co-operative societies, and social innovation labs or consultancies. Less than 20 per cent of the respondents had worked with these entities:

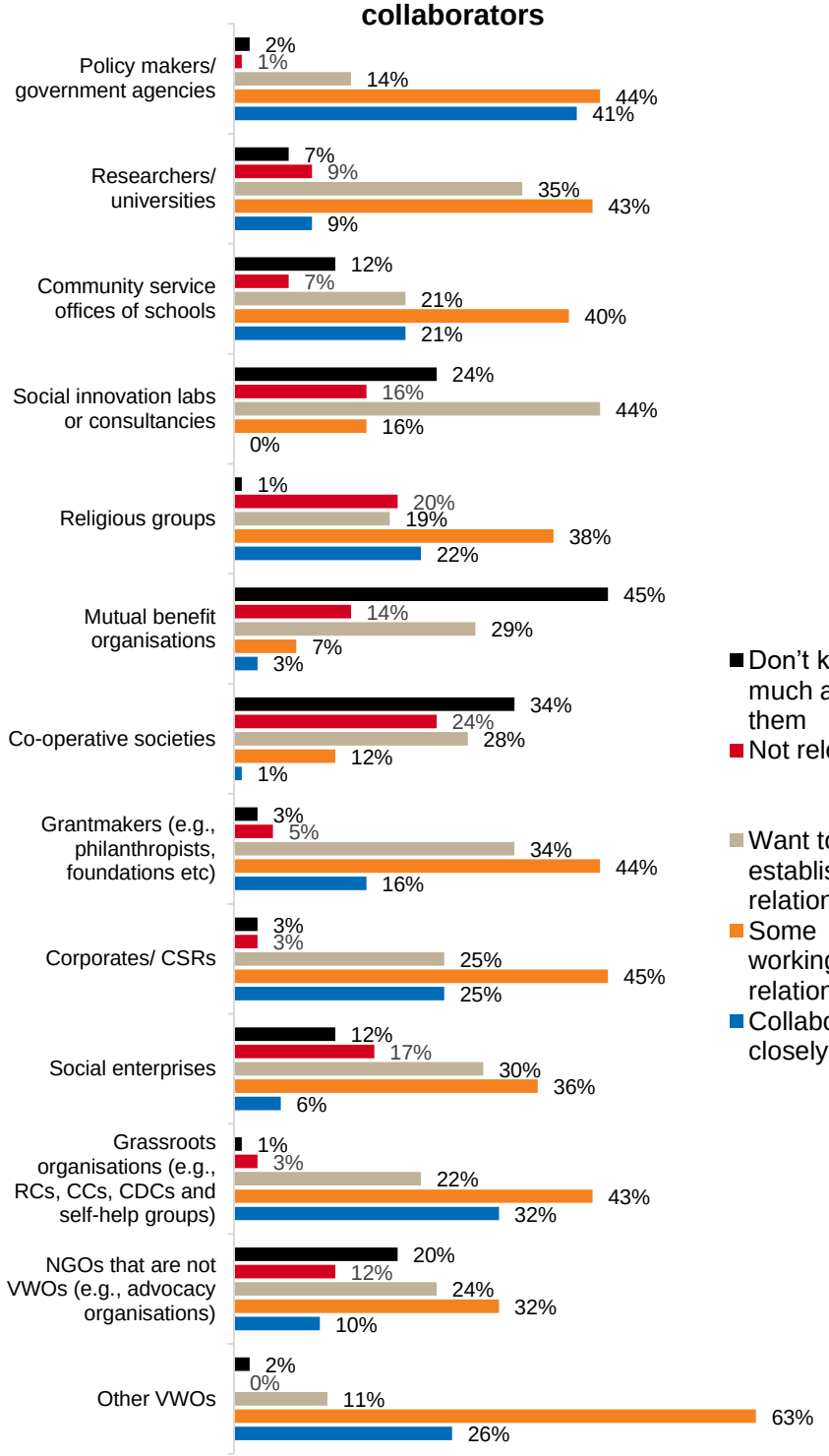
- Mutual benefit organisations: 45 per cent of respondents did not know much about them, and 14 per cent considered them irrelevant.

- Co-operative societies: 34 per cent of respondents did not know much about them, and 24 per cent considered them irrelevant.

- Social innovation labs or consultancies: 24 per cent of respondents did not know much about them, 16 per cent considered them irrelevant.

However, a number of SSAs wished to establish relationships with mutual benefit organisations (29 per cent of respondents); co-operative societies (28 per cent of respondents); and social innovation labs or consultancies (44 per cent of respondents).

Figure 17: Distribution of respondents according to collaborators



Chapter 8

Views on Strategic or Policy Issues

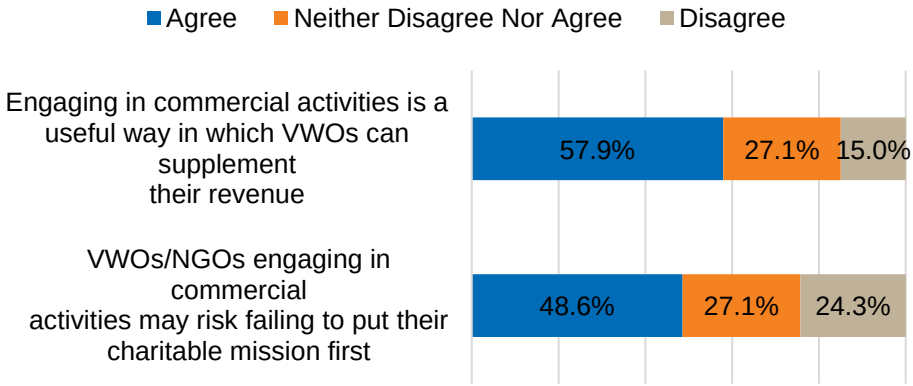
VIEWS ON STRATEGIC OR POLICY ISSUES

SSAs were also asked about key policy issues that affected them, in the areas of commercialising activities to generate revenue, sharing of performance data, funding policies and requirements, and state-NGO relationships that include the coordination of the social service sector.

