

Packages of care: the reform of community care

Paul Spicker

*Published as an Occasional Paper no 5, Department of Political Science and Social Policy,
University of Dundee, 1992*

Abstract. Although the idea of 'community care' is subject to many interpretations, the practice of community care is now firmly associated with the development of a range of alternative services from which a care plan can be selected. In theory, this should mean that services can develop incrementally in order to meet individual needs. In practice, care plans are necessarily based on available resources, which cannot be adapted flexibly to the needs of each individual; plans are more likely to be based in a set of fixed alternatives between which choices have to be made. It is unclear whether the current reforms of community care are likely to work, but even if they do, they are primarily addressed to the wrong issues. The mismatch of resources to needs which is a commonplace of community care policy does not stem simply from problems of co-ordination and co-operation between services, but is intrinsic to the kinds of service which exist in practice.

The conceptual problems associated with 'community care' are, by now, fairly familiar. The term excites widespread approval from policy makers not least because it means something quite different to each of them. Bayley (1973) made the celebrated distinction between care in the community and care by the community; but even within this distinction, there is considerable ambiguity. Care in the community includes care that is not in an institution; care in ordinary housing; and the development of independent social roles. Care by the community includes care by community services; care through the 'community', broadly understood; and care by informal carers. (Spicker, 1989)

Although there is a substantial overlap, each of these different approaches can be seen as having different implications for policy, and to some extent the problems with the concept reflect its adaptation to a variety of different circumstances and kinds of policy. The development of the idea of community care was progressively extended across client groups, with an element of cross-fertilisation of ideas and models of practice between services for mentally ill, mentally handicapped, elderly and physically disabled people (and even, in some cases, services for children in care). This led, unsurprisingly, to the idea of 'community care' acquiring different meanings in different contexts. So, for mentally ill people, the term remained firmly associated with de-institutionalisation; for elderly people maintenance in ordinary or sheltered housing; for mentally handicapped people, the issue was primarily that of normalisation or empowerment.

Equally, the idea of community care developed in a political context, and its meaning has altered as policies have been developed. When 'community care' policies were first introduced in Britain in the late 1950s and early 60s, the term clearly referred to deinstitutionalisation (Cmnd 1973, 1963); it was gradually expanded by a process of identification with 'community studies', and ideas like social networks and participation (see, e.g., the Seebohm report, Cmnd 3703, 1968); following work on mental handicap, particularly Bayley's (1973), it came to be identified with issues like independence and normalisation; emphasis in the 1970s fell on the informal sector (Bulmer, 1986), and voluntarism, which together developed into a model of welfare pluralism (Brenton, 1985). In the 1980s, concern about the operationalisation of the concept has shifted the emphasis increasingly towards co-ordination,

cost-effectiveness and planning and management (e.g. Audit Commission, 1983; Challis and Davies, 1986).

Despite the ambiguity, it is difficult to represent community care as a 'contested concept'. The idea has developed as part of a long and complex policy process, and it has come as part of this process to have some surprisingly specific implications for the delivery of services. The consensus which has come about has more to do with the methods of implementation than with the ultimate aims. In general, implementation has to be sufficiently flexible and robust to allow a variety of different ends to be achieved. Community care has been operationalised in large part through the concept of the care 'package', an idea which is probably also attributable to Bayley (1973). Bayley emphasised that the primary role in the provision of social services for mentally handicapped people was taken, not by statutory services, but by the families. The statutory services had to be seen as contributors to a network of services (the position is also at the root of the case for welfare pluralism). The provision of services became, then, not a matter of the state providing comprehensively for each individual, but the development of a range of alternative services. From this range, each individual could be offered a programme selected for that person - a 'care plan'. The principle behind establishing a diverse series of options is that it improves the robustness of planning for individual cases: a service for any individual can be selected from a range of available services. This constitutes a major part of the approach to community care enshrined in the government's White Paper (Cm 849, 1989), and subsequently in the practice recommendations of the Social Services Inspectorate and Social Work Services Group (SSI, 1991).

