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CONSENSUS, COLLABORATION AND COMMUNITY CARE FOR ELDERLY PEOPLE

BY

ADRIAN ROY TURRELL

A Doctoral Thesis
submitted in partial fulfilment of the requirements
for the award of

Doctor of Philosophy of the Loughborough University of Technology

October 1990

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DEDICATION

This Thesis has been like the worst kind of a never-ageing new born child; demanding my attention day and night, needing endless changing, causing years of lost sleep, frayed nerves and many tears, It is dedicated to my wife, Jacquie, my daughter, Jenny, and my sons, John and Thomas, who have certainly borne the enormous opportunity cost of its completion, and who, like I, often thought "will this never end?"

ACKNOWLEDGEMENTS

Many thanks to the following people to whom I have been indebted at different times over the years for helping me to continue with, and complete, this Thesis;

To Brian Hardy most especially for his invaluable comments on the content, structure and style of this Thesis,
To Rob and Sarah Walters, Ivan Filby, Mark Bonnington, Alison Dee and Phyllis Butler for proof reading various parts of various drafts of this Thesis,
To Gill Budworth and Alison Dee for typing early drafts of Chapters before the Word Processor was born!
To the Social Science Department at Loughborough University and Julie Woodin for the loan of Word Processors without which this Thesis certainly would not have been completed,
To my parents and Jonathon Gibson for the loan of their houses as a haven in which to work,
To many others for their constant exhortations to finish this work, amongst whom figure many friends, fellow postgraduates, my Supervisor, Professor Webb, and members of my family.

Also to the then Department of Health and Social Security for giving me access to files on "A Happier Old Age" and to Derbyshire County Council for helping pay some travel costs during the course of some of the fieldwork, and for giving me access to various staff and documents.

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CHAPTER ONE

Consensus, Collaboration and Community Care: An Overview

Introduction: Thesis Origins and Focus

This Chapter introduces the key issues addressed by this Thesis, and the method by which they are explored. The Thesis was stimulated by experiences of statutory carers as a volunteer supporting elderly people living in the community. My observations of these carers (such as social workers, district nurses, home helps and G.P.s) and the support they provided to elderly people in the community suggested that there was a fundamental contradiction between, on the one hand, their avowal of the virtue of maintaining elderly people at home for as long as possible (in the 'spirit' of community care policy) and, on the other hand, their ability and willingness to collaborate to achieve this end. To explain this situation, this Thesis explores three aspects of the theory and practice of community care for elderly people;

- the historical and conceptual diversity of community care policies in England and Wales as revealed by government publications over the period 1800-1982 and a range of professional and academic literature;
- the degree to which community care policies have been officially regarded as dependent upon inter-agency and inter-professional collaboration, and whether in practice community care practitioners have lent such policies their support and agreed on their meaning and implications;
- the relevance of these two aspects to implementing local community care policies.

Prior to examining these three aspects some assumptions were made about community care policy. In terms of the first aspect, it was assumed that community care was a comparatively recent (post Second World War) policy movement away from institutional care, and that as such it was a relatively simple and coherent policy. In terms of the second aspect, the assumptions were that community care was indeed dependent upon the collaboration of statutory community carers, and that these carers did commonly support community care policy. In terms of the third aspect, in the context of the public sector expenditure constraints of the early 1980's, it was assumed that resource constraints acted as the main barrier to the delivery of local community care services to elderly people.

Footnote: *The term "professional" is used in the text to embrace all community care practitioners referred to in this Thesis (including home helps, wardens, district nurses and social workers). This is to simplify the language of the text, although clearly not complying with a strict sociological use of this word.*

Thesis Structure and Content

The main Sections of this Thesis explore each of the three aspects of community care identified above to different degrees, and by different methods, as summarised below. As a result, some of the assumptions originally made in relation to community care are modified.

Section I, This Section comprises a historical and conceptual analysis of "community care" between 1800 and 1982 - thereby primarily focusing on the first of the three aspects of community care. Findings in this Section are based on a broad review of government, professional and academic literature reflected in the lengthy and detailed Appendices to this Section (Appendices 2 to 4 inclusive). Overall (see p65), the evidence from this literature review indicates that community care;

- considerably pre-dates the second world war as a policy movement;
- cannot be reduced to anti-institutionalism;
- is best understood as an umbrella term representing a range or policies which are diverse in nature rather than simple, easily defined or coherent;
- is officially - and explicitly - described in general terms as banner goal statements of intent which are commonly perceived as 'good';
- has been regarded as dependent upon collaboration particularly since the 1950's;
- is potentially vulnerable not merely because of resource constraints but also because of its dependence on collaboration, given the acknowledged barriers to collaboration.

Section II, Given the association between community care policies and collaboration, this Section examines whether those practitioners expected to collaborate to provide community care have similar perceptions of the meaning and implications of such policies. The Section compares the perceptions of professional and organisational interest groups on similar features of community care policies through a content analysis of (i) professional journals, and (ii) responses made to the 1978 government document 'A Happier Old Age'. The lengthy Appendices to this Section (Appendices 5 and 6) detail the evidence on which the Section conclusions are based. This Section focuses primarily on the second aspect of community care.

Content analysis of the journal articles and responses to 'A Happier Old Age' shows that;

- there was mixed support for community care banner goals in the journals but widespread support in responses to "A Happier Old Age". Consensus - in so far as it existed - tended to centre on issues of a high order of generality;
- there was little agreement across groups on specific features of community care; many of which seemed to generate disagreement over time, across and within groups;

- the variable support for specific features of community care reflects the association of community care policies with many different rationales which underpin these policies. These rationales were not necessarily understood or accepted in the same way by community care practitioners and agencies, given their separate interests, values and priorities.

These findings confirm those of Section I regarding the diversity and complexity of community care policies, their collaborative nature and their capacity to be broadly interpreted. The tendency to support community care at a general level may explain its robust support, but the disagreement on policy details suggests that collaboration around specific features of community care may prove difficult (see pp111-113).

Section III. Section I indicates that official national (i.e England and Wales) community care policies are complex and diverse, and have recently been regarded as dependent upon collaboration for their success. Section II indicates that there may be limited professional consensus on the detail of community care policies for elderly people. Section III examines further the relationship between consensus and inter-professional collaboration, exploring the relevance of findings from Section I and II in terms of the implementation of community care for elderly people - the third aspect of community care being explored.

Section IV. This Section summarises findings in relation to the three aspects of community care being studied. Reference is made to the broader implications of these findings for the future of community care, suggesting that in explaining the failure of collaborative community care policies - or predicting their success - greater attention may still need to be paid to professional barriers, despite a rapidly changing policy environment.

As these Section summaries indicate, the focus of analysis in this Thesis changes:

- *from* a general study of community care policy development across all relevant client groups, *to* a particular study of community care policy for elderly people;
- *from* a study of national policies, and perceptions of those policies held by national interest groups, *to* a study of local professionals and organisations collaborating in order to implement such policies;
- *from* a study of the theory of community care - as stated in official documents - and professional perceptions of this theory, *to* a study of local practice: how professionals jointly provide community care.

Consensus, Collaboration and Community Care: A Discussion of Inter-Relationships

Section I indicates that government expressions of community care have tended to take the form of loosely defined banner goal statements of intent. For example, many official documents have associated community care with a phrase such as **'Old people should be maintained in their own homes for as long as possible'** (see Chapters Two to Four inclusive). It may be argued that such a banner goal statement is supported across professions and organisations because of its generality, its capacity to be broadly interpreted and because it is perceived as 'good'. Conversely, there may be less support for the many possible interpretations and applications of this banner goal statement because of their practical implications for different professionals; the detail of community care may not be commonly perceived as 'good'. Thus, inter-professional consensus surrounding community care banner goal statements may not produce professional support for more specific interpretations of those banner goal statements (see Chapter Three). Indeed, the differences between professional priorities, models of care and objectives suggest that it would be naive to expect professionals to interpret community care banner goals in the same way, or for organisations to translate them into similar operational policies, principles and procedures. Once community care policies have been disaggregated into statements about the nature, style, focus and purpose of professional/organisational activity, they become value-laden and impinge directly on different professional practices, values and priorities. Therefore, as the specificity of community care policies are explored, consensus across professional groups may become less likely although collaboration between these groups may be all the more necessary to deliver effective care to individual elderly people.

This raises issues about the relationship between consensus and collaboration. On the one hand, professionals must agree on something to be able to work together at all. On the other hand, professional disagreement will, at some point, decisively interfere with collaborative activity. Consensus and collaboration are inter-related. In terms of community care policies, this relationship is perceived as particularly important because, as noted, collaboration has been regarded in the community care literature as essential to delivering effective local care. This fact, together with the evidence that community care policies may only generate widespread consensus at banner goal level, suggests that the quality of collaboration at field level may decline as it is centred on specific details of community care practice. For example, in the case of terminal care for an old person:

- Medical practitioners may think it inappropriate to keep that person at home, based on clinical judgements of how to maximise physical and mental well-being;
- Social workers may emphasise the rights and wishes of old people to remain at home

irrespective of the effects this might have on their own of their carers' personal comfort or their effective treatment;

- Managers of public sector services might judge it inappropriate to keep old people at home because of the limited availability of services, the cost of providing appropriate terminal care or the capacity/willingness of statutory carers to provide that care.

Thus, this illustration shows that despite probable agreement that community care is 'a good thing', perceptional gaps may exist between practitioners as to its particular application to the needs of the terminally ill and their families. This lack of consensus may in turn disrupt desired levels of inter-professional collaboration.

Thesis Methodology

The methodology of this Thesis is introduced here, but described more fully in Appendix 1.

As noted, Section I comprises a content analysis of various community care literatures. The primary purpose of this documentary analysis was to chart the historical and conceptual diversity of community care policies. Chapters Two and Four build up a picture of the history of community care in England and Wales between 1800 and 1982 by drawing on official government publications relating to community care policies; Chapter Three draws on a broader range of literature to illustrate the many meanings of the phrase "community care". The period analysed for the historical review was 1800 to 1982; 1800 was chosen on the basis of document availability; 1982 was chosen because it coincided with the end of my first years' research and the commencement of my fieldwork studies. The value of initially studying the general movement to community care was that it identified policy themes common to several care groups; themes which were subsequently applied to the needs of the elderly. Where possible, primary literature sources were analysed; most notably in respect of Chapters Two and Four where every Annual Report of the Local Government Board and the Ministry of Health from 1871 to 1967 was analysed plus numerous Command Papers, Royal Commissions of Enquiry and a range of other official and semi-official committees of enquiry and Parliamentary Debates.

Section II of the Thesis explores inter-professional perceptions of community care policies for elderly people through a content analysis of (i) selected professional journals and (ii) responses to the 1978 government document 'A Happier Old Age'. Data from professional journals in three contrasting time periods were analysed; 1961-63, 1971-74 and 1976-82. The first period, 1961-63, was when the government explicitly promoted 'community care' policy through the 1962 Hospital Plan and the 1963 Health and Welfare Plan. The second period, 1971-

74, was one of comparative resource growth in the health and social services when community care policy had developed beyond infancy and local authority social service departments had been established. The third period, 1976-1982, was a time of increasing financial constraints in the public sector during which the government identified national priority services and groups, service norms for health and social services and introduced ten year strategic plans which were to influence local service development.

The source journals chosen for this study covered four main interest groups - medical, nursing, social work and housing. Two principal journals were selected as representative of each of these professional groups over the three periods, with the exception of the period 1961-63 when different journals had to be reviewed to obtain a 'social work' perspective (see Appendix 1). For each journal, articles and views were analysed under three headings; (i) community care policies in general, or as applied to elderly people, (ii) the general care of elderly people and (iii) collaboration between carers of elderly people. These selection criteria yielded over 1200 articles (excluding editorials and letters) each of which was analysed in terms of the perceptions of professional groups on similar issues.