ENGAGING IN COMMERCIAL ACTIVITIES

60 per cent of the respondents agree that engaging in commercial activities is a useful way to supplement SSAs' revenue. Nevertheless, half agreed that SSAs engaging in these activities might risk failing to put their charitable mission first.

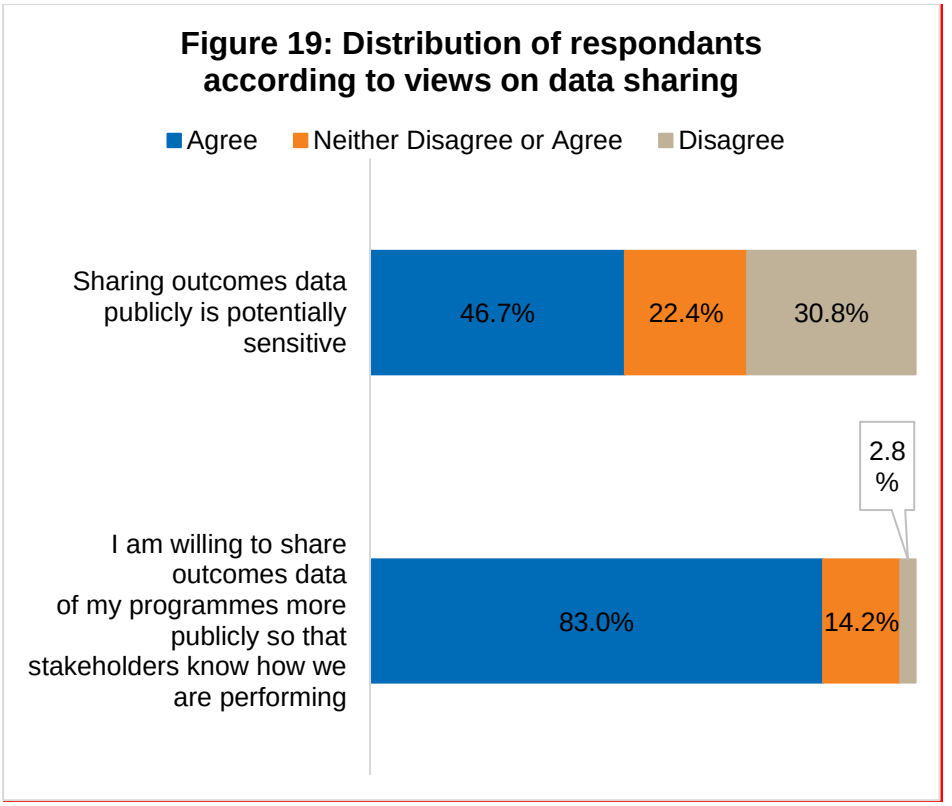
Figure 18: Distribution of respondents according to views on engaging in commercial activities



DATA SHARING

Most SSAs were willing to share outcomes data of their programmes more publicly so that their stakeholders knew how they were performing. More than 80 per cent of the respondents were willing to share outcomes data publicly with stakeholders, and only 2.8 per cent of respondents disagreed. Nevertheless, close to half of the respondents thought that sharing outcomes data might be potentially sensitive.

Figure 19: Distribution of respondants according to views on data sharing



Further analysis reveals that agencies of all sizes were willing to share outcomes data. However, small organisations (with fewer than 10 staff) and large organisations (with more than 40 staff) tended to be more concerned with data sensitivity than medium-sized organisations (with between 11 and 40 staff).[1]

[1] We note that the sample did have a disproportionately large number of SSAs that were "small organisations (less than 10 staff).

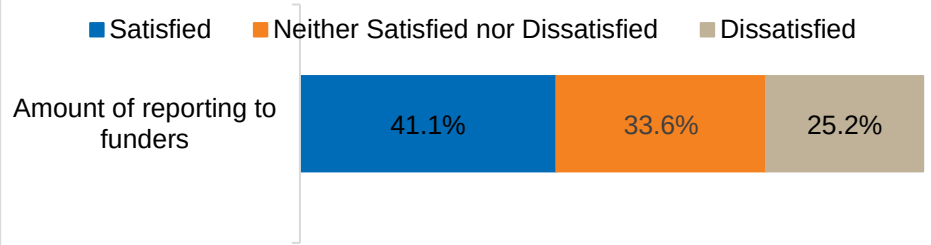
Table 13: Respondents' views towards sharing outcomes data, by agency size (proxied by staff count)

Organisation staff count (%)		How much do you agree or disagree with the following statements?		
		Disagree	Neither Agree Nor Disagree	Agree
Q23I I am willing to share outcomes data of my programmes more publicly so that stakeholders know how we are performing.	0 – 10 staff	9.1	18.2	72.7
	11 – 25 staff	0.0	9.1	90.9
	26 – 40 staff	0.0	18.2	81.8
	41 – 55 staff	0.0	14.3	85.7
	Above 55 staff	0.0	12.5	87.5
Q23J Sharing outcomes data publicly is potentially sensitive.	0 – 10 staff	17.6	20.6	61.8
	11 – 25 staff	36.4	22.7	40.9
	26 – 40 staff	72.7	18.2	9.1
	41 – 55 staff	28.6	14.3	57.1
	Above 55 staff	28.1	28.1	43.8

FUNDING POLICIES

SSAs were split in terms of their satisfaction with the amount of reporting to funders; only about 40 per cent of the respondents were satisfied with the amount of reporting to funders.