The advantages of this kind of approach are considerable. First, it is based in a recognition of the limitations of existing services, and in particular of the services provided by the state. Bayley made the case that, despite pretensions to the contrary, the services provided by government actually constituted only a limited part of the responses made to the needs of people with mental handicaps. If the idea of 'community care' has been acceptable to both right and left, it has been because the central observation about the inadequacy and limitations of state services have been difficult to dispute; the main difference between political factions, as one might expect, is what to do about it.

Second, the approach makes it possible to do something. If the issue is that the services do not meet needs, then offering a range of options helps to increase the scope to meet those needs. If the level of provision is inadequate, it can be expanded.

Third, it makes it possible to plan services both rationally and cost-effectively. Much of the literature on community care in practice has been concerned with cost-effectiveness, not (as it so often appears) in the sense of cost cutting, but in the sense of providing the minimum level of service appropriate to the needs of each individual.

Lastly, and most remarkably, it makes it possible to meet the needs, not only of the main categories of dependent people, but of each individual - which is a startlingly bold claim in view of the history of provision of services. "Care management", the SSI claim,

"is the process of tailoring services to individuals' needs." (1991, p.11) The idea of the 'care plan' depends on operation within the constraints of existing services, but the elements within each care plan of assessment, review of options, and selection of services allows (at least in theory) a high level of flexibility and responsiveness.

It is hardly surprising that the the idea of the care plan meeting needs with a package through a range of options has won such acceptance, or commanded such a high level of support. It seems almost too good to be true. Unfortunately, it is.

What's wrong with care packages?

The problems associated with the range of options are of two kinds. There are both practical difficulties in tailoring services to the needs of individuals, and problems in planning and developing services appropriately for client groups.

Meeting individual needs

The practical problems of delivering 'care packages' are considerable. Take, for example, the case of a psychiatric patient who is about to be discharged from an institution. The patient has, like everyone else, a number of basic requirements, which will include an income, possessions, social contact and housing; a number of individual requirements, which may or may not include domestic care, engagement in leisure activities, employment prospects, medical care; and, beyond this, a number of services specific to the issues around mental illness, including as necessary monitoring, medication, certification, therapy or support. In theory, a range of services can be drawn on. In practice, the constraints are enormous. Many of these needs might be met by families, which is one reason why care plans are likely to depend on family support, but that assumes that both the family and the patient will accept such a situation indefinitely, which is often not the case. Some needs may be met by existing statutory services, like income, housing and social work, but here there are well-known problems: different priorities within the services (which are designed for the general public), the lack of staff trained to deal with the circumstances (particularly in housing and social security), inadequate funding for the type of case, and problems of co-ordination between services. In order to develop an adequate range of community care services, specialised services in the locality have to be drawn on, most typically for accommodation, organised activities and psychiatric care.

"Care planning", the SSI advise, "should not be seen as matching needs with services 'off the shelf', but as an opportunity to rethink service provision for a particular individual" (1991a, p.63). But the selection of the appropriate services is not made, whatever the theory of community care, on the basis that these services best meet the needs of the individual patient. Plans have to be realistic, and the principal constraint on the selection of options is the type of service provided. Services have to be chosen because they are the best available, even though they may be inappropriate to an individual's needs - perhaps not wholly inappropriate, but second- or third-best. Some part of this reflects lack of funding - one wonders how many problems with budgeting, self-care, domestic management, transport, social contact and housing might be removed if people simply had more money to spend. Sometimes, though, what is

needed is a service which offers a distinctive and dedicated set of responses to special needs; and it is uncertain that such a service will be available, in the right place, at the right time, for the individual in question. Discharged psychiatric patients may need permanent accommodation, and have to accept temporary; some may need a staffed hostel, but have to enter accommodation with a much lower level of support; some might be best placed in sheltered employment, but may have to accept activities in a day centre instead; some may need social work support and receive psychiatric care instead. In the relatively unusual cases where a specialised service happens to become available - like an employment scheme, a chance of referral for counselling, a new cluster home - referrals are made to 'get the client in' because it is the best opportunity available at that particular point in time.