In terms of the 1978 government discussion document 'A Happier Old Age', responses to the document from key public sector professional and organisational groups were analysed. The document itself was a prime example of the government's approach to consensus-based policy making; it was intended to stimulate the views of key professions and organisations and consumers of services in order to influence the first ever White Paper on services for elderly people. The document posed a series of questions about the future development of elderly services. In total, over 1400 individuals and groups responded to the document. Of these respondents, 156 major national bodies replied, from which 23 responses from public sector groups were chosen for detailed study (see Chapter 6 and Appendix 1). These 23 responses were broadly divided into health and local authority interest groups. On a number of specific questions, responses from these groups were compared. Unlike the journal analysis, responses to 'A Happier Old Age' were more likely to precisely reflect 'official' professional/organisational views - being the formal responses made by formal committees of these groups. Thus, whilst the journal analysis reflected individual professionals' views on spontaneously raised issues during three time periods, responses to 'A Happier Old Age' provided a snapshot of corporate, 'official' perspectives on the same issues raised by the government at a single point in time (the summer of 1978).

In Section III of the Thesis, three case studies were undertaken to test the relevance of findings from the content analysis undertaken in Section II; Each study examined collaborative ventures or networks which sought to keep elderly people at home;

Study A A broadly-based pilot project aiming to re-structure and co-ordinate all caring services available to elderly people within a geographical area. The project underwent many years of formal planning and negotiation, requiring substantial resource investment from two statutory authorities and the commitment of a third. The project involved a radical reorganisation of local services.

Study B A quite specific low cost initiative, managed and staffed by a voluntary agency, attempting to co-ordinate and improve services at the boundary of hospital and community care. The project worked in the absence of any formal planning process or management structure, relying heavily on improving inter-professional relationships associated with discharge processes through a voluntary services co-ordinator on a largely informal basis.

Study C Within three inner city and suburban localities, a range of practitioners working with elderly people were interviewed. There was no locally agreed joint strategy or specific project designed to keep elderly people at home, although interviewees expressed general support for the goal of keeping elderly people in their own homes for as long as possible. As such this study is regarded as a "control" locality.

Fieldwork data were generated in three ways; first, and most importantly, by conducting semi-structured interviews with a total of 196 individual officers (see Appendix 1) from a range of statutory agencies (health authority, local authority social services department and housing departments) and one voluntary organisation; second, by documentary analysis of primary sources in each of these agencies; and third, (in the case of Studies A and B) through non-participant observation. By drawing on these latter two sources, it was possible to confirm, or otherwise, interview material.

In Section IV, the findings of this Thesis are summarised, and some conclusions are drawn as to their significance in terms of the past failure and future development of community care for elderly people.

Overall Summary

This Thesis explores three aspects of community care policies for elderly people; (i) the

historical and conceptual diversity of such policies in England and Wales between c1800 and 1982; (ii) the relevance of inter-professional collaboration to implementing these policies and the extent to which different professionals agree on their meaning and implications; and (iii) the relationship between inter-professional consensus, collaboration and the implementation of community care.

In Section I of the Thesis, a content analysis of government, academic and professional community care literatures show this policy to be neither of recent origin nor conceptually simple. This literature also suggests that community care is best understood as a range of policy themes which have traditionally been expressed by governments and supported by professionals as banner goal statements of intent which disguise rather than reveal their implicit values, assumptions and underpinning rationales. The same literatures confirm that these policies are perceived as dependent upon collaboration for their success, although simultaneously recognising the existence of fundamental barriers to public sector collaboration in general.

In Section II an analysis of professional perceptions of community care policies reveals that consensus surrounding these policies becomes less likely as they are specified in more detail. Section III explores the relationship between this pattern of consensus and the collaboration regarded as necessary to implement community care. The section indicates that a lack of such consensus may not crucially affect policy implementation because inter-professional consensus and collaboration may not always be central to implementing community care. But equally, given the collaborative nature of community care policies, the broad range of inter-professional barriers to community care cannot be ignored.

Section IV suggests that the relationship between inter-professional consensus and collaboration and the implementation of community care for elderly people is complex; depending on the features of each individual policy and the significance of professional and other barriers to local practice. In general, it is argued that in explaining any failure to successfully implement collaborative community care policies, in addition to the impact of structural, organisational and financial barriers to such policies, greater attention may need to be paid to professional barriers, not the least of which may the inability of professionals to agree on what should be done to provide community care for elderly people, when, how and by whom. It is argued that these issues still merit attention in the 1990's even given an environment which assumes the competitiveness of community care providers and the specification of services through contractual arrangements.

SECTION I

CHAPTER TWO

The origins and development of 'community care' in England and Wales 1800 to 1969

Structure and Content of Section I

This is the first of three Chapters in Section I of this Thesis. The Section as a whole explores the historical and conceptual development of community care in England and Wales between 1800 and 1982 (see p1). Chapter Three provides a conceptual analysis of community care, whilst Chapters Two and Four examine the historical development of community care policies. Of these latter two Chapters, this Chapter covers the period 1800-1969 and Chapter Four the period 1970-1982. Both the two historical Chapters draw mainly upon data from a review of government and semi-official publications. Chapter Three draws on a broader range of community care literature.

Chapter Structure and Assumptions

This Chapter is in three parts relating to separate historical periods: 1800-1899, 1900-1938 and 1939-1969. The analysis ends at 1969, prior to the establishment in England and Wales of local authority social service departments. Although focusing where possible on community care policy for elderly people, both this Chapter and the first Section in general locate elderly-specific policy within the general movement towards community care. Thus, reference is made to policy initiatives for the family and children and for mentally handicapped, mentally ill and elderly people. In the 19th Century, this more broadly based analysis of "community care" was necessitated by the fact that government welfare policy predominantly took the form of income and housing support policies together with a range of social control mechanisms which tended to be targetted at paupers as a whole rather than groups such as the aged or handicapped. By comparison, in the 20th Century health and welfare policy was increasingly organised on a care group basis, and took the form of a growing range of more positive health and social support mechanisms.

Since "community care" has only been popularised as government policy since the 1950's, this Chapter assumes that prior to this time community care policy has been pursued in nature rather than by name, particularly during the 19th Century. For example, support mechanisms in the 19th Century designed to provide care in 'normal' and 'homely' settings are identified as community care policy themes, being closely associated with elements of the community care movement today. Thus, a 1978 publication argued that the origin of community care lay with the Local Government Board at the turn of the century when it recommended 'more homely' accommodation than the workhouse (1); this accommodation was taken as a feature of community

care which pre-existed named community care policy. More generally, Westmoreland has argued; "The trend towards community care is mistakenly thought to be an entirely modern development ...Originally, care within the community was the only form of care since no other was available...we have...come full circle to the starting-point, except that community care today is a positive policy rather than an inescapable situation" (2).

The General Relief of the Poor 1800-1899

Prior to the 1834 Poor Law Amendment Act, welfare provision for those seeking relief from the parish was predominantly community-based. Institutions for paupers had been encouraged in the 18th Century by statute (3), but their relative importance diminished as the volume of outdoor relief for the able-bodied unemployed and low paid grew, itself encouraged by a statute such as Gilberts Act of 1782 (4). The 1834 Poor Law Amendment Act sought to reverse this trend, establishing institutional provision - the workhouse - as the primary approved source of parish relief (5). The justification for this reversal of emphasis from community to custodial relief was moral and economic. The moral motivation was related to a notion of social justice; that people supported by the parish should enjoy fewer freedoms and social privileges than people who supported themselves. The institution provided a disincentive to 'scrounging', thus preventing indolence. On a different moral theme, Edwin Chadwick, promoted new (1834) Poor Law principles, on the basis that they 'went beyond measures of cure or alleviation or the repression of evil to prevention and by preventative measures to the improvement of the condition of the population' (6). In terms of economic motivations, those who financially supported the poor wanted to reduce the scale of their commitment by linking receipt of poor relief to residing in the workhouse, to deter claims on the poor rate.

Although the 1834 Act meant that, in theory, almost all able-bodied paupers were to seek relief in the workhouse, in practice the volume of outdoor relief varied widely across parishes, and in the second half of the 19th Century increased nationally (7). By the 1870's this increase of relief in the community, together with the bewildering array of philanthropic and charitable giving to the poor, led to the investigative work of the Charity Organisation Society (COS). Created in 1869, the COS sought to eliminate indiscriminate community relief, and the moral decay many believed it produced (8) through careful individual casework and assessment of need.

By contrast, in the conclusion to his empirical study of the life and labour of the London poor, Charles Booth proposed a different strategy to combat pauperism; the establishment of 'industrial communities'. Booth's research led him to reject the idea that the rigours of the

workhouse or discriminate charitable relief were sufficient to reform the poor (9). For him, the habits of the labouring classes could only be improved by a more concerted effort from the wider (and wealthier) community, and the State (10) to create a new environment in which to re-educate the poor. The salvationist William Booth advanced a similar strategy, based on spiritual conviction rather than empirical evidence. He established artificial 'colonies' - the city, farm and overseas colonies - as a means to reform paupers (11). Like Charles Booth, he believed the poor needed rescuing from the corrupt society in which they lived, and placing in man-made 'ideal' communities. Other institutional and community-oriented forms of care are described below for specific subgroups of the 19th Century poor.

The Aged Poor

Thomson argues that there is no evidence that large numbers of old people were forced into the workhouse after 1834. Indeed; 'in the middle decades of the last century the aged formed a minor part of any workhouse population' (12). Nonetheless, towards the end of the 19th Century the deterrents applied to aged and infirm paupers in the workhouse were consistently challenged. Charles Booth asserted that sickness and general incapacity not idleness prevented the aged from working, thus the stigma and harsh conditions of the workhouse were inappropriate. The gradual acceptance of this view led to the classification of many aged people as the 'deserving' poor. As a result, some Poor Law guardians, as early as the 1830's, gave preferential treatment to the aged by making the workhouse a more homely environment, and some guardians exempted the aged from having to receive any relief in the workhouse (13).

In the late 19th Century, the Old Age Pensions movement increased pressure to improve conditions for the aged poor inside the workhouse and to develop initiatives to support them both outside the workhouse and the Poor Law itself. In 1895, the Royal Commission on the Aged Poor referred to the need to 'brighten the lives' of the aged in the workhouse - essentially promoting a kind of lifestyle which a normal person in the community might enjoy (14). By 1900 a Local Government Board Circular stated that 'aged deserving persons should not be urged to enter the workhouse at all unless there is some cause which renders such a course necessary, such as infirmity of mind or body, the absence of house accommodation or of a suitable person to care for them' (15). Thus, over time, the workhouse was seen as an institution used by the aged in the exceptional circumstances of poor health or inadequate social support (16). Non-institutional care was, in theory, to be available to the majority of old people. However, Poor Law Unions varied greatly in their enthusiasm to provide an alternative to the workhouse. Sometimes positive reasons were given for providing limited community-based relief; 'Taking aged or infirm or sickly persons out of crowded and filthy

places and putting them in places where they might be well attended (i,e in the workhouse) was a beneficial and humane course' (17),

Children

The transformation from an agricultural to industrial society in the 18th and 19th Centuries meant that many children of the labouring classes were subject to exploitation, neglect and cruelty in institutions, industry and the family (18). In response to middle-class fears of corruption, educational theorists asserted that middle class children could escape the corruption of society by living in educational institutions which were to 'raise a wall' around the child's soul (19). Here children were 'educated' to be ignorant of societal prejudice and vice, so being better prepared for adult life (20). Likewise, the 1834 Poor Law Amendment Act intended that pauper children should be raised and educated in the workhouse (21). But poor standards of workhouse education and care, combined with instances of blatant child cruelty led to the development of non-workhouse education for children (22); cottage homes, scattered homes and boarding out' initiatives. The latter being where children were fostered by families. These smaller, more personal care/educational settings were thought to be cheaper, and better for the child (23).