Figure 20: Distribution of respondents according to views on funding policies

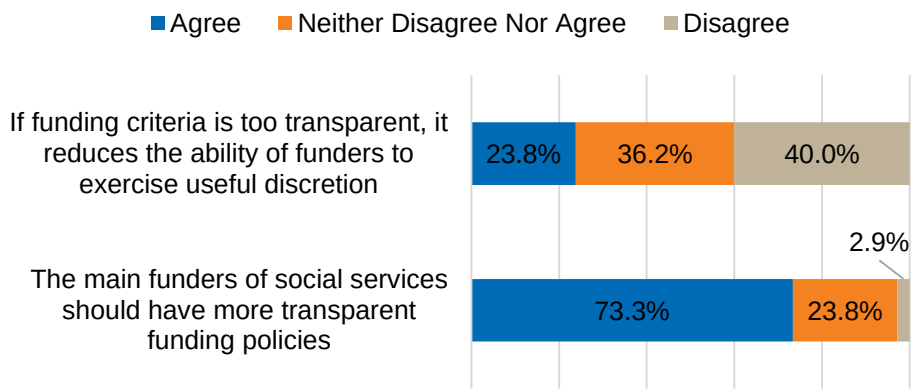


SSAs generally felt that funders should have more transparent funding policies. More than 70 per cent of the respondents agreed that funders

should have more transparent funding policies, while only 2.9 per cent disagreed.

A significant number of SSAs did not believe that transparent funding policies would reduce funders' ability to exercise useful discretion. 40 per cent of the respondents disagreed that funders would lose discretion by making their funding policies more transparent.

Figure 21: Distribution of respondents according to views regarding transparency of funding policies



Slightly more SSAs agreed that given limited resources, more funding should go to the most efficient charities rather than as many charities as possible, although the divide was almost even. Among the respondents, 48.6 per cent believed that a larger proportion of funding should go to the most efficient charities/organisations, limiting the amount for the other charities. On the other hand, 43.9 per cent of respondents believed that funding should support as many charities as possible, even if each charity would potentially receive less when compared with a funding model that prioritised organisational efficiency more.

Table 14: Preference for specific financial disbursement strategies given limited resources

Which of the following financial disbursement strategies do you prefer, given limited resources?	Larger proportion of funding going to the most efficient charities/ organisations, limiting the amount for the other charities	48.6%
	To support as many charities as possible, with each charity potentially receiving less financial support than the previous model	43.9%
	Did not answer	7.5%

When the findings were further analysed according to organisation size, it appeared that the majority of small SSAs preferred supporting as many charities as possible; 62.5 per cent of SSAs with fewer than 10 staff chose this option. In comparison, more than 60 per cent of large SSAs (with more than 40 staff) supported funding charities that were most efficient.

Table 15: Respondents' views towards financial disbursement strategy type, by organisation size

Organisation size (%)	Which of the following financial disbursement strategies do you prefer given limited resources?	
	Larger proportion of funding going to the most efficient charities/ organisations, limiting the amount for the other charities	To support as many charities as possible, with each charity potentially receiving less financial support than the previous model
0 – 10 staff	37.5	62.5
11 – 25 staff	55.0	45.0
26 – 40 staff	54.5	45.5
41 – 55 staff	66.7	33.3
Above 55 staff	62.1	37.9

SSAs that served niche social groups also tended to support funding as many charities as possible, with 61.9 per cent of the sample indicating so. Among SSAs that served seniors, 53.2 per cent supported funding as many charities as possible. In comparison, more than 60 per cent of SSAs serving children and youth preferred a funding model based on efficiency.

Table 16: Respondents' views towards financial disbursement strategy type, by client type served

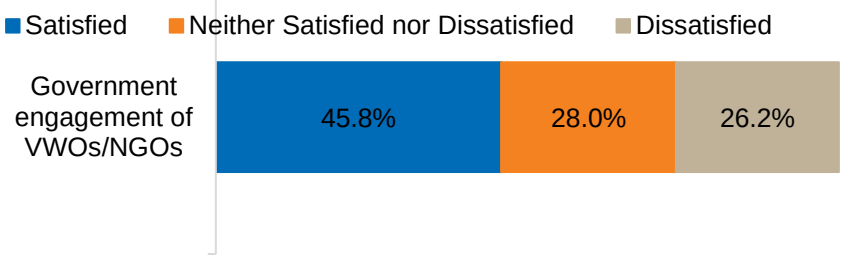
Client type served (%)	Which of the following financial disbursement strategies do you prefer given limited resources?	
	Larger proportion of funding going to the most efficient charities/ organisations, limiting the amount for the other charities	To support as many charities as possible, with each charity potentially receiving less financial support than the previous model
Children	61.1	38.9
Youth	60.0	40.0
Families	56.9	43.1
Elderly	46.8	53.2
Disability	55.2	44.8
Mental Health	55.2	44.8
Caregivers	56.5	43.5
Others	38.1	61.9

STATE-SSA/NGO RELATIONSHIPS

Government engagement of Social Service Agencies

Less than half of the respondents were satisfied with the government's engagement of SSAs/NGOs.