Glennister et al (1990) argue that mental illness is in important ways different from other services, because of the large input from psychiatric care. But many of the issues which this example raises are easily extended to the other client groups. The options which are selected for any individual are not, in real life, necessarily tailored to the needs of the individual. Rather, individual packages have to be devised which make the best use of available resources. However, if in practice services do not exist which are exactly suited to the needs of the client, it is necessary to settle for alternatives which are actually available. "It is easy", the SSI comment, "to slip out of thinking 'what does this person need?' into 'what have we got that he/she could have?'" (SSI, 1991) But in practice, there may be little alternative. This leads to some services being over-subscribed, and others under-developed, relative to needs.

Planning and developing services

The problems stem partly from the inadequacy of the range and levels of provision, and partly from the practical problems of operationalising a range of provision in the way intended. The received wisdom of community care policy is that this situation can most effectively be addressed by expanding the range and level of services. The position is not unreasonable, but I am doubtful that it can work.

The place from which community care begins in practice is not one in which services have been geared to the needs of clients. The services which are most extensively available are those initially designed for the general public - like social security, public housing, medical care and education. Although these services have come to play a large part in the provision of community care, the adaptations have sometimes been made only with difficulty - as in the problems of providing financial assistance for community care needs, or of providing housing as part of a care plan. The central difficulty in adapting services has been that the financing, organisation, planning and staffing of these services has been inappropriate to meet community care needs; the resources and skills required are often different.

The problems which occur are, first, institutional: agencies have different aims, and different criteria by which to measure success or failure. Social security is primarily devoted to income maintenance, not to the provision of care - which means that issues like value for money or maximising effectiveness by selective purchase of resources does not arise. The primary aim of housing services is not to ensure that people are adequately housed, not to improve caring relationships, so a referral which principally

depended on this aspect would not necessarily receive any priority. Doctors are mainly concerned with treating sickness, and are not required or trained to make an holistic assessment of a person's needs; a lack of social contact or an unduly limiting family environment is not part of the problems doctors are meant to deal with.

Second, there are professional problems: the different professions involved have different methods of work, language, and standards of professional practice. In housing, for example, the appropriate management of cases usually is interpreted as a rationing process giving priority to those in greatest need. In social security, the requirement is for efficient management which will enable claimants to receive their entitlements; one does not, for example, advance or speed through the case of an individual whose need appears to be greater. In medicine, the emphasis falls on professional judgment to respond appropriately to the needs of each person.

Third, there are structural issues affecting administration and finance. Community care is managed by several different authorities, most importantly health, personal social services, housing and social security. The main services dealing with general needs work to different administrative structures, different authorities, different budgets, and often different boundaries. For an old person, for example, transfer from local authority sheltered housing or hospital to residential care, for example, requires a major shift from the housing budgets or the NHS to Social Services or Social Security budgets, and from district councils and health authorities to county councils and central government.

The ways in which needs are met is not, then, one which lends itself to a free-ranging selection of appropriate services, and it is not clear, given the status quo, how packages of care can be devised. On paper, it may look as if it is possible to draw on a range of different services; but the priorities this implies may be different from the services on the ground, and administrative structures may not be prepared to implement the plan.

Care management

The kinds of problem which I have considered are not insuperable, but it is necessary to think about ways in which the constraints can be circumvented. A number of administrative reforms were introduced as part of the 1974 reorganisations of the NHS and local government. One was the supposed local integration of health services - 'supposed' because obvious disparities remained in the organisation and notional boundaries used for primary care and hospital catchment areas. There was the introduction in most areas of coterminous boundaries between health and personal social services. Both these steps were effectively abandoned in the 1982 reorganisation. There was the introduction of joint planning and priorities on the basis of client groups - an exercise which was also to become notional, because of the premature death of the local authority contribution to the planning process (see Booth, 1983).