In 1885 the Local Government Board appointed a national Inspector of boarding out schemes. In reports to the Local Government Board, this Inspector justified the progressive shift away from the workhouse to boarding out by asserting that;

(i) Family life and community involvement were the ideal vehicle for socialisation and future social security (24),

(ii) Individual morality, physical and mental health development were maximised in non-segregated, small, personal, normal, home-like environments (25),

(iii) The cost of maintaining children in such settings was lower (26),

However, set against these advantages of community integration was the fragility and variability of family and community life; 'while no other system offers the advantages of boarding out, none is exposed to such risks,,,boarding out is either the best or worst of systems' (27). Yet, in practice, it proved so difficult to move children out of the workhouse that as late as 1909 the Royal Commission on the Poor Law had to recommend that 'Effective steps be taken to secure that the maintenance of children in the workhouse be no longer recognised as a legitimate way of dealing with them' (28).

By contrast, the poor quality of family life in the growing towns and cities - slum life, child exploitation in industry and the family (for example, child prostitution), high

mortality and morbidity of both infants and parents - served to undermine the moral integrity and stability of family life. One product of this was the move by philanthropists to 'rescue' children from society and the family (29). In this context, charitable, albeit institutional, provision was deemed preferable to neglect or abuse in the community.

The Mentally Abnormal

Another exception to the principle of community-based care for children was in respect of provision for the mentally feeble child who was to be cared for in 'small institutions' (30). Jones attributes the advocacy of this type of care to the publicised treatment of the 'wild boy of Aveyron' at the end of the 19th Century. Dr. Itard's work with this boy suggested that mental defect could be ameliorated by therapy in special institutions, thereby enabling such children to return to the community (31). The growth of institutional provision for the mentally abnormal adult in the early part of the 19th Century was advanced on similar principles; segregation in institutions was viewed as a positive alternative to community life and 'was urged as being vital on both humanitarian and therapeutic grounds' (32). Yet this therapeutic optimism evaporated within a few years to be replaced by the belief that feeble-mindedness was hereditary and therefore incurable. In response there was a move away from short-term 'therapeutic' institutional care to permanent segregation in institutions - a policy supported by the eugenics movement (33).

Summary (1800-1899): The Pursuit of the Ideal Community

Table 1 illustrates trends towards institutional and community care for the poor noted above, and the similarities and differences in the rationales underpinning such care;

Table 1. 19th Century trends in institutional and community-based care

(a) *Institutional support*

Group	Themes/rationales	Expression
Paupers	Moral - social control & reform	The workhouse
	Eugenics - to protect society	" "
	Economic - to reduce cost	" "
	Protection - reform of pauper	Industrial communities/colonies
	Humanitarian - to rescue from society	Artificial 'communities'
	-o-	
Aged	Humanitarian - if no family/to escape poor care in the community	The workhouse
	Punishment - to reduce indolence	" "

	Practical - if sick, incapacitated	Special workhouse/infirmary
	Care - to help treat the Aged	Smaller/separate buildings
	-o-	
Children	Socialisation - to morally educate	Educational Institutions
	Humanitarian - to protect from community	Institutional rescue initiatives
	-o-	
Mentally	Therapeutic - treatment/cure	Short-term, small institutions
abnormal	Eugenics - protect society	Long-term institutional care
	Humanitarian - to protect from society	" "
	-o-o-	

(b) ***Community-based Support***

Group	Themes/rationales	Expression
Aged	Social conscience	Charitable giving/philanthropy
	Care not punishment	Outdoor relief better than workhouse
	Income support mechanism	" " as option to workhouse
	Community provision by default	" " because no alternative
	-o-	
Children	Humanitarian - rescue from workhouse	Cottage homes, scattered homes & boarding out
	Moral - return to family/community	" "
	Economy - cheaper than institution	" "
	Social control - education & reform	" "
	-o-o-	

As the Table and text indicate, in the 19th Century institutional and community-based forms of pauper relief existed side by side. The percentage of the pauper population served by these two forms of relief varied through time, by client group and locality. There was no simple progressive movement away from institutional to community relief in the 19th Century. Indeed, rationales for developing both types of poor relief were similar; related to individual reform, re-education and therapy; moral concerns about enforcing individual, family and community responsibilities; eugenics and national efficiency fears; simple financial cost. An explanation for such common rationales is that the creation of artificial environments like the workhouse, therapeutic communities (as envisaged by the Booths), the reforms of the workhouse itself, and the pursuit of community-style accommodation were all concerned with the same goal; the production of 'normal', morally responsible people within ideal 'community settings'. Moreover, both the workhouse and the 'rescue' movements sought to reproduce economic independence and self-help which the community failed to engender. Thus,

the common theme to institutional and community-based initiatives was the creation of ideal communities re-socialising people to hold 'normal' attitudes and values. The support for these ideal communities changed through time and by client group and came from politicians, Poor Law administrators and financiers, 'experts' in education and treatment of the socially maladjusted and mentally abnormal, social and moral reformers, economists, empiricists and philanthropists alike. All these groups, for different reasons, had cause to promote 'ideal' community lifestyles. Many of these reasons - whether concerns about the role of the family, the erosion of self-help, promoting normalisation - remain as features of community care policy today in some form or other. Similarly, in other circumstances, and at other times both forms of care were perceived as cruel and repressive, or as morally and socially corrupting. Only towards the end of the 19th Century did a clear consensus begin to emerge across care groups that institutional care was to be used exceptionally for specialist care or therapy and that smaller family-type accommodation and care provided a better environment in which to educate, support and reform the poor.

Welfare Policies: 1900-1938

The Aged

During this period the ideological shift away from institutional care for the aged poor gained momentum. There were several reasons for this (34), for example, the 1909 Royal Commission on the Poor Law promoted the use of 'small homes' to accommodate the aged poor both 'on the ground of economy to the ratepayer and increased happiness to the recipients' (35). Nevertheless it has been argued that reforms of, and moves away from, institutional care for the aged were uncommon prior to World War One, and virtually non-existent in the case of the chronically sick and frail (36). Accordingly, the number of aged people in institutions grew between 1851 and the start of the 20th Century, only dropping during World War One and the three decades following (37). But as more and more groups were cared for outside the workhouse, 'the aged were left behind,,,(thus) the workhouse became, more by default than design, the institution of the aged' (38). Even the introduction of old age pensions in 1908 initially provided little security against the need to enter the workhouse (39); soon after World War One it was revealed that 20% of people over 70 receiving relief were old age pensioners (40).

Campaigns for better treatment of old people in institutions continued throughout the 1930's and initiatives such as separate quarters for aged inmates were promoted. Experiments 'in the type of Home to be provided' for old people was encouraged by the Ministry of Health such as Homes with 'small and homely day rooms with verandahs and easy access to the open air' (41).

Outside the workhouse, some cottage homes existed with single bedrooms, 'small and cheerful sitting rooms', some with infirmaries for the bed-ridden (42).

Children

Despite explicit policy to remove children (as well as the aged) from the workhouse throughout this period (43), in 1920, 30% of pauper children were still kept in workhouses (44). Limits on capital building following the 1914-18 War curtailed the growth of smaller, more local homes for children (45) despite arguments in favour of facilitating their integration into the community. Some benefits of community life were cited by the Ministry of Health; 'It is impossible to lay too much emphasis upon the importance of making proper provision for the physical, mental and moral welfare of children,,,(they) start with the serious handicap of not having had the proper attention of parents,,,(the authorities) can never compensate fully for the loss of the advantages of ordinary home life' (46).

Family-oriented Services

The poor health of troops conscripted for the Boer Wars at the turn of the 19th Century increased concern about the state of the Nation. One historian noted that 'Arguably, the single most important precondition for the spate of social reforms between 1905 and 1914 was fear of the consequences of an unfit and debilitated population' (47). The school medical service, free school meals, and training in mothercraft resulted from this national efficiency drive, further fuelled by the temporary prominence of eugenics arguments (48).

Fears about the poor health of the nation re-surfaced throughout World War One, and, combined with anxiety to reduce infant mortality, led to consolidation and improvement of the 1902 Midwife Act through the 1918 Maternity and Child Welfare Act. The latter made first reference to the home help service, and established local authority services for expectant and nursing mothers and children under five. During the 1920's, the responsibilities of the home nurses, health visitors and home helps expanded (49) but their overall numbers remained small, varying widely by locality (50); although local authorities could use powers to employ such staff, few did. By 1925, the range of community based services which local authorities could provide included not only the staff referred to, but also Day Nurseries (51), Maternity and Child Welfare Centres, and boarding out facilities.

Mental Health Services (52)

At the turn of the 20th Century fears raised by the eugenics movement led to the appointment of the Royal Commission on the Care of the Feeble Minded in 1904. Yet Jones argues that the

Commission's main criterion for institutional segregation of the mentally feeble was their protection and happiness rather than the purification of the race (53). The 1913 Mental Deficiency Act expanded the range of 'protective' provision for the mentally subnormal to include statutory guardianship, institutional care, and license from the institution which 'made it possible for many defectives to continue living in the community while still receiving a degree of care and control' (54). Yet shortfalls in the number of institutions, largely due to the high cost of building and maintaining them (55), meant that such underprovision (exacerbated by the army's use of hospitals during the War) led the Board of Control responsible for implementing the Act 'to consider methods of community care' (56).

After the War, improvement of mental institutions to allow for earlier treatment and discharge was also hindered by capital building restrictions. In the 1930's, a change in professional treatment of mental illness produced a 'gradual realisation that community care was in many cases not only cheaper and more practicable, but better for the patient' (57). This view was reflected in the Report of the 1926 Royal Commission on Lunacy and Mental Disorder, which recommended a new approach to the treatment and care of the mentally ill - mental illness was to be tackled by preventative and after-care measures - so patients could be cared for in their own homes (58). Amendments to the Mental Deficiency Act in 1927 meant that 'the system (became) more flexible, and allowed for a variety of provision suited to the needs of the individual defective. He might go to an institution, or he might remain in the "community"; but in deciding his future, his own well-being and happiness would be the primary consideration' (59). Likewise, the 1930 Mental Treatment Act gave official blessing to the main thrust of this Royal Commission, viewing mental illness as potentially remediable, thus justifying earlier hospital discharge and community treatment and more out-patient clinics and after-care facilities (60).

This emphasis on the flexible deployment of hospital and community-based services was maintained in the 1929 Wood Report; 'the different forms of care are not to be regarded as detached and separated from one another by fixed barriers, but as methods which it may be necessary to vary from time to time during the lifetime of the individual according to his requirements' (61). The Wood Report appears to have been the first official document to refer explicitly to 'community care'; using the term to distinguish between placing people in institutions and 'leaving them in the general community and providing such degree of supervision, training and care as their condition may require or circumstances may render practicable' (62). This Report viewed the institution not as custodial but as a means to 'prepare patients for life in the community' (63). It was assumed that community-based and

institutional services were inter-dependent and inter-related, and that the former was a stepping stone to the latter, hence the emphasis placed on the co-ordination of services to allow patients to flow between them (64).

In practice, most 'community care' took place by default rather than design; the Report admitted that defectives under supervision or guardianship within the community would 'for many years far outnumber those who can be received in institutions...The control of defectives in the community must play a more important role in the general care of defectives in the future than it has ever done in the past'. It was thought very important to ensure that 'the utmost use is made of the existing forms of extra-institutional or community care' (65) in treatment, although anti-social and immoral defectives 'should in all cases be sent to institutions' (66). One consequence of failing to improve community care was noted; that defectives would 'sooner or later require the more costly provision of an Institution' (67).