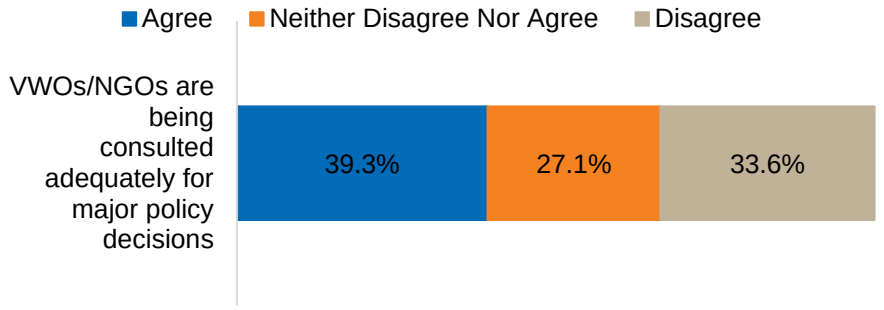
Figure 22: Distribution of respondents according to their views on government engagement of VWOs/ NGOs



Consultation for policy decisions

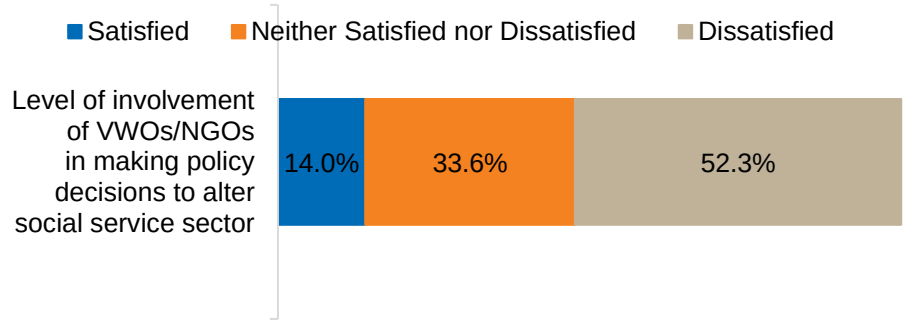
SSAs were split about how adequately VWOs and NGOs were consulted for major policy decisions. Close to 40 per cent of the respondents felt adequately consulted for major policy decisions, though more than 30 per cent disagreed.

Figure 23: Distribution of respondents according to their views on consultation for policy decisions



A majority of SSAs were dissatisfied with the level of involvement of SSAs and NGOs in policy decisions concerning the social service sector. More than half of the respondents were dissatisfied, and only 14 per cent of respondents were satisfied at the level of involvement of SSAs/NGOs in making policy decisions to alter the social service sector.

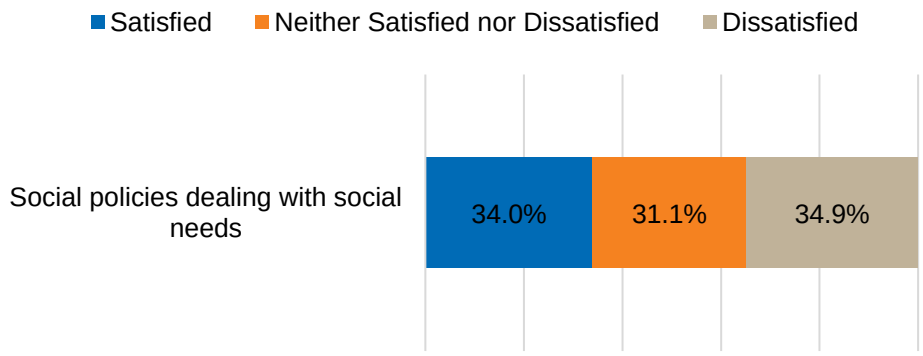
Figure 24: Distribution of respondents according to their views on their level of involvement in policy decisions



Social policies

SSAs were divided in terms of their satisfaction with social policies that deal with social needs. There was an even split between SSAs satisfied with such social policies (34 per cent of respondents) and those who were dissatisfied (34.9 per cent of respondents). (0.9 per cent difference = one SSA)

Figure 25: Distribution of respondents according to their satisfaction with social policies



Taking client type into comparison, additional analyses reveal that dissatisfaction was most apparent for SSAs in the disability sector, with 60 per cent of respondents that served clients with disabilities indicating so.

Table 17: Respondents' views towards strategic/policy issues (Q24), by client type served (Q12)

Client type served (%)		How satisfied are you with the following?		
		Dissatisfied	Neither Satisfied Nor Dissatisfied	Satisfied
Q24C Social polices dealing with social needs	Children	35.7	28.6	35.7
	Youth	36.5	28.8	34.6
	Families	37.3	29.4	33.3
	Elderly	29.4	31.4	39.2
	Disability	60.0	20.0	20.0
	Mental Health	37.9	27.6	34.5
	Caregivers	44.0	28.0	28.0
	Others	21.7	34.8	43.5

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Appendices

ANNEX A – SURVEY QUESTIONNAIRE[27]

For all questions in this survey, please indicate your answer by placing a tick (✓) in the appropriate box or write your answer in the appropriate boxes as needed.

Part 1: SSA/NGO Information

1. What is your role in your organisation?	
☐ 1	CEO / Executive Director
☐ 2	Senior Management
☐ 3	Others _____
2. How long have you worked in this senior position? (Record in years)	
_____ years	
3. How long have you worked in the social service sector? (Record in years)	
_____ years	

4. How long has your organisation been in existence? (Record in years)
_____ years
5. How many staff does your organisation have in total?
_____
6. Approximately how many active volunteers does your SSA manage in total?
7. What is your SSA's estimated annual revenue?
8. What is your SSA's estimated total annual expenditure?