The government's proposals on community care contain a number of measures to deal with the kinds of problem I have outlined - the effective targetting of resources being

a major objective both of the Griffiths report (1988) and the White Paper which followed it (Cm 849, 1989). But the kind of practice envisaged by the Griffiths report is, I think, very different from what emerged from later discussions. Griffiths argued for a 'budgetary approach ... which aligns responsibility for achieving objectives with control over the resources needed to achieve them' (para 5.6). Those responsible for planning care should purchase appropriate packages from different services, and different sectors of welfare provision. He suggested it may be possible to transfer control of important elements to Social Services through contracts for services, and laid the ground for this model to operate in the specific case of residential care. It has been commented that the basis of these contracts seems very unclear:

"the White Paper ... can talk on the one hand of 'consumer interests and consumer choice' and yet also sees the local authority as the 'customer/purchaser' using its purchasing power to achieve value for money." (Churchill, 1991, iv).

The intention seems to be less to define lines of accountability than to reproduce some of the conditions for an internal market in community care. If this model seems familiar, it is only because it bears more than a passing resemblance to the model of the internal market currently being forced on general practice; and it seems bizarre that the logic of his proposals should have attracted such a high level of support in relation to personal social services at the same time that the idea of an internal market in health is being widely condemned.

The way in which the Griffiths proposals have generally been interpreted is, however, very different from that of an internal market, if only because the basic principles of an internal market are impossible to apply. The report was, and is, very ambiguous about the roles which care managers and practitioners (or 'case managers', though the term seems to be out of favour) would have; some possible interpretations are given in table 1. If I read Griffiths right, the initial intention was probably to give care managers the role of enablers, while practitioners would have purchased resources; but this seems to have been supplanted by a model in which care managers purchase, and practitioners enable.

Table 1: The roles of care managers and practitioners

	'Care manager'	'Practitioner'
Purchaser	Establishment of number of claims on service, and relative priorities; allocation of practitioner budgets	Assessment of individual cases; purchase of requisite services
Enabler	Assessment of needs; overview of range of problems	Liaison and co-ordination; negotiation of appropriate packages of services

Assessments of need or demand are fairly fundamental to planning, but many of the assessments must be for services outside the competence of Social Services. As a result, health authorities are left with substantial responsibilities for planning; and even if social services have nominally become the lead department, the resulting system is one which rests on co-ordination rather than contract. Care and case management has become, instead, a process in which general assessments are made, priorities are set and needs responded to, in a framework of liaison and co-ordination between services (SSI, 1991).

The role of the practitioner seems to have become that of a key-worker, concerned with primary contact and role co-ordination (see Challis, 1990; Dant and Gearing, 1990). This is a model which is familiar from child care, and indeed from much of social work practice; its primary limitations are that social workers do not necessarily command the resources which are necessary to put care plans into effect (see, e.g., Sedley et al., 1987, on the Tyra Henry case). But to the extent that the practitioner will be working under similar constraints as now, the problems which frustrate adequate co-ordination and co-operation are only too likely to recur.

Whatever the merits or demerits of these reforms, they fail to address the central points raised earlier. The main issues which the Griffiths report was addressed to concerned administration and control. Are these the most important problems? It seems to follow from the argument I have made that, even if services were co-ordinated and managed perfectly, there would still be serious deficiencies in the services. Part of this, of course, would be true under any system which is underfunded - perfect management cannot compensate for inadequate resources. But there are also serious structural defects in the system. The basic social services are not primarily concerned with community care or with meeting needs on the model of a range of options, and problems of referral, allocation and transfer are likely to remain. If the partial centralisation of planning and contracting out of care will solve the issues of the mismatch of needs and resources, it is unclear how this is going to happen.