Summary (1900-1938): Community Care - Theory and Practice

In this period large institutional settings were not considered ideal 'communities' in which to place the aged and children - they were too large, impersonal and repressive. The general response to this was twofold; to establish smaller, more personal institutions; or to move people into community settings. However, despite the emphasis on these two preferred locations for care, in practice, both these groups formed a significant proportion of the traditional workhouse population. Recourse to smaller or more local and homely dwellings for the aged and children were promoted on different grounds; for the former, to reproduce family and community living to maximise welfare and possible future handicaps, and for the latter, to allow greater personal freedom and privacy. Yet despite these arguments, financial limitations largely precluded the development of more appropriate care settings.

A comparable shift in ideology away from institutions *per se* never developed for the mentally abnormal. At the start of the 20th Century, mentally abnormal people were kept in institutions for seemingly positive reasons - their protection and happiness - the same reasons for keeping other groups in the community. Eugenics ideology reinforced a policy of long-term segregation in institutions. However, changes in treatment models and professional practice meant that for the less severely disturbed patients, after-care and community living was seen as a practicable. Unlike the case of the aged and children, however, there was no dominant belief that the institution should be avoided. Instead, the mentally abnormal were treated in a broader range of institutional and community-based settings deemed appropriate to their needs. (By comparison, institutional care for the elderly narrowed, as emphasis was

placed on a flexible range of short-term, out-patient and after-care facilities.) However, in practice the movement to community-based care settings was forced on many mentally feeble people as a result of the wartime evacuation of hospitals, and consequent difficulties of maintaining and building new, more progressively managed institutions following the war. The outcome was community care by default; being left in the community with little or no support.

The term 'community care' seems to have been first used in the official debates surrounding the needs of the mentally abnormal (68). It was used in a descriptive not a pejorative sense to indicate extra-institutional facilities - not, as noted above, resulting from an anti-institutional or de-institutional philosophy, but rather in the context of a continuum of care, of which institutions were an acceptable part.

Much of the emphasis placed on community-based care settings in this period was reactionary and negative; because living in the institution was perceived as the greater evil and because there was no practical alternative. However, the development of services for expectant and nursing mothers focussed on providing more support within the home through health visitors and home helps or near to the home through welfare centres. These initiatives were distinct from others during this period, being based on more positive action to provide practical support at home to enhance family and community life - community work centred on the individual's home. This community support was not, as in the 19th Century, restricted to income or housing support, but marked the serious but slow development of domiciliary care to improve mothercraft and the quality of the home environment in which children were raised.

Community Care with special reference to Elderly People: 1939-1969

One impact of the Second World War was to force the dependent elderly (and mentally ill) out of institutions as they were used by the army and for injured civilians (69). In addition, existing community networks were disrupted as cities were evacuated, women worked in munitions factories and domiciliary services were in short supply (70). After the War there were profound changes in welfare provision, especially in terms of family support. The evacuation of working class children from industrial centres to the country again revealed the poor health and education of young children (71) and generated concerns in Ministry of Health Reports about the quality of mothercraft (72). Further national efficiency concerns expressed by the likes of William Beveridge (73) were reflected in the momentum to develop a range of services for mothers and young children (74). Competing for welfare resources were the elderly who by contrast were perceived in some quarters as a burden on the public purse, being referred to as 'an intolerable burden on the community' (75).

In 1940 the National Council for Social Service held a conference on the welfare of the elderly, and as a result formed the National Old People's Welfare Council (NOPWC) which in turn established local Old People's Welfare committees to assist elderly people in need. In 1945, the Nuffield Foundation set up the Rowntree Committee to investigate the problems of caring for an ageing population. The Committee Report spoke of 'aged persons dying in circumstances of great squalor and loneliness because local authorities, although asked, have been unable to fulfil their legal obligation to receive them into an Institution' (76). The Committee called for the building of more small homes to replace existing - outdated and large - institutions, a recommendation supported in Parliament (77). On a different tack, demands to humanise former workhouse accommodation continued in the 1940's and 1950's; the 1949 Ministry of Health Report noted 'The workhouse is doomed. Instead, local authorities are busy planning and opening small, comfortable homes, where old people can live pleasantly and with dignity. The old "master and inmate" relationship is being replaced by one nearly approaching that of a hotel manager and his guests' (78). Nevertheless, despite such optimism, there was generally slow progress in building such homes (79).

The spontaneous establishment of the NOPWC reflected an emphasis of much post-war legislation; the encouragement of voluntary sector provision. The Feversham Committee of 1939 and the Rowntree Committee of 1945 both supported the enhanced role of the voluntary sector (80). The latter of the two Committees warned that domiciliiary care would not necessarily be cheaper (81); the former that 'community care' offered 'the most striking example of effective co-operation between the statutory authority and a voluntary association' (82).

The 1948 National Health Service and National Assistance Acts gave health and local authorities the power to provide a wider range of domiciliary services directly or through voluntary agencies (83); the former Act required health authorities to ensure provision of health visiting, home nursing and after-care services; the latter Act required local authorities to ensure provision of residential accommodation for the aged and infirm in need of care and attention not otherwise available to them (84). Both Acts gave expression to the change in service emphasis away from hospital-based care to care centred on the person's home as did the development of specialist housing schemes for elderly people in the late 1940's (85). As the Younghusband Report was later to note, this increase in statutory and voluntary community care services required more effective collaboration; 'The welfare of older people in their own homes must be ensured by the co-ordinated use of the resources available under the National Health Service and National Assistance Acts, including the voluntary services,.. Since 1948, Circulars,..have drawn attention to the need for close collaboration between

local authorities and voluntary organisations in ensuring the satisfactory care of older people in the community, and also to the range of help which may be required from health, welfare and housing departments, voluntary services and good neighbours' (86).

Despite the growth of welfare legislation in the 1940's, uniform and comprehensive services for the old failed to materialise. By the 1950's, shortages of staff and facilities were reported by the Ministry of Health across the whole range of health and welfare services (87). This underprovision was exacerbated by the growing elderly population - a matter of great concern to the 1949 Royal Commission on the Population which sought to constrain future government expenditure on the elderly amidst projections of a shrinking wealth-creating working population (88). In fact, in the 1950's economic cutbacks served to prevent any large scale hospital building programme in response to the growing elderly population. The alternative, and cheaper, response was seen as to forestall demand on long-stay hospital beds by the development of geriatric services (to improve rehabilitation and thereby improve discharge), domiciliary treatment by primary health care team and welfare domiciliary services, more rigorous use of clinics for discharged patients, and out-patient facilities to prevent re-admission (89). For example, the purpose of the latter was baldly stated in a Ministry of Health Report as being to 'keep them out of hospital as long as possible and get them out of hospital as quickly as possible' (90).

De-hospitalisation was also promoted in the mental health field. The 1957 Royal Commission on Mental Illness and Mental Deficiency recommended 'a shift of emphasis from hospital to community care,,,there is increasing medical emphasis on forms of treatment and training and social services which can be given without bringing patients into hospital as in-patients, or which make it possible to discharge them from hospital sooner than was usual in the past,,, The aim of hospital treatment,,,is to make the patient fit to return to life in the general community' (91). Other reasons for developing non-hospital services were that they were preferred by most people, were cheaper, and provided relief for relatives (92). For example, a Ministry of Health Report described the policy 'to encourage old people to stay as long as possible within the familiar surroundings of their own homes' as 'desirable not only on economic grounds, but because old people are generally happier and more comfy (*sic*) in their own homes than elsewhere' (93); day hospital treatment for elderly psychiatric patients was seen as 'much less costly' and 'a much better therapeutic instrument for some patients' (94).

The economic climate of the 1950's, however, ensured that the financial advantages of non-hospital provision dominated. The 1954 Phillips Committee referred to the financial burden of

growing numbers of elderly people (95) and in this context referred to hospitals as 'the least economic form of provision' (96). Thus, hospitals were perceived as a means to another end; to facilitate active treatment, speedy discharge and return to the community. Community care was therefore believed to be 'desirable on grounds of both social happiness and finance that the old should be encouraged to live at home as active members of the community and look after themselves as long as possible' (97) on the basis that 'the broad aim should be to enable old people to live in their own homes where they can continue to be happy and useful members of the community in touch with their relatives and neighbours' (98). The corollary to this Committee view was that services centred on the home would further facilitate early discharge and delay admission to hospital and residential care (99), thereby increasing further savings to the Exchequer. The 1956 Guillebaud Committee inquiring into the costs of the NHS agreed that 'The first aim should be to make adequate provision wherever possible for the treatment and care of old people in their own homes...The development of domiciliary services for this purpose will be a genuine economy measure, and also a humanitarian measure in enabling old people to lead the sort of life they would prefer' (100). Similarly, the 1957 Boucher Report concluded that 'The key to the problem stemming from an aging population lies with preventive and domiciliary services; the extension of communal accommodation as the only measure will not provide a solution' (101).

In 1953, in a Parliamentary debate on the accommodation needs of the chronic sick and aged, it was argued that, in addition to public service provision, 'families must not attempt to avoid their responsibility' in caring for the elderly. Having warned of the danger that the development of health and welfare services for the elderly could impose 'an intolerable burden on the community', the Parliamentary Secretary to the Minister of Health pointed out that providing care for elderly people was a 'vast problem', which could only be solved by the joint action of 'the State, the community, the various voluntary services, and, not least, the family' (102). Prior to this, another Parliamentary Secretary to the Minister of Health referred to special housing schemes and hostels as means to keep old people in the 'natural flow of the community and in the life of the community' (103), along with a range of other provision (104). Not surprisingly, therefore, Means argues that a further strand to welfare policy resulting from the economic emphasis of the 1950's was that local authorities were 'encouraged to place the elderly in residential rather than hospital care because it was better for them to remain part of the community. "Community care" became popularised in the early sixties and came to mean keeping people out of hospital' (105).

As community-based welfare services grew then the practical difficulty of co-ordinating those services increased. The Phillips Committee acknowledged this (106); and the Guillebaud Committee called for boundaries of responsibility between hospital and local authorities to be clarified (107). For example, Watkins identifies the division of responsibility between authorities managing hospitals and welfare homes at this time as being blurred; 'there arose a situation in which hospitals complained that their beds were "blocked" by patients who should have been in welfare accommodation, while the staff of old people's homes complained that they had to care for patients in need of a degree of nursing care for which they had neither the equipment nor the staff' (108). The Ministry of Health argued that such fine divisions of responsibility meant that it was important to 'achieve the closest and smoothest co-operation between hospitals and local authorities,,,Continuous and flexible,,,co-operation between the statutory welfare and hospital authorities and the voluntary organisations is a vital part in the nations' effort to meet the needs of the elderly and infirm', such co-operation would 'ensure that the care of patients matches their needs and that the best use is made of accommodation' (109). Similarly, the Boucher Report stated that 'The hospital, local authority and general practitioner services are inter-dependent and a better co-ordination between the various interests would be to the advantage of the old people and could prove more efficient' (110).

In the 1950's mental health policy development became more explicitly geared to maintaining family and community contacts during treatment and rehabilitation of patients. The 1957 Royal Commission on Mental Illness and Mental Deficiency argued that 'it should be remembered that the sense of belonging to a family may be of great importance to the patient' (111). This view was reflected in the arrangements made for mentally subnormal hospital patients who were 'better treated either in their homes or in small units near their homes' and were to have access to leisure, work and recreational activities to ensure 'more contact with the community'. Moreover, 'the maintenance of community ties' was to be encouraged through 'regular visiting, weekend leave, shopping expeditions etc'. Alternatively, in-patients should be accommodated in 'reasonably small hospitals, so that the patients do not become cut off from the community' (112). The Royal Commission defined community care broadly including:

i) Preventative services - 'which help people to develop an active social life'; social clubs and community centres, information and counselling services.

ii) General social support - local health and welfare services plus national assistance, employment and voluntary services.

iii) Helping services - a range of educational, training and occupational activities for adults and children (113).