[27] The questionnaire provided here is for reference on how questions were asked. Some questions which are not discussed in this report have not been included in this version of the questionnaire.

9. What is the estimated total number of clients your organisation serves in a year? (In terms of direct service provision?)

10A. What is the legal status of your organisation?	
☐ 1	Registered Society
☐ 2	Company Limited By Guarantee (CLG)
☐ 3	Charitable trust
☐ 4	Others, please specify: _____
10B. Does your organisation have Charity and IPC status?	
☐ Yes ☐ No	Charity
☐ Yes ☐ No	Institutions of a Public Character (IPC)

11. What would *best* categorise your organisation? (Please pick one)	
☐ 1	Residential Home, Hostel or Temporary Shelter
☐ 2	Home-Based Care please specify: _____ (e.g., hospice home care, senior home care, home care for people with disabilities)
☐ 3	Halfway House
☐ 4	Day Care, Day Activities Centre or Drop-in Centres please specify: _____ (e.g., Senior Activities Centre, Dementia Day Care, etc.)
☐ 5	Counselling Centre
☐ 6	Family Service Centre
☐ 7	Addiction Recovery / Aftercare Case Management
☐ 8	Crisis Intervention (suicide, pregnancy, family violence)
☐ 9	Employment Support Service
☐ 10	Caregiver Support Service
☐ 11	EIPIC – Early Intervention Programmes for Infants and Children
☐ 12	SPED – Special Education School

☐ 13	We run a wide variety of social service programmes
☐ 14	Others, please specify:_____ (e.g., advocacy, membership body, self-help group)

12. Which are the *main* segments of society your SSA caters to? (Please check all that apply)	
☐ 1	**Children** (Please specify: _____) (e.g., abused children, pre-schoolers, low-income, etc.)
☐ 2	**Youth** (Please specify: _____) (e.g., youth-at-risk, latchkey, juvenile delinquents, school drop-outs, etc.)
☐ 3	**Families** (Please specify: _____) (e.g., single parents, spousal abuse)
☐ 4	**Elderly** (Please specify: _____) (e.g., isolated seniors, end of life, frail elderly, etc.)
☐ 5	**Disability** (Please specify: _____) (e.g., hearing impaired, visually impaired, cerebral palsy, intellectual disability, etc.)
☐ 6	**Mental Health** (Please specify: _____) (e.g., depression, anxiety, addictions, etc.)
☐ 7	**Caregivers** (Please specify: _____) (e.g., caregivers of elderly, or special needs children, etc.)
☐ 8	**Others**, please specify:_____ (e.g., migrant workers, animal rights, women, etc.)

13A. Is your organisation affiliated with any local charity, religious group or association?	
☐ 1	Yes
☐ 2	No **(Please proceed to Q 14)**
13B. Which types? (tick all relevant)	
☐ 1	**Religious group** Please specify:_____ (Please answer **13C below**)
☐ 2	**Cultural organisation**, e.g., clan association, self-help group (SINDA, Mendaki, CDAC) Please specify:_____ (Please answer **13D below**)
☐ 3	**Others, e.g., parent organisation or parent charity** Please specify:_____ (Please answer **13E below**)

13C. Has your affiliated RELIGIOUS GROUP provided any support in the past 2 years? (please tick all that apply)	
☐ 1	Personnel (administration, management, board)
☐ 2	In-Kind (goods, material, transport, etc.)
☐ 3	Space (offices, storage, accommodations)
☐ 4	Finance (grants, loans, loss write-off, etc.)
☐ 5	Strategic direction/vision
☐ 6	Others, please specify: _____
13D. Has your affiliated CULTURAL ORGANISATION provided any support in the past 2 years? (please tick all that apply)	
☐ 1	Personnel (administration, management, board)
☐ 2	In-Kind (goods, material, transport, etc.)
☐ 3	Space (Offices, storage, accommodations)
☐ 4	Finance (grants, loans, loss write-off, etc.)
☐ 5	Strategic direction/vision
☐ 6	Others, please specify:_____
13E. Has your PARENT ORGANISATION provided any support in the past 2 years? (please tick all that apply)	
☐ 1	Personnel (administration, management, board)
☐ 2	In-Kind (goods, material, transport, etc.)
☐ 3	Space (offices, storage, accommodations)
☐ 4	Finance (grants, loans, loss write-off, etc.)
☐ 5	Strategic direction/vision
☐ 6	Others, please specify:_____

Part 2: Social Needs and Gaps

14. Emerging Needs: In the next few years, what social needs should Singapore prioritise?		
	Potential areas of focus	**Rank from 1 to 3 (1 is most important)**
A	Children	**If top 3, fill in 14A**
B	Families	**If top 3, fill in 14B**
C	Youth	**If top 3, fill in 14C**
D	Elderly	**If top 3, fill in 14D**
E	Disability	**If top 3, fill in 14E**
F	Mental Health	**If top 3, fill in 14F**
G	Others, please specify:	**If top 3, fill in 14G**

For the top 3 you have ranked, identify the specific issues you think are important

14A. CHILDREN		
Pick all relevant Issues		**Why is this a problem? (You may choose more than one)**
☐ 1	Abuse or neglect	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 2	Adoption / Lack of foster families	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 3	Early childhood interventions	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 4	Others, please specify	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____

14B. FAMILIES	
Pick all relevant Issues	**Why is this a problem? (You may choose more than one)**

☐ 1	Incarcerated family member	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 2	Single parent	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 3	Divorce, reconstituted or step-families	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 4	Others, please specify	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____