This is not to say that there have not been positive developments. The model of practice which seems to be emerging is one in which Social Services take responsibility for co-ordinating local planning for priority groups, with some funding dedicated to realising those plans. After 1974, one aspect of the procedures for health care planning at the local level was to prove outstandingly effective: joint finance. In England and Wales this proved to be an important means of breaking the kind of impasse which commonly resulted when case management encountered different priorities and imposed burdens on services which were ill-disposed to meet them - although there were still substantial limitations created by organisational constraints (Renshaw et al, 1988.) The type of service which commonly resulted from joint finance was different from the type of broadly based co-ordination of existing services which seemed to be envisaged within the reforms. Because money was available which might only be used in specific contexts for client groups, the type of service provided tended to be a specialised project - and not, say, for the growth of existing services. This might be expected to be a major use of funds under the emerging system of community care.

Services 'off the shelf'

If clients are not to have individually tailored packages of services, what are they going to have? Services are not supposed to be bought 'off the shelf', but it is difficult to see how else services could be delivered if they are being bought in. Places organised by service providers, large or small, will be sold in blocs to commissioning authorities; care managers will buy accommodation in residential care, places on training schemes, time in a specialised group. The nearest model for this type of provision currently is the special project - like the drop in centre, the programme of education, or the nursing home. The implications of the development of such projects are very different in principle from the idea of drawing of services from a range of options. Projects are developed not for individuals but for client groups. A service is developed to increase the range of options, or the number of places, for people with particular classes of need. One might, then, see developed as a special project a core and cluster unit for mentally ill people; a base for employment for mentally handicapped people; or very sheltered housing for elderly people. This is quite different in principle from a 'dowry' or fund used to commission work for specific individuals, or to provide them with grants (on the model of, say, the Family Fund), and it is much more difficult to make it respond to individual needs.

Services are commonly established to in response to a level of need in the community which exceeds the ability of the local services to cope, and changing the nature of the service is likely to change the type of response the services are able to make. One might, for example, re-equip a cluster home for mentally handicapped people to deal with the needs of a group which is more profoundly handicapped, but that does not overcome the problems of the group for whom the home was initially established. Equally, it is fairly common in half-way houses for psychiatric patients to find that the residents do not wish to move; but once the places are filled, they become unavailable to others who need short or mid-term placements. The whole idea of 'half way houses' is that people should move on. Taken too literally, the idea of tailoring services to individual needs would be self-contradictory; if the residents did not on the whole need the type of care offered within the unit, they should be somewhere else.

Services which are appropriate to the needs of client groups can only be flexible within limits. Probably the best examples of this kind of problem are supplied by the residential care sector, where accommodation is provided together with a specific programme of services and specific kinds of staff. The Wagner report (NISW, 1988) makes the case, appealingly, for the development of a range of services in which residential care is seen in the same light as community care, and progressively greater levels of support are given within different kinds of accommodation. In practice, however, the distinctions between the differing kinds of setting in which care is delivered are not so easily eroded. Because support is organised in relation to accommodation, there is an identifiable pattern of services associated with particular residential units. Some of the difficulties are practical - stemming from the pattern of building, organisation and staffing - but there are good organisational reasons why residential units should offer a specific pattern of services, in terms of administration, competence, and control.

The 'options' which are provided as services develop are not, then, a range of services which can be adapted to the needs of each individual, but a set of alternatives within which choices will have to be made. This has a major bearing on the process of planning provision. If a full range of alternatives is to be provided, some lesser needs will have to be provided before greater or more pressing ones - because, if only the greatest needs are dealt with, and they fall into specific categories, so will the services provided for them. The 1989 White Paper states as a priority that services should be concentrated on those in greatest need. One wonders why, if the government believes that, they should wish to pursue a pattern of flexible responses for community care.

A second implication for planners is that, if the problems of transfer and referral are to be overcome, it is necessary deliberately to over-provide - to produce spare capacity - in each service and each locality; there will not otherwise be vacancies for individuals at the point where they need it. However, this does not seem to fall within the government's current priorities.