These services, Jones argued, 'did much to break down the old distinction between being totally well (at home) and totally sick (in hospital), Britain began to attempt the provision of a flexible range of services to meet the varying needs of individuals' (114). In the 1960's, attempts to further shift the balance of care away.from hospitals were facilitated by major advances in drugs and technology, together with changes in professional opinion regarding the most appropriate and effective treatment for the mentally ill, mentally handicapped, chronic sick and elderly (as expressed in the 1959 Mental Health Act).

The publication of two ten-year plans on the development of local health and welfare services - the 1962 Hospital Plan and the 1963 'Health and Welfare' Plan - was an explicit admission that any rationalisation of hospital services relied on the expansion of complementary community care services (115). The former of the two documents, in its 'care in the community' section, stated that 'the aim will be to provide care at home for all who do not require the special types of diagnosis and treatment which only the hospital can provide. Thus, any plan for the development of hospital services is complementary to the expected development of services for prevention and for care in the community' (116).

Neither of these plans made any attempt to standardise service provision, but left respective authorities to respond to the general emphasis of the documents in the light of their local needs. Thus, wide variations in welfare provision documented in the Health and Welfare Plan (117), continued to exist. This latter plan evinced the principle on which future service provision for the elderly was to be based; 'The basic need for the elderly is a home of their own where they can enjoy privacy and comfort, with the social contact which they desire. The majority will live in their own homes, alone or with others, in complete independence, availing themselves when necessary of the ordinary range of health and welfare services. A proportion will need special support to enable them to continue to live in their own homes' (118). Residential accommodation was to be provided for those who became 'too infirm to live at home even with help', 'but was to be as homelike as possible' (119); 'a substitute for normal home life' (120). These sentiments were endorsed in a Ministry of Health Circular - 'it is the general objective of both health and welfare services, working in co-operation, to maintain the elderly in the community and to accept admission to hospital and residential care as the right course only when an old person himself accepts the necessity for this and when he has reached a point when community services are no longer sufficient' (121). Similarly, a Housing Circular noted that 'it is widely recognised today that old people want to lead an independent life for as long as they can' (122).

In the 1960's, community care was associated with the principles of normalisation and social integration. The Ministry of Health described community care as 'an attempt to retain wherever possible the normal social structure, and to avoid the development of artificial social groups too sharply divided by age or handicap' (123). In this period, the Ministry of Health reported that 'The emphasis is now on the need for a place in the home, the family and the community,,,a normal or near normal social environment,,,can play an essential part in maintaining or restoring health and purpose in life. Community care, as it has come to be called, is seen in its widest sense as an aid to the prevention of admission to, or shortening the stay in, hospitals and homes and the break-up of family life, as a necessary complement to hospital treatment for those returning to their own homes' (124). Likewise, the Report of the Seebohm Committee in 1968 attributed many benefits to community care; the 'network of reciprocal social relationships'; the 'mutual aid' and 'sense of well being' felt by the community (125); the avoidance of feelings of dependency and stigma, and the increase in self-help and participation (126), all of which underpinned informal care (127).

The focus of the Seebohm Report was to co-ordinate welfare services to meet family need taking into account the caring capacity of each family unit. Statutory services were to work alongside the primary carers - relatives, friends, neighbours and the 'wider community' - to 'best enable such potential assistance to be realised' (128). Prior to the Seebohm Report, the Ministry of Health had pressed for closer links between residential services for elderly people and reference was made to the 'joint planning' of such services (129). Seebohm stated that 'the overall planning and co-ordination of services and resources, both statutory and voluntary, is,,,of the utmost importance' (130). Any response to elderly people 'must pay great attention to the contribution to the care of old people which is, or could be made by relatives, friends and the wider community. The care which a family gives to the older members is of prime importance and nothing is quite an adequate substitute. Therefore the social services,,,should make every effort to support and assist the family which is caring for an older member' (131). As Bayley was later to note (132), Seebohm envisaged a relationship between the social services department and the community in which the staff of the former 'will need to see themselves,,,as part of a network of services within the community' (133). The social services department was to act as a catalyst, effecting the mobilisation of community resources, 'especially volunteers', the co-ordination of whom was an 'important' aspect of the administration of the social services department (134) since they were to 'complement the teams of professional workers,,,they can assume,,,many of the duties which need not be carried out by a qualified professional worker' (135). Thus, Derricourt argues that the Seebohm Report 'played a crucial part in transposing the meaning

of community care *in* the community,,,to care *by* the community, provided by the dependent person's family' (136).

The Seebohm Report also referred to institutions such as hospitals and residential homes as 'part of the community' (137). The Report suggested that the work done by the employment and resettlement services of the Department of Employment and Productivity, the Supplementary Benefits Commission, local education and housing departments, home helps and home nurses, probation and after-care services, the Police, the churches, the voluntary societies and, 'most importantly', employers, workmates, friends, neighbours and landlords as being the 'community caring' (138). Thus, social services were to be 'directed to the well-being of the whole community', emphasising community participation and community development as part of community care (139).

The 1969 Local Authority Social Services Act implemented the main recommendations of the Seebohm Report. As a result, the child and welfare departments of the former welfare authorities merged, whilst responsibility for mental welfare passed to the health department. This shuffling and merging of responsibilities took place at a time when new duties were thrust upon the social services departments as a result of the 1968 Health Service and Public Health Act and the 1970 Chronically Sick and Disabled Persons Act, which reflected an 'increased State commitment to community care' (140).

Summary (1939-1969): Developing Community Care as a Partnership

During and immediately following the war the care provided for elderly people in the community was poor; not only were the dependent elderly forced out of institutions, but in the community there were comparatively few sources of practical help available. The top priority group targetted for community services at this time were again mothers and young children. The growing elderly population was perceived as a political and financial problem - as illustrated in the text, in the 1950's frequent reference was made to the economic burden of the elderly population on the Exchequer which led to the search for cheaper forms of accommodation for dependent elderly people. Thus, there was a strongly supported move away from long-term hospital care to a range of preventative, early discharge and after-care services, along with the optimal use of local authority part III homes. In respect of the latter, the attempts to humanise older workhouse type buildings continued. Lastly, from the 1950's onwards, the concept of supported independence sought through part 2 (and later part 2½) accommodation - sheltered housing - became a growing feature of housing policies.

perceived as a half-way point between the health and local authorities' residential accommodation and ordinary housing.

A significant change in the latter half of this period was the development of a wide range of domiciliary services available to the elderly as well as to mothers and children. Statutory responsibilities to provide such services increased considerably. At the same time, the activities of the voluntary sector grew as voluntary organisations acted as agents for the statutory authorities. As professional and voluntary services grew, so the need for effective co-ordination of these services was recognised. In the 1960's in particular the model of domiciliary service development changed further; it was no longer a case of co-ordinating statutory and the formal voluntary sector services; the input of informal carers was recognised as a vital part of community support, as were the welfare contributions of the wider community (friends, neighbours and workmates). State services, the voluntary sector, informal care and the wider community were to be partners in the provision of health and welfare support to elderly people. Statutory carers were increasingly expected to mobilise the support of the non-statutory sector, acting in an enabling role, co-ordinating services, matching resources to needs. There were many reasons for this shift from 'care in the community to care by the community' which Bayley identified. Not the least of the reasons was financial - domiciliary services and particularly non-statutory care, were thought to be cheaper to provide than long-stay hospital care. But economic rationales, although important, were not the only reasons behind such a service shift. From the 1960's onwards a much higher profile was given to the rights and wishes of elderly people, many of whom, it was commonly supposed, wanted to stay in their own homes for as long as possible. It was also clear that the therapeutic effects of keeping a person within the community underpinned humanitarian moves to remove people from institutions.

Attitudes to institutions - as opposed to the community - fluctuated throughout this period. The official de-hospitalisation movement in the 1950's was to a considerable extent a reaction to costs. But the 1960's move away from institutions (hospitals and residential homes) was a reaction to much publicised scandals about the the poor standard of care offered in such accommodation, together with a recognition that many people neither needed (in terms of effective acute treatment and appropriate use of technology) nor wanted to be in such places. Retaining links with families and friends was of paramount importance; segregation was increasingly viewed as bad practice amongst health and social care professionals. However, by the late 1960's this latter view was changing too. The 1959 Mental Health Act, and later the 1968 Seebohm Report, took a more liberal view of institutional care, preferring

to view all potential sources of care as part of a continuum, each part of the continuum was to be drawn on in the general attempt to keep people in the community as their needs changed. Thus, de-hospitalisation (in the form of more use of out-patient facilities, day care, after care etc) was seen not an end in itself, but as an attempt to use the specialist hospital services on a short-term basis to keep people at home. Resources were to be used flexibly, not rigidly, as was implied by the adoption of an anti-institutional or de-institutional stance. Institutional and community services were in partnership; mutually dependent and complementary rather than competitive or conflicting in aim. Community care was a positive policy rather than the outcome of anti-institutional policy *per se*. This more flexible approach inevitably led to some overlap between the roles of services such as sheltered housing and residential homes, highlighting the need to co-ordinate resources effectively.

Changes in community care themes and rationales reflected developments in professional practice and in the governments view of legitimate and affordable ranges of state services. Generally speaking, public sector professionals became more likely to positively view the role of community services in treating dependent people, especially in the mental health field, fuelled by changes in drugs and technology and the growth of domiciliary services. Sociological research and official committees of enquiry into the mis-management of various institutional services played an important role in effecting a shift away from institutional care in the 1960's.

Political support for community care seemed robust across party groups, but for different reasons. For example, to the Conservative Party it was indicative of a faith in self-help, individualism and the role of the family (as opposed to an emphasis on the State services); but to the Labour Party, it reflected a belief in the community with a social conscience.

Lastly, a final change in the focus of community care policies concerned the recipients of care. In general terms, as time progressed, not only was the dependent person in need a beneficiary of care, but so too were their carers. This was reflected in the idea of 'caring for carers', and the more abstract notion of caring for the community as a whole, expressed in the Seebohm Report, and later by Walker (141).

Conclusion: The Changing Face of Community Care

This Chapter illustrates that a number of policy themes associated with the care of the poor since 1800 are recognisable as similar in nature to some aspects of contemporary community care policies;

- the emphasis on "normal" (family and community-based) care settings rather than artificial (institutional) care settings;
- the emphasis on small, local care settings;
- the growing association of moral, financial, social and therapeutic benefits with community-based forms of care, although allowing the retention of some institutional care for special treatment/therapy and care;
- the development of a growing and co-ordinated range of professional support geared to keeping people in their communities;
- a concern about the relative responsibilities of State, family and community to care for dependent people, with a developing emphasis on partnership arrangements based on the assumption that informal carers must continue to be the primary carers.

The emphasis placed on these themes have varied throughout this 170 year period reflecting a number of different motivations. In the 19th Century community assistance to the poor was limited; State help being expressed in the form of income and housing support. The State did not consider providing direct social 'care' for the poor, primarily because the poor were deemed to be responsible for their own poverty. The establishment of institutions - the workhouse, asylums and infirmaries, educational establishments and private 'colonies' or 'industrial communities' - did not reflect the same concerns. The workhouse was viewed under the 1834 Poor Law Amendment Act as a tool of repression, punishment and reform. It was intended to deter dependence on the State. Asylums and infirmaries were used for different purposes; to provide "therapy" and treatment, to protect the sick from society and to protect society from the sick. Changes in 'professional' and public opinion determined their usage and role; to cure or care, to provide short-term or long-term refuge. Philanthropic and educational institutions had other purposes; to rescue people from the vices of society and town life and re-establish 'normal' moral behaviour. All these developments assumed that the family and the local community were where ordinary people should be raised and supported. Institutions were means to re-establish the principles of family life and individual moral responsibilities, albeit for different reasons; to reduce the cost of maintaining the poor; to address fears fostered by the eugenics movement; to make genuine attempts to relieve suffering; an acceptance that the poor needed help and care rather than punishment.