14C. YOUTH		
Pick all relevant Issues		**Why is this a problem? (You may choose more than one)**
☐ 1	Juvenile delinquents, trouble with the law	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 2	School drop-outs	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 3	Bullying (including cyberbullying)	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 4	Teenage pregnancy	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 5	Others, please specify	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____

14D. ELDERLY		
Pick all relevant Issues		**Why is this a problem? (You may choose more than one)**
☐ 1	Financial independence	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 2	Social isolation	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 3	Dementia	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 4	End of Life	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 5	Others, please specify	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____

14E. DISABILITY		
Pick all relevant Issues		**Why is this a problem? (You may choose more than one)**
☐ 1	Physical accessibility	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 2	Information accessibility	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 3	Education	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 4	Employment	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____

☐ 5	Public awareness & acceptance	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 6	Others, please specify	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____

14F. MENTAL HEALTH		
Pick all relevant Issues		**Why is this a problem? (You may choose more than one)**
☐ 1	Employment	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 2	Public awareness and acceptance	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 3	Treatment and rehabilitation	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 4	Others, please specify	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____

14G. Others		
List all relevant Issues		**Why is this a problem? (You may choose more than one)**
☐ 1	Please specify	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 2	Please specify	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____
☐ 3	Please specify	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation

		☐ 4 Others, please specify: _____
☐ 4	Please specify	☐ 1 Rising incidence / trend ☐ 2 Inadequate service provision ☐ 3 Inadequate policy or legislation ☐ 4 Others, please specify: _____

15. Please check all the SERVICES your organisation provides. Subsequently, out of those chosen, RANK those you believe require more government support.

	Area of Service Provision	**My organisation provides this**	**Needing more government support (RANK from 1 to 3, 1 being the most important)**
A	Information, advice and referral	☐	**If top 3, fill in 16A**
B	Advocacy or public education	☐	**If top 3, fill in 16B**
C	Addiction treatment and support	☐	**If top 3, fill in 16C**
D	Therapy and rehabilitation	☐	**If top 3, fill in 16D**
E	Casework or counselling	☐	**If top 3, fill in 16E**
F	Befriending or mentoring	☐	**If top 3, fill in 16F**
G	Financial assistance	☐	**If top 3, fill in 16G**
H	Employment related services	☐	**If top 3, fill in 16H**
I	Residential care or sheltered homes	☐	**If top 3, fill in 16I**
J	Day activity centres, day care or drop-in centres	☐	**If top 3, fill in 16J**
K	Home care services	☐	**If top 3, fill in 16K**
L	Others, please specify:	☐	**If top 3, fill in 16L**
M	Others, please specify:	☐	**If top 3, fill in 16M**
N	Others, please specify:	☐	**If top 3, fill in 16N**

16. Of the top 3 areas of service previously chosen, where do you think the GAPS are and WHY do you think they exist?

16A. Information, advice and referral	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients)	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____
2. ☐ Effectiveness of solution	
Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information	
6. ☐ Others, please specify:	

16B. Advocacy or public education	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients)	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____
2. ☐ Effectiveness of solution	
Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information	
6. ☐ Others, please specify:	

16C. Addictions treatment and support	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients)	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____
2. ☐ Effectiveness of solution	
Accessibility to client	

3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information	
6. ☐ Others, please specify:	

16D. Therapy and rehabilitation	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients)	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____
2. ☐ Effectiveness of solution	
Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information	
6. ☐ Others, please specify:	

16E. Casework and counselling	
Service Gap (pick *ONE* most important gap)	**Main Reason for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients)	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____
2. ☐ Effectiveness of solution	
Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information	
6. ☐ Others, please specify:	

16F. Befriending or mentoring	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients)	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client
2. ☐ Effectiveness of solution	

Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information	☐ Others, please specify:_____
6. ☐ Others, please specify:	

16G. Financial assistance	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients)	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____
2. ☐ Effectiveness of solution	
Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information	
6. ☐ Others, please specify:	

16H. Employment related services	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients)	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____
2. ☐ Effectiveness of solution	
Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information	
6. ☐ Others, please specify:	

16I. Residential care or sheltered homes	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients)	☐ Adequacy of funding

2. ☐ Effectiveness of solution Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information 6. ☐ Others, please specify:	☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____

16J. Day activity centres, day care or drop-in centres	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients) 2. ☐ Effectiveness of solution Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information 6. ☐ Others, please specify:	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____

16K. Home care services	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients) 2. ☐ Effectiveness of solution Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information 6. ☐ Others, please specify:	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____

16L. Others : _____	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**

1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients) 2. ☐ Effectiveness of solution Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information 6. ☐ Others, please specify:	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____

16M. Others: _____	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients) 2. ☐ Effectiveness of solution Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information 6. ☐ Others, please specify:	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____

16N. Others: _____	
Service Gap (pick *ONE* most important gap)	**Reasons for that Gap (please tick *ALL* that apply)**
1. ☐ Capacity to meet demand (e.g., long waitlist or turning away clients) 2. ☐ Effectiveness of solution Accessibility to client 3. ☐ cost 4. ☐ physical/distance 5. ☐ lack of information 6. ☐ Others, please specify:	☐ Adequacy of funding ☐ Capability of practitioners ☐ Relevance to client ☐ Others, please specify:_____

Part 3: Organisational Needs

17. In the following section, please do the following: • **Tick the corporate functions that exist to support your SSA's work.** • **Rank the top 3 areas where your SSA most need external support**			
	Organisational functions	**Does this function exist in your org?**	**Top three areas requiring external support (Rank from 1 to 3, 1 being the most important)**
A	Information technology	☐	**If top 3, fill in 17A**
B	Marketing and communications	☐	**If top 3, fill in 17B**
C	Human resource	☐	**If top 3, fill in 17C**
D	Finance	☐	**If top 3, fill in 17D**
E	Organisational planning and development	☐	**If top 3, fill in 17E**
F	Fundraising	☐	**If top 3, fill in 17F**
G	Volunteer recruitment and management	☐	**If top 3, fill in 17G**
H	Community and corporate engagement	☐	**If top 3, fill in 17H**
I	Policy advocacy and research	☐	**If top 3, fill in 17J**