Community care policy

The kind of service which is likely to emerge under the influence of this strange consensus is difficult to summarise neatly. Although it seems to offer a varied, flexible range of services, this is not what has emerged. The services present at best not a gamut from which a package of options are selected, but different alternative packages. This is some sort of advance; the options available for elderly people, for example, have certainly improved since the 1960s. But there may have been other routes to follow.

Community care policy has developed in most of the United Kingdom on a haphazard basis, with services being developed piecemeal. The lack of appropriate specialised services outside institutional settings was frequently passed over; criticisms of the inadequate range of community care (e.g. Bayley, 1973; Walker, 1982) have never achieved the moral force of the condemnations of institutional life, if only because of the virtually universal conviction that community care ought to be a Good Thing. (The current complaints that mentally ill people are likely to find themselves homeless after discharge from hospitals are nothing new; they were being made in the 1960s: Jones, 1972.) If it was pointed out that services in the community were insufficient in number or scope (e.g. Bebbington, 1979), the argument was not usually made to make the institutions better; it was to steam ahead with the further development of community care.

It has not been possible, however, to meet individual needs in the way which was originally envisaged. In theory, what is supposed to happen is that services are selected from a range available in the community in order to meet the needs of each individual. In practice, the services which exist are designed not to be tailored to each individual, but to meet an identifiable pattern of needs in the most effective way possible, often through a specific unit with specialised equipment, staff and skills. The difficulties which are found in adapting to individual variations do not arise, then, through any aberration or inefficiency within the approach to community care. They are rather intrinsic to the kinds of service which exist in practice.

The problem with 'community care' is not that it has developed incrementally - although to grace the development of much of what is called community care with the term 'planning' does violence to the language. Nor is the central problem that it has been underfunded, though that would be no less true; adequate funding twenty years ago might well have accelerated the growth of problems which are now apparent. The problem is that the direction of incremental development has been based in an ideal which it is not possible to achieve. It is not clear, though, how community care could have developed, or might yet develop, from its present position into the idealised, devolved, multi-faceted, flexible service which is envisaged in so much of the literature. If we wanted to achieve that, it would have been better to have started somewhere else.

Even if the ideal cannot be reached, some point on the road might still be arrived at; but it not follow that this kind of second-best alternative will be better than some of the other approaches which might be taken. There are a number of alternatives. One is the universalist approach: concentration on the provision of non-specialised services, like social security, which could obviate much of the need to make exceptions. A second is the reform of special units and residential institutions, with an emphasis on enabling the client; in *Normalisation* (1972), Wolfensberger argues not for the closure of institutions, but their development to allow an intensive, highly equipped response to make normalisation possible. Third, rather than the kinds of devolved and variegated pattern favoured in most community care strategies, it may be desirable to develop centralised (possibly peripatetic) services which offer a minimum standard of care. Each of these measures has potential disadvantages; but there is a case for pursuing second- and third- best alternatives when the ideal proves to be impossible to achieve.

Constraints on community care

Any discussion of community care in practice would be incomplete without some attempt to put the issues into some kind of political context. The idea of community care has developed with strong (if contradictory) ideological elements. Initially, criticisms of state services in the community were taken to imply that there should be a substantial expansion in the level and quality of state services; more recently, the principles of community care have been firmly linked with welfare pluralism, and so with the role of the private and voluntary sectors. There is clearly, within the concept of a range of options, scope for contributions from a range of different services. This has, in turn, provided a central justification for the development of services in the private sector - most notably, if perversely, in the provision of residential services for elderly people (see Bradshaw and Gibbs, 1988). The effect is not to prevent the development of community care by state-run agencies, but it would clearly be unrealistic to make care plans without taking this contribution into account.