In the early part of the 20th Century the range, scale and type of community support changed, albeit slowly. This reflected factors such as the continuing fears about the 'state of the nation' and the acceptance that illness and infirmity should generate practical care and treatment in normal or near-normal social settings. The result was an attempt to humanise

institutions and develop community-based forms of care. Increasingly the State accepted that the needs of children and elderly people in particular should not be met in large, impersonal institutions divorced from society. It was in the case of the mentally abnormal that first reference was made to 'community care' in an official document - the resources of the community were seen as part of a range of therapeutic support (including institutions) which were available to meet the individual needs of the mentally feeble.

The Second World War had a profound effect on social consciousness, triggering the creation of the Welfare State. The immediate post-war period saw the establishment of a wide range of health and local authority services particularly for mothers and children; and the encouragement of voluntary sector activities especially in support of elderly people. In terms of the latter, financial concerns seemed to hinder the development of residential services and to a certain extent 'community care' took place by default. By the late 1960's, however, further statutory measures led to the positive development of domiciliary care on a much broader scale alongside the more specialist use of hospital and residential services.

Overall, this Chapter indicates that community care policy themes have neither recent nor simple historical origins. Indeed, community care has had at least three primary meanings (which are elaborated in Chapter Three, pp32-35):

- as a reactive and largely negative policy of de-institutionalisation;
- as a proactive and positive policy, embodying a positive philosophy and commitment to developing good quality care in community settings;
- as a neutral policy - seeing institutional and community-based provision as complementary and thus requiring close co-ordination.

However, even this typology is a simplification since these primary meanings of community care have been based on many motivations and rationales. For example, one long standing community care theme has been the concern to establish therapeutic care settings; the need to maximise physical and mental health by harnessing the strength of human networks (and thus social exchange, reciprocity etc) by encouraging a mix of professional care and the participation and involvement of family, friends, neighbours and the wider community. Yet this theme has resulted from different stimuli; moral concerns about reforming the dependent; genuine humanitarian concerns about the most appropriate and effective forms of care; a changing body of theory regarding the effect of normal living on individuals; concerns at national level about the purity of the race, and its future productiveness; professional convictions about the value of family life; ways to secure low-cost health benefits. Thus,

although community care may have been supported on the basis of its therapeutic impact, the reasons for this support have varied. This community care theme - and indeed, community care as a whole - has not been supported for the same reasons through time.

All this is to suggest that community care is best viewed as an umbrella term representing a number of policies which in turn have reflected various humanitarian, financial, moral, professional and organisational priorities and rationales. This inherent complexity reflects the long history of community care policies, their adoption (and interpretation) by a number of professionals in the field; and their application to many client groups rather than one.

Lastly, this Chapter also shows the start of the association between the implementation of community care (as an end in itself) and collaboration (as a principal means to achieve that end). After the Second World War particularly, co-ordination and collaboration were cited as prerequisites of effective community care; a logical implication of the fact that community care for elderly people has increasingly been perceived as involving the family, the community, a growing range of voluntary organisations and statutory community care practitioners in housing, health and social services authorities.

Community care policies have, therefore, not only become conceptually diverse, but also historically and organisationally complex. This conceptual diversity is explored in more detail in Chapter Three; the historical and organisational complexity is explored further in Chapter Four.

CHAPTER THREE

The Meanings of Community Care

This Chapter breaks down community care 'banner goals' statements, to show how community care policies may be interpreted (1), thus illustrating the breadth and diversity of meanings associated with these policies. The meanings of community care are analysed at three levels; through *primary meanings* derived from the historical development community care policies; through *operational meanings* (the ways in which community care is applied at national and local level); and by examining some *community care concepts* implicit in the primary and operational meanings of community care. Whilst primary and operational meanings address the 'superstructure' of community care; the conceptual analysis explores the 'substructure' of community care. Each set of meanings indicate how community care for elderly people has, and can be, understood.

Primary Meanings of Community Care: A Typology of Policy Development

Chapter Two concluded (p30), community care policies have three primary historical meanings:

- as a reactive and largely negative policy of de-institutionalisation;
- as a proactive and positive policy, embodying a positive philosophy and commitment to good quality care in community settings;
- as a neutral policy - seeing institutional and community-based provision as complementary and thus requiring close co-ordination (2).

This typology does not imply that these three types of community care policy have existed independently of each other through time (3). Rather, history reveals that they have been associated with a variety of care groups at different times, as well as with the same care group simultaneously (see Chapters Two and Four). For example;

(i) In the mental health field, the movement away from institutional care since 1800 has been overlain by the retention of certain types of institutional care and the rejection of some aspects of community-based care.

(ii) In the late 19th Century institutions caring for pauper children were seen as havens - protecting children from community life in the towns and cities; simultaneously in workhouses across the country children were being moved out into smaller, community based accommodation.

(iii) From 1890, there were initiatives to humanise the institutions for the elderly poor, later reserving them for special cases of need, and so developing one form of institutional care (the residential home) at the expense of another (the Poor Law hospital).

Contemporary community care reflects a diversity and interweaving of such primary meanings. Further distinctions can be made between these forms of primary community care meanings; between proactive or reactive initiatives; between intended policy outcomes which were the result of a conscious decision-making process, and unintended outcomes which were the product of other policies or a lack of policies and thus non-decision-making (4). Tables 2 to 4 below give some examples of how primary community care meanings can be further analysed;

Table 2: Community care as a negative policy of de-institutionalisation

EXPRESSION AND CHARACTERISTICS	EXAMPLES
(i) A movement away from particular types of institutions as a key but essentially incidental aspect of a wider reaction to established policies and practices. In this sense 'this move towards community care was probably inspired as much by negative considerations as by any positive set of objectives' (5).	The reaction against the workhouse was part of a wider movement against the Poor Law regime. The reaction against hospital care in the 1950's & 70's was part of a wider drive to cut public expenditure.
(ii) A movement against a particular model of institutional care - or from institutional care per se - because it was viewed as inappropriate (6). This impetus led to a search for alternative provision, shifting the balance of care. Community care was preferred, the differences between community care and institutional care were relative rather than absolute (7). Thus institutions were humanised, and their functions became more specific (8).	The education of pauper children in 19th Century. The 1950/60's anti-institutional movement based on concern for individual health, welfare and happiness. Also the move away from hospital care in the 1960's to enable doctors to practice 'real medicine' (acute treatment).
(iii) The movement away from institutional care without a specific intention to do so. Insufficient institutional provision led indirectly to the provision of community care - such care did not result from positive policy making and was not financed by the Exchequer (9). There have been a number of variations on this theme;	Shortages of staff and facilities since 1900; reflected in variations of local services.

a) unplanned reductions in institutional services in unforseen circumstances; forced de-institutionalisation, b) unplanned reductions in institutional services in foreseen circumstances	During and following both World Wars, Although the elderly population was predicted to rise, hospital and residential services have not kept pace,
c) planned reductions in institutional services - either as part of a wider policy policy emphasis (for example on cheaper forms of care) or as part of a policy move within the health and welfare services in particular (11); compare with 1(i) and 1(ii),	Evident since the 1962 'Hospital Plan' and the later 'Health & Welfare' Plans (10), 'Priority' documents from 1976 onwards, Also 19th Century policies & policy from 1950 and 1979 onwards,

Table 3: Community care as a positive policy

EXPRESSION AND CHARACTERISTICS	EXAMPLES
Community care as a direct policy with a positive meaning (12), pursued deliberately in its own right, This is reflected in 1(ii) above and 3 below, Positive support for the policy can be based on economic, moral or humanitarian principles, It may be individualistic or collectivist in emphasis, reflect service delivery principles or value judgements about the worth of the home, the family and 'normal' life,	Education of pauper children in 19th Century From 1900 help given to mums and young families, General development of domiciliary services, 1960's mental health policies, Emphasis of Seebohm Report,

Table 4: Community care as a neutral policy: part of comprehensive care

EXPRESSION AND CHARACTERISTICS	EXAMPLES
(i) Community care as a range of services which include institutional provision, Community care is a complementary alternative, Emphasis is on providing care appropr-	The work of the Charity Organisation Society in the 19th Century, The 1924 Wood Committee and 1927

iate to need through co-ordination and flexible use of resources (13). Alternatives encouraged to give greater client choice.	Mental Deficiency Act. The 1939 Feversham Committee. 1948 National Assistance and NHS Acts. The 1968 Seebohm Report.
(ii) The broadest expressions of community care incorporate some or all of aspects of institutional care. Community care as a philosophy or set of objectives can embrace other services in harmony with that philosophy/objective. Thus individual freedoms, cheapness, choice, continuity and flexibility of care can be the common ground for linking open and closed care settings under the community care banner (14).	Some aspects of the dehospitalisation movement from 1960's onwards. The Seebohm Report.

This analysis suggests at field level that there may be different interpretations of the purposes of community care activity. An examination of the explicit operational meanings of community care below indicate that this is indeed the case and gives a possible indication of why conflict between community care practitioners might arise despite apparent commitment from these practitioners to the overall pursuit of community care policies.

Operational meanings of community care: an overview

The community care literature has tended to describe this policy movement in the form of banner goal statements of intent. These explicit statements partly constitute the superstructure of community care and comprise generalisations which, by nature, are vague and superficial. This section continues to examine this superstructure by looking at five different operational features of community care policy - the WHERE, WHO, WHOM, WHY and HOW of community care policies:

1. WHERE are people cared for? - the location of community care.
2. WHO is cared for? - the recipients of community care.
3. Caring done by WHOM? - the providers of community care.
4. WHY are they cared for? - the rationales of community care.
5. HOW are they cared for? - the manner in which community care is delivered.

These features of community care policies are not mutually exclusive or exhaustive. Indeed, the fifth feature, in particular, is a combination of the other four.

Before elaborating on these features, it is worth noting that there have been other attempts to clarify the meaning of community care. In 1973, Bayley (15) referred to;

a) care out of the community - permanent segregation in institutions (p2,5,20);

b) care in the community in institutions not involved with the community (p343);

c) local authority care in the community - which may or may not involve residential care (pp19-20);

d) care at home in the community but isolated from it (p343);

e) care in the community at home (pp1-2) involving non-institutional local authority services (pp3-4);

f) care by the community at home comprising untrained family help (p343);

g) as f), but care by the community includes the participation of the whole community; not just family, but also friends and neighbours (p2, 19-20);

h) care by the community, interweaving c) and f) above, so that statutory social services, voluntary aid and informal care combine to produce local, flexible, mutually supportive networks of care (p9, 342-4); what Bayley called care by and with the community (16).

Bayley's principal distinction was between 'care <u>in</u> the community' and 'care <u>by</u> the community'. However, in terms of the analysis in this section the distinctions between these two forms of care are a little confused because they simultaneously highlight a number of community care features. Thus, the notion of care <u>in</u> the community, expressed in the form b) to e) above, describes community care taking place in institutional and home-based settings (WHERE care takes place), referring principally to local authority statutory carers as the providers of such care (care provided by WHOM). Bayley also addressed WHO is cared for - the dependent person rather than the carers - and incorporating ideas about HOW caring is done by, emphasising that in practice statutory carers operated in isolation from informal care.