For those top 3 areas you ranked, indicate the reasons for the capability gap.	
Organisational Functions	**Reasons for capability gap (tick *ALL* relevant)**
17A Information technology	☐ Lack of funding for the function
	☐ Unable to retain staff
	☐ Staff does not have requisite skills
	☐ Others, please specify:_____
17B Marketing and communications	☐ Lack of funding for the function
	☐ Unable to retain staff
	☐ Staff does not have requisite skills
	☐ Others, please specify:_____

17C Human resource	☐ Lack of funding for the function
	☐ Unable to retain staff
	☐ Staff does not have requisite skills
	☐ Others, please specify:_____
17D Finance	☐ Lack of funding for the function
	☐ Unable to retain staff
	☐ Staff does not have requisite skills
	☐ Others, please specify:_____
17E Organisational planning and development	☐ Lack of funding for the function
	☐ Unable to retain staff
	☐ Staff does not have requisite skills
	☐ Others, please specify:_____
17F Fundraising	☐ Lack of funding for the function
	☐ Unable to retain staff
	☐ Staff does not have requisite skills
	☐ Others, please specify:_____
17G Volunteer recruitment and management	☐ Lack of funding for the function
	☐ Unable to retain staff
	☐ Staff does not have requisite skills
	☐ Others, please specify:_____
17H Community and corporate Engagement	☐ Lack of funding for the function
	☐ Unable to retain staff
	☐ Staff does not have requisite skills
	☐ Others, please specify:_____
17I Policy advocacy and research	☐ Lack of funding for the function
	☐ Unable to retain staff
	☐ Staff does not have requisite skills
	☐ Others, please specify:_____

18. What COLLABORATIONS does your organisation have with other charities and non-profits? (You may tick more than one).	
☐ 1	Exchanged information
☐ 2	Shared practical expertise
☐ 3	Undertook joint projects
☐ 4	Lobbied the government, advocated for cause
☐ 5	Shared equipment
☐ 6	Made a joint funding application
☐ 7	Shared office space
☐ 8	Shared staff
☐ 9	Others, please specify: _____

19.	In each of the following organisational functions, please indicate which forms of technology have been adopted.					
	Organisational Functions	**Pay-to-use software / services or Freeware** (e.g., SPSS. Cloud Services, Excel, Google Docs, Facebook, etc.)	**Hardware not including laptops and PCs**	**Customised Software or Customised Web-based platforms** (e.g., SSNet, giving.sg)	**Not applicable**	**Please Specify**
A	**Direct Service to Client**	☐	☐	☐	☐	
B	**Marketing and public communications**	☐	☐	☐	☐	
C	**Human resource**	☐	☐	☐	☐	
D	**Finance**	☐	☐	☐	☐	
E	**Fundraising**	☐	☐	☐	☐	
F	**Volunteer recruitment and management**	☐	☐	☐	☐	
G	**Community and corporate engagement**	☐	☐	☐	☐	
H	**Policy advocacy and Research**	☐	☐	☐	☐	
I	**Others, please specify: __**	☐	☐	☐	☐	

20. Rank the top three organisational functions you think technology could have the most impact.	
Rank (From 1 to 3)	**Organisational Function**
	Direct Service Delivery
	Marketing and public communications
	Human resource
	Finance
	Fundraising
	Volunteer recruitment and management
	Community and corporate engagement
	Policy advocacy and research

Part 4: Research Needs

21. In the following section, please do the following:

- **Indicate if each research function is important to your organisation.**
- **Indicate if your organisation has engaged in this function during the past 2 years**
- **Indicate what support is necessary, if you think it is important but currently do not engage in the function**

		Does your SSA engage in this?	**How important is this to your SSA?**	**What support do you need for this? (pick *ALL* relevant or none if not required)**
A	**Needs assessment** (to understand client needs, social problems and prioritise services)	☐	☐ 1 Very important ☐ 2 Important ☐ 3 Useful, but not crucial ☐ 4 Not very Important ☐ 5 Not important at all	☐ Funding ☐ Training ☐ Tools and frameworks ☐ Buy-in from staff ☐ Others, please specify: _____
B	**Programme design and development** (to develop solutions)	☐	☐ 1 Very important ☐ 2 Important ☐ 3 Useful, but not crucial ☐ 4 Not very Important ☐ 5 Not important at all	☐ Funding ☐ Training ☐ Tools and frameworks ☐ Buy-in from staff ☐ Others, please specify: _____
C	**Evaluation of programmes** (to determine whether services work)	☐	☐ 1Very important ☐ 2 Important ☐ 3 Useful, but not crucial ☐ 4 Not very Important ☐ 5 Not important at all	☐ Funding ☐ Training ☐ Tools and frameworks ☐ Buy-in from staff ☐ Others, please specify: _____