However, although there is nothing within the concept of community care which is inconsistent with the expansion and development of state services, community care policy has not been significantly interpreted in this way since the mid 1970s (unless, of course, one wishes to view the 1990 Act in this light). The development of services has been notoriously underfunded; this is in many ways bound up with the kinds of

issue which community care has been intended to tackle. The move towards de-institutionalisation in the 1950s and 60s was based not only in criticisms of institutions or the potential to control mental illness in the community, but also in a fundamental change in the balance of costs between institutions and community care; Scull (1977) has argued that that this was the only major influence on the policy of the time. Community care was seen consistently as a cheaper option than institutional care. If the same level of care was to be given in the community as in an institution, it would inevitably be true that care which was decentralised and devolved would prove more expensive to run. The case for the transfer from institutions to the community depended crucially on the view that institutional residents were being over-provided for. The emphasis on economy which has dominated the development of community care since its inception indicates that what is being looked for is not necessarily an ideal of community care - and certainly not a situation in which there is excess provision intended to allow some choice.

This implies that there may be serious cause for concern about a strategy which depends on developing and enhancing a range of options within the community. I have argued that, with the best will in the world, such a strategy cannot work as envisaged. But one has to question whether the policy will be carried out with the best will in the world. One of the criticisms most frequently made of the proposed internal market in primary health care has been that essential services may be denied to people with serious needs. This is a problem which has been more than familiar in the field of community care for a long time - from the early days of the 'revolving door' to the current problems of homelessness and isolation. Certain kinds of care which are especially expensive - particularly long-term nursing care - are likely to be closed off from the range of available options. 'Community care' seems all too likely to imply a reduction of choices and alternatives, rather than a response to individual needs.

References

- Audit Commission, 1983. Community care: care of mentally handicapped people, HMSO.
- M Bayley, 1973. Mental Handicap and Community Care, RKP.
- A C Bebbington, 1979. "Changes in the provision of social services to the elderly in the community over 14 years", *Social Policy and Administration*, 13(2).
- M Bulmer, 1986. *Neighbours*, Cambridge University Press.
- T Booth, 1983. "Whatever happened to LAPs?", *Policy and Politics*, 11(2).
- J Bradshaw, I Gibbs, 1988. *Public support for private residential care*, Avebury.
- M Brenton, 1985. *The voluntary sector in British social services*, Longmans.
- D Challis, B Davies, 1986. *Matching resources to needs in community care*, Gower.
- D Challis, 1990. "Case management: problems and possibilities", in I Allen (ed), *Care managers and care management*, PSI,
- J Churchill, 1991. "Contractual matters", *Community Care* 28 March pp iii-iv.
- Cmnd 1973, 1963. *Health and welfare*, HMSO.
- Cmnd 3703, 1968. *Report of the committee on local authority and allied personal social services*, HMSO.
- Cm 849, 1989. *Caring for people: community care in the next decade and beyond*, HMSO.
- T Dant, B Gearing, 1990. "Keyworkers for elderly people in the community: case managers and care co-ordinators", *Journal of Social Policy*, 19(3).
- H Glennerster, J Falkingham, M Evandrou, 1990. "How much do we care?", *Social Policy and Administration* 24(2).
- R Griffiths, 1988. *Community care: agenda for action*, HMSO.
- NISW, 1988. *Residential care: a positive choice*, HMSO.
- K Jones, 1972. *A history of the mental health services*, RKP.
- J Renshaw, R Hampson, C Thomason, R Darton, K Judge, M Knapp, 1988. *Care in the community: the first steps*, Gower.
- A Scull, 1977. *Decarceration*, Prentice-Hall.
- S Sedley (chair), 1987. *Whose child?: the report of the public inquiry into the death of Tyra Henry*, London Borough of Lambeth.
- Social Services Inspectorate/Social Work Services Group, 1991. *Care management and assessment*, HMSO.
- , 1991a. *Care management and assessment: practitioner's guide*, HMSO.
- P Spicker, 1989. *Social housing and the social services*, Longmans.
- A Walker, 1982. *Community care*, Blackwell.
- W Wolfensberger (ed.), 1972. *The principle of normalisation in human services*, National Institute on Mental Retardation, Toronto.