In terms of care <u>by</u> the community, Bayley's ideas are equally broad; the location of care (the WHERE feature) is the same as for care *in* the community. The notion is much more concerned with the source and style of care (the WHOM and HOW features). In terms of the former, this notion in its simplest sense refers to the care given by the untrained community itself - family, friends, neighbours, volunteers. Indeed, prior to Bayley's book (17), and subsequently, this was the sense in which care *by* the community was defined. Yet Bayley categorically stated; 'That is not what I mean by <u>by</u> the community' (18). Bayley's purest definition of care <u>by</u> (and with) the community expressed an emphasis on HOW services were to be provided as well as by WHOM they were provided; he saw care <u>by</u> the community as involving statutory and informal carers working in tandem; with the statutory carers ensuring that

informal carers were catered for as well as the dependent person, WHERE care was provided was secondary to HOW it was provided. Locally integrated flexible services were the principal focus of this second notion. Thus, for example, Bayley spoke of a broad range of care going far beyond home care, to include acute hospital and residential care in a later explication of care by the community (19). This discourse itself shows how relatively simple notions can be interpreted differently according to the features emphasised in definition.

In 1978 Abrams used another means to identify the essential features of community care. He proposed a two dimensional grid (see Table 5 below) to define community care in terms of a relationship between two of the five features (the WHOM and WHERE features) identified above. In general terms, Abrams defined community care more stringently than Bayley; all four forms of care and treatment Abrams cited would fit into Bayley's notion of care *in* the community. What Abrams calls 'community care' would fit into Bayley's simple notion of care by the community; but none of his four forms of care would fit into Bayley's purest definition of care by and with the community. Walker has subsequently argued that Abrams definition of community care 'presents some difficulty for policy analysis, because, in practice, the development of community care policies has been concerned with the provision of care by paid social services workers *in* the community rather than by the community' (20).

Table 5: Diagramatical representation of Abrams' view of "Community Care"

PERSONNEL \ SETTING	CLOSED	OPEN
PROFESSIONAL/ SPECIALIST	INSTITUTIONAL TREATMENT	COMMUNITY TREATMENT
LAY/NON-SPECIALIST	INSTITUTIONAL CARE	COMMUNITY CARE

Source; Barnes, J and Connelly, N (1978) Social Care Research London; Bedford Square Press, p78.

Derricourt later broadened Abrams definitions (21) by citing three other kinds of community care which to some extent addressed Walker's criticism;

(i) activity initiated by professionals performing a permanent supportive or monitoring role using volunteers and low paid workers;

(ii) activity initiated by professionals in a temporary supportive role so that activity can eventually continue in their absence;

(iii) activity undertaken by lay-people largely independent of professional help.

In 1982, Walker admitted that he had to 'forego some definitional clarity by following the direction of public policy in widening the concept of community care to cover care *in* the community by members of formal organisations or informal networks' (22). Walker's definition of community care is based on practical public policy analysis; he starts from what is and what has been rather than what in theory could be. His concern was 'with the concept of care *in* the community, which may be provided "informally", through kinship networks, by friends, neighbours and volunteers, or "formally", by statutory social services' (23). Walker distinguishes between the formal, quasi-formal and informal care provided, choosing not to generalise as to WHY community care might be provided in any of these ways; 'it is not assumed,,,that informal care is necessarily more desirable than formal care, both may be narrowly or expansively conceived and operated, they may enhance or reduce dependency, deny or facilitate rights and restrict or enlarge freedom. Both may be more or less egotistic or altruistic in operation' (24). In sum, Walker defined community care as 'help and support given to individuals,,,in non-institutional settings,,,provided by informal, quasi-formal or formal helpers or by a combination of all three' (25). In focusing on the public policy of community care, however, Walker defines 'care' broadly to encompass individual self-care to care *for* the community. The latter being the measures taken to increase the caring capacity of the entire community and its infrastructure (26).

Taking these four analyses together, it is apparent that each author has defined the term 'community care' in different ways. In terms of WHOM does the caring, Bayley and Abrams both focus on untrained help (although Bayley incorporates professional help in a secondary supportive role); Derricourt and Walker, however, both emphasise the contribution of the statutory carers (although Walker does not necessarily regard them as of greater importance in community care than informal and quasi-formal carers). In terms of HOW care is provided, Bayley and Derricourt both distinguish between jointly provided and unco-ordinated care, though Bayley distinguishes further between short and long-term interactions between carers. Abrams, by contrast, chose to distinguish between the structure of the care environment

(open/closed settings). The important point to note here is that not only can community care be defined in different ways according to the perspectives adopted in analysis, but it can also be variously construed according to different aspects of the same perspective. Thus, for example, although Abrams distinguished between four forms of care and treatment in Table 5, he writes in a note to the table that, apart from Institutional Treatment, the three other forms of care were similar since they sought 'to operationalise a common underlying idea; that the milieux of social life are somehow the peculiarly appropriate settings in which social care will have its optimum impact' (27). The crucial point in defining community care, therefore, is to pinpoint the feature by reference to which the phrase is defined. The perspectives examined below are an attempt to disentangle these different features of community care policy.

Operational meanings: The five features of community care

1. WHERE care is provided.

Community care has been traditionally defined in terms of WHERE it happens. Indeed, consensus as to the meaning of community care has since the 1950's most often revolved around the issue of location; community care happens outside institutions or closed institutional regimes (28). But this in itself means little and is a comparatively superficial definition. For example, doctors might support the above definition of community care because it enables them to practice acute medicine in hospitals. On the other hand, the social work profession might support it because it gives greater expression to the rights of people to choose and enjoy 'normal' lifestyles. Community care exclusively defined in terms of location is therefore imprecise; the location may be chosen for a multiplicity of reasons.

WHERE community care happens can itself be determined by economic, humanitarian, political, professional and organisational criteria - as these criteria vary so too does the importance and relevance of the location of community care services. In the various literatures analysed in this Section the location of community care has been interpreted to include;

a. Care of persons in ordinary housing (29).
b. Care of persons in special housing located in the individual's community.
c. Care of persons outside residential establishments in general (30).
d. Care of persons outside hospitals specifically (31).
e. Care of persons outside all institutional or closed settings (32).
f. Care in open institutions - therapeutic communities (33).
g. All care except long-term care in institutions (34).
h. Care provided in any residential establishment at any time (35).

i, Care provided within hospitals (36),

j, Any care deemed appropriate in achieving the return of people to the community (37),

These locations of community care may reflect different criteria - perceptions of therapeutic impact, cost, stigma, rights and wishes or, say, resource availability (38),

2, **WHO is cared for?**

It is perhaps stating the obvious to say that the dependent person is the subject of care, Yet, even if this is obvious, the implications of this statement are unclear, Individuals may be cared for according to their perceptions of need, their wishes, choices or according to 'objective' definitions of need, available resources, organisational priorities and procedures, Service provision can emphasise the philosophy of individualism (i,e privacy, independence, rights, choice, wishes etc) or community life (i,e social interaction and integration, engagement etc), Thus, even if it is the individual who is to be cared for, this does not clarify HOW that care is to be provided (39); provision for the individual may reflect a range of ideologies, professional models of care, different interpretations of need and priority, changing administrative systems,

One element of a corporate approach to individual need is to consider the individual's carers as well, This has become a popular contemporary community care theme (40), If the family is to be cared for, along with the dependent person, then the implications for targetting service are more complex, Also, once more than one group is to be cared for by the same services, a potential clash or trade-off of interests can result,

Caring for the community as a whole is an approach mentioned by Walker (41), This approach suggests a co-ordinated programme of state action to ensure that the caring capacity of the community is maximised, For example, the Seebohm Report (para 337), in the context of creating 'the most advantageous social environment' for patients, ex-patients and their families, spoke of the community caring through the services of the Department of Employment and Productivity, the Supplementary Benefits Commission, local education and housing departments, domiciliary, probation and after-care services, the police, churches, voluntary agencies and private industry (42),

3, **Caring done by WHOM?**

This feature is heavily influenced by moral and economic values, Self-care is at one extreme of the WHOM perspective, It relates to ideas about self-help, self-realisation, self-actualisation, the maximisation of individual capacity and autonomy, Self-care is a

recognisable element of Conservative Party ideology. As one Conservative Minister said, 'A state which does for its citizens what they can do for themselves is an evil State' (43). A recent Conservative document stated that since 1979 'Much has been done,,,to build on the old virtues of self-help, self-reliance and personal responsibility and to remind our fellow citizens of their duties to their families, their local community and their country' (44). Similarly, Williams stated that 'the provision of care in itself is not the prime aim,,,but rather the education and encouragement of old people to care for themselves' (45).

Apart from the individual's duty and responsibility to care for himself, care can be provided by the family. Indeed, as recent governments have made clear, far from being the domain of statutory carers, community care is responsibility of the family; especially female kin (46). Family care has often been extolled by governments. The Seebohm Report stated that 'the care which a family gives to its older members is of prime importance and nothing is quite an adequate substitute' (47). Walker states that one of the main reasons for lack of government commitment to community care has been 'its reluctance to intervene openly in the provision of care by the family, and its desire to maintain the existing structure of relationships within the family' (48). If true, the State has moved beyond exhorting the value of family life to extorting such care through limited professional support services - family care by default (49). More recently, the State has given greater credence to family support through encouragement of measures to care for carers (50).

Beyond immediate family, participation in care by the wider community of friends, neighbours, and volunteers might be sought (51) and, beyond this, the participation of the entire community might be advocated. In respect to the latter, one author has written that 'the success of any plans to make a better, richer life for old people,,,must ultimately depend on the involvement of,,,the wider community, which includes us all' (52). In the broadest sense, the wider community shares the burden of care through taxation and charitable giving.

Conservative Party ideology supports the integration and engagement of old people into the community; 'The purpose of any system designed to serve people in their old age must be to maintain them in dignity and independence through a full and fruitful relationship with the rest of the community' (53). A decade later this was more categorically stated - 'Voluntary and community organisations are more than an expression of a free society; they are the ribs of such a society. They reinforce individual and community values,,,By helping others, people help themselves and become less reliant on the State' (54). However, to apply this model would, to some commentators, be unrealistic. Jones et al comment that 'To talk of the outside

world as "the community" is to assume a level of social support which may not in fact exist' (55). Likewise, Goldberg and Connelly call such a stance 'more in the nature of a declaration of faith than of realistic guidelines for practice' (56).

Statutory provisions to help elderly people remain in the community have grown from pure income support and housing policies to encompass a broad range of practical help, advice and support services provided by community-based professionals. The nature of statutory community care services have been analysed by Webb and Wistow (57) who assert that community care has its centre of gravity in a number of settings;

a) within the personal social services, through domiciliary social services, housing, day care or through professional social service input to carers;

b) within the health service, as a means to facilitate throughput in the acute medical sector, or as a broader preventative medicine approach (58); and

c) within a joint setting involving a) and b) through jointly planned, jointly financed and co-ordinated services.

In terms of formal statutory community care input therefore, the organisation of community care is likely to vary between localities according to the resources and priority placed on different organisational structures and networks.

The WHOM feature as a whole illustrates further how community care can be pursued as a positive or negative strategy or indeed, as a non-strategy, reflecting again a range of philosophical and political concerns, objectives and emphases.

4. WHY community care?

This feature can be discussed at two levels. First, at the level of macro-rationales which underpin community care. Second, at the micro-level of conceptual detail. The second level will be analysed in the next section below (p44).

The major rationales which have led to the pursuit of community care are;

(a) ***Need-based.*** As the number of elderly people has risen in absolute and proportionate terms, institutional provision has not kept pace; community care' results by default. Equally, though in a different sense, community care has become a more practical and desirable option due to changes in available treatment, facilities, models of care and professional opinion. Individual need can be met more easily and appropriately through this policy (59); community care also results from this positive demand.