Part 5: Views on Strategic or Policy Issues

22. Relationship with other assets and stakeholders						
		Indicate the relationship you have with the following				
	Assets	**Collaborate closely with**	**Some working relationship**	**Want to establish relationships**	**Not relevant**	**Don't know much about them**
A	Other SSAs	☐	☐	☐	☐	☐
B	NGOs that are not SSAs (e.g., advocacy organisations)	☐	☐	☐	☐	☐
C	Grassroots organisations (e.g., RCs, CCs, CDCs and self-help groups)	☐	☐	☐	☐	☐
D	Social enterprises	☐	☐	☐	☐	☐
E	Corporates/ CSRs	☐	☐	☐	☐	☐
F	Grantmakers (e.g., philanthropists, foundations, etc.)	☐	☐	☐	☐	☐
G	Co-operative Societies	☐	☐	☐	☐	☐
H	Mutual Benefit Organisations	☐	☐	☐	☐	☐
I	Religious groups	☐	☐	☐	☐	☐

J	Social Innovation Labs or Consultancies	☐	☐	☐	☐	☐
K	Community Service Offices of schools	☐	☐	☐	☐	☐
L	Researchers/ Universities	☐	☐	☐	☐	☐
M	Policy makers/ government agencies	☐	☐	☐	☐	☐

23. How much do you agree or disagree with the following statements?						
		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
A	Turf issues prevent SSAs from collaborating with one another.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
B	There are many collaborations happening within the social service sector.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
F	SSAs/NGOs are being consulted adequately for major policy decisions.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
G	The main funders of social services should have more transparent funding policies.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
H	If funding criteria is too transparent, it reduces the ability of funders to exercise useful discretion.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I	I am willing to share outcomes data of my programmes more publicly so that stakeholders know how we are performing.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
J	Sharing outcomes data publicly is potentially sensitive.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
K	SSAs/NGOs engaging in commercial activities may risk failing to put their charitable mission first.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
L	Engaging in commercial activities is a useful way in which SSAs can supplement their revenue.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

24. How satisfied are you with the following?

		Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
A	The level of collaboration between SSAs/NGOs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
B	Government engagement of SSAs/NGOs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
C	Social polices dealing with social needs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
D	Level of involvement of SSAs/NGOs in making policy decisions to alter social service sector	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
E	Funding policies for SSAs/NGOs and transparency in fund allocation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
F	Amount of reporting to funders	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
G	How services of SSAs/NGOs are currently measured (performance management framework)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

25. Which of the following financial disbursement strategies do you prefer given limited resources?	
☐ 1	Larger proportion of funding going to the most efficient charities/organisations, limiting the amount for the other charities
☐ 2	To support as many charities as possible, with each charity potentially receiving less financial support than the previous model

THANK YOU FOR YOUR PARTICIPATION!

ANNEX B – LANDSCAPE OF SOCIAL SERVICES: AN ANALYTIC CLASSIFICATION BASED ON GENERAL AREAS OF NEED

	Preventive or Developmental (for optimal functioning)	**Remedial or Recovery** (for support and maintenance)	**Crisis Intervention** (for acute & urgent measures)
Basic Material & Security Needs	Financial independence	Financial security, nutrition	Financial aid, food security, homes and shelters
Health	Prevention & early identification	Community health	Medical care
Mental Health	Prevention & early identification	Community mental health	Mental health crisis intervention
Family	Family strengthening	Family preservation	Family crisis intervention, family substitutes
Social & Community Functioning	Community strengthening & social integration	Social adjustment	Criminal justice
Education	Education supplements	Education support	Drop-outs
Employment	Employment supplements	Employment support	Employment subvention

While these categories are not entirely neat, it offers the ability to see broad investment target areas across the whole sector instead of specific services. From the top to bottom rows, the need categories broadly fall across a spectrum that range from more “basic” to “higher” level goals, therefore bringing into play a sense of priority, e.g., considerations about whether it is difficult to focus on higher level needs when more basic needs are not fully met. Starting from the second row, “basic material & security needs” cover food, shelter and money. Once basic security needs are met, people need to be healthy and have proper social adjustment before it is possible to make the most out of education or employment.

Looking at the columns, there is an analytic distinction between crisis areas that demand urgent interventions, more remedial kinds of services that support people to recover from problems faced, and then developmental or preventative interventions that help people thrive. For example, just taking the row “basic material & security needs” and focusing on money, we see that at the crisis level, there is financial aid, then measures that focus on financial security at the remedial level, and finally financial independence. The benefit of this distinction is that we can see broadly in Singapore that statutory social services tend to be provided for the third column of services while SSAs provide second and some first column services.

About the Authors

Justin LEE is a Senior Research Fellow at the Institute of Policy Studies. He is interested in issues related to disability, community development and social services. He has created a wiki platform that allows mass participation in the mapping of social needs (socialcollab.sg) and co-founded a skilled volunteer matching platform (serve.sg). He is Chairman of ArtsWok Collaborative, and also serves on the Board of Trampolene and the Research Committee of Singapore Children's Society.

MATHEW Mathews is a Principal Research Fellow at the Institute of Policy Studies and Head of its Social Lab. He has been involved in over 50 research projects, mostly focused on social policy issues. He has researched and published on social service professionals and has been involved in several research projects with social service agencies. He was past President of Alive Community Network and serves on the boards of OnePeople.sg and the National Volunteer and Philanthropy Centre (NVPC). He is a Research Advisor to the Ministry of Social and Family Development and is part of the VWOs-Charities Capability Fund Panel and Families for Life Council.

Andrew LIM is former Research Assistant at the Institute of Policy Studies, where his research focused on disability, community development and the social service sector in Singapore. He holds a Bachelor of Social Sciences (Honours) in Sociology from the National University of Singapore, where he also double-majored in Psychology. Presently, Andrew has a keen interest in mental illness, clinical psychology and community approaches to mental wellness, as well as the application of qualitative research methods in these areas. He also volunteers for several community-based mental health agencies in Singapore.