(b) ***Humanitarian-based,*** MacIntyre identifies humanitarian considerations to be one of the main rationales behind the development of social policy for the elderly since 1834 (60). The 1956 Guillebaud Committee spoke of domiciliary services as being more economical and also 'a humanitarian measure enabling old people to lead the sort of life they much prefer' (61). Reference to individual preferences is a common theme in community care policy statements for elderly people. For example, in 1979, the Royal Commission on the NHS stated that 'cost considerations apart, most of us would prefer to live at home rather than in a institution or hospital, however congenial' (62). Community care is also strongly associated with the happiness of clients; related to concepts such as privacy, independence, dignity, choice, self-help, family contact, maximisation of personal freedoms, capacities and rights.

(c) ***Resource-based,*** Economy of provision and efficient use of resources have been central to community care policies, as primary or important secondary considerations. For example, in the late 19th Century, non-institutional provision was commended because it was cheaper to the rate payer (e.g boarding out for children, see Chapter Two). In the 1920's and 30's, community services for the mentally deficient developed partly in response to the high cost of institutional care. The 1949 Royal Commission on Population was concerned about the rising cost to the Exchequer of an ageing population, as were the Phillips and Guillebaud Committees of the 1950's. Economic anxiety as to the cost of public services was re-awakened from the 1970's onwards in response to the world economic recession. A variation on this theme, is the pursuit of community care to ensure more efficient use of residential resources such as part III homes and acute hospital beds (for example, resource rationalisation from the 1960's onwards). Here community care was not pursued to avoid high cost institutional care, but to make optimal use of those limited resources (63).

(d) ***Morally-based,*** Hawks describes community care policy as having many of the features of a 'moral enterprise' (64). Some rationales underpinning community care (e.g, economic and humanitarian rationales) self-evidently suggest that this policy ought to be pursued (65). Similarly, community care expressed through family and informal care can be a primarily moral policy; reflecting ideas that the family/community are morally irreplaceable.

(e) ***Organisationally-based*** (66). Community care can be about 'better' ways of organising services to meet need. It may be about the development of flexible, local services or client sensitive, family oriented services, or concerned with client participation, prevention, co-ordination of care, continuity of care, 'normal' forms of care.

Each of these five broad rationales for community care can be manipulated and emphasised to suit professional, political or organisational concerns simultaneously because they involve relative concepts such as individual freedom, economy, social justice, organisational efficiency which can be broadly interpreted.

5. HOW care?

Community care policies as applied locally, will reflect any/all of the above four perspectives. Thus, local strategies of community care can be complex or simple, conflicting or harmonious, positive or negative.

The concept of community care - Policy substructure

The interpretation of community care may be based on its primary or operational meanings - the superstructure of community care policy. In addition, there are at least four ways in which the concept of community care can be explored in more detail;

1. as values or principles;
2. as philosophies - a structured set of values comprising theories of need;
3. as objectives or goals;
4. as outcomes - what happens in practice, whether intended or not.

Again these parameters are not mutually exclusive or exhaustive; neither will they all necessarily apply to each community care policy. Community care may be generated on the basis of a set of values, formulated in an explicit philosophy, implemented through a strategy, and may have explicit objectives. Yet official community care policy has been rarely, if ever, explicitly specified in such detail. Indeed, policy analysis literature elsewhere indicates that policy solutions may not bear a direct relationship to the problems or rationales associated with them (67) as the diagrams below illustrate. Just as operational meanings associated with community care may not be consistent with each other, so the same applies to concepts. Thus, whilst MacIntyre suggests that community care from the 1950's was a policy which reconciled humanitarian and organisational perspectives (68), these perspectives are likely to be in part incompatible in terms of their implicit values and objectives. Complicating this inter-play of concepts and meanings, community care may be constructed as any combination of emphasis of values or objectives, philosophies or strategies; it might be defined first and foremost in terms of objectives, from which strategies or philosophies are developed or, as a strategy without explicit values or objectives. Lastly, as the history of community care shows, community care policies may be pursued as means to other ends, ends with unspecified means, or a set of values with neither means nor ends. Diagram 6 below

illustrate some of the ways in which community care policies can be constructed. Following these, the analysis of values, philosophies, objectives and outcomes continues.

Diagram 6: <u>Illustrations of possible constructions of community care policies</u>

A. Strategy; normalisation and de-institutionalisation

⇓

Values; emphasise client choice, rights, risk etc

⇓

Philosophy; old people have the same status/rights as other people

⇓

Goals; old people are more happy, healthy & independent

; old people integrated into the 'normal' community

B. Philosophy; importance of family/community as caring sources

⇓

Values; emphasis on moral obligations of family and mutual aid

⇓

Strategies; enabling/residual role of statutory carers

; encouragement of voluntary services

; support of informal carers

⇓

Goals; old people are happier since remain in family/community

⇓

Outcome; a cheaper way of caring & adhering to above philosophy

C. Philosophy; services should be matched to old people not vice versa

; 'consumerism' should govern service delivery

⇓

Strategies; increase range of services and thus choice

; improve service co-ordination, joint planning

⇓

Goals; improved service delivery

; improved continuity of care

; less disorientation/manipulation of old people

⇓

Outcome; more demand for statutory health, housing & social care

D. Goals; minimal use of long-term hospital beds
; use residential resources appropriately
; use resources cost-effectively

⇓

Strategies; encourage early discharge, after-care, 'active' treatment
; encourage out-patient treatment, use of day hospitals
; encourage preventative and rehabilitative services
; encourage continuity of care

⇓

Philosophy/Values; old people prefer to live outside hospital
; old people only need short-term hospital care
; hospital care creates pathology

Values and principles

Some prime values of community care are listed in the three columns below - these columns relate to the five rationales identified on pp42-43, 'Organisational' values draw on from need-based, organisationally-based and resource-based rationales, Humanitarian values draw on right-based rationales, Political ideology draws on moral rationales, Scrutiny of Table 7 shows that community care values may also be compatible or incompatible, simple or complex;

Table 7: Comparison of Organisational, Humanitarian and Political values of community care

Organisational values	Humanitarian values	Political values
To pursue:	To pursue:	To pursue:
decentralisation & local autonomy; service flexibility; service co-ordination; multi-disciplinary & joint working; economy & resource constraints; cost-effectiveness & resource control; prevention of need; democratic decision-making; organisational responsiveness,	individual independence; dignity; self-worth; privacy; rights; choice; individual participation in own welfare; personal happiness and healthiness; the ability to engage in 'normal' life-styles,	self-help and individualism; self-help and small-scale collectivism; self-help and large-scale collectivism; pure collectivism; social integration; individual freedom/freedom from state intervention; organisational, professional and administrative efficiency,

Philosophies of community care

The primary meanings of community care illustrate the sense in which community care can be a positive, negative or neutral philosophy. Need-based, resource-based, organisational-based, moral-based and rights-based rationales are detailed above (pp42-43). In real terms, these broad policy rationales are expressed in other philosophical forms. One example of this is illustrated here - the philosophy of home-based care. Tinker pointed out in 1984 that 'A consistent theme of official statements has been the desirability of elderly people remaining in their own homes' (69). This principle has been re-established throughout the period since 1800 (70) and is reflected in the motivation to humanise institutions, and build near-normal but 'special' housing accommodation for the elderly. Some reasons why home-based care is advocated are given below;

- it is an economically cheaper form of making provision for needs (71);
- it is a small, personal, individualistic care setting;
- it is the place people choose to live;
- it emphasises social interaction with the family and neighbourhood (72);
- it allows for individual expression, privacy, choice of lifestyle;
- it is associated with individual happiness and healthiness (73).

Some of these justifications for home-based care can amount to philosophies in their own right - for example, the philosophies of social integration (74), normalisation (75) and individualism. In addition, some values like those of independence and choice whilst supporting the right to home-based care also support the right to other forms of care (76). The last point lends itself to the all encompassing notion of community care as 'appropriate' care rather than merely as home-based care. Yet of all the philosophies related to community care this is the most vague. Community care may be appropriate in a number of senses;

- in the quantity, quality or range of services offered (77);
- in its administration; continuity, integration and flexibility of services (78);
- in its focus; consumer oriented, direct/indirect care services;
- in effect; on outcomes on health/happiness;
- in that it is allocated by the recipient, the family or the professional(s);
- in that it draws upon the skills and resources of formal/informal care;
- in that it is cheaper, cost-effective or by some criteria more efficient;
- in that it is preventative; minimising future calls on other resources;
- in that it accords with particular models of care;
- in that it meets specific needs in specific ways (79);
- in that its 'benefits' outweigh its 'costs' (80).

Appropriate care is a value-free phrase. Some of the interpretations of appropriate care are not. What constitutes appropriate care depends on definitions of priority, relevance and urgency; on value judgements and loyalties. Appropriateness therefore can be related to a number of factors; who decides, what is provided and why, the environment and manner in which services are made available, the perceived costs/benefits of alternative forms of care, the range of alternatives available and the process by which they are allocated, and the objectives of organisations, professionals and individuals (81).

Applying any or all of these aspects of appropriate care may produce different outcomes. For example, services might be deemed appropriate in that they integrate or segregate old people from their families/communities, or alternatively, in that they safeguard the health and security of old people. But, to provide a hospital bed for an old person - because it is deemed appropriate to the maximisation of their health and security - is not appropriate relatve to their integration into the community. Application of philosophies and principles associated with community care can thus produce serious policy ambiguities (82).

Objectives

A 1981 DHSS study of community care listed some community care objectives;

- 'to treat conditions which do not require in-patient services and to select for referral those cases requiring secondary care;
- to facilitate early discharge of acute in-patients;
- to provide back-up for day surgery or out-patient treatment;
- to provide an alternative for some of those people currently cared for long-term in hospital or residential care;
- to enable an individual to remain in his own home wherever possible rather have him cared for long-term in a hospital or residential home;
- to give support and/or relief to informal carers,,,so that they can cope with the stress of caring for a dependent person;
- the delivery of appropriate help, by the means which cause the least possible disruption to ordinary living, in order to relieve an individual, family or neighbourhood of the stress and strains,,,of physical or mental health needs;
- to provide the most cost-effective package of services given the needs and wishes of the person being helped;
- to integrate all the resources of a geographical area in order to support the individuals within it' (83).

These 'objectives' could in some cases be viewed as 'strategies'/'philosophies' of community care, depending on the way in which they are used. What they clearly show is the range of assumptions and viewpoints from which community care can be applied to particular needs.

Outcomes

Community care outcomes may affect the individual consumer, the carers or the professions and organisations delivering care. Positive outcomes often associated with community care include the impact on personal health and happiness, family and community cohesiveness, professional and organisational sensitivity and effectiveness. Negative outcomes might be couched in terms of the 'costs' of caring on the carers, the relative neglect of consumers left in the community, the allocation of services which produce discontinuities of care and the variations in local service provision. Yet the attractiveness of community care policy, remains; as a policy it offers positive outcomes to a wide range of people - clients, carers, politicians, civil servants (84). Although clearly what is perceived as 'good' to one group may be perceived as 'bad' by another. Indeed two conflicting outcomes can be perceived as 'good' by separate interest groups (85).

Within the community care literature analysed for this Section, the outcomes of community care policy have been repeatedly criticised particularly since the early 1960's. In part, dissatisfaction with community care policy has resulted from different expectations engendered by the diffuse historical, conceptual and operational meanings of the term. Thus, Walker describes the history of community care as 'one of painfully slow progress towards very limited and misleading goals' (86), and Scull speaks of 'a profound disjuncture between the myth and reality of community care' (87). The literature on community care is peppered with similar disenchantment. Clearly, just as the principal meanings of community care are varied and confusing (88), so is the practice of community care. For example, Clarke suggests that the community has become a 'dustbin' into which 'the disadvantaged citizen is dumped and told to make out as best he can and not to return to be a burden on the State' (89). He goes on to ask whether 'the soft machinery of community care is worse than the coercive control of the institution' (90). Richards writes polemically that 'we have gone far along the convenient path of community care, and ignored for too long its true costs. There is no evidence that old people prefer it. There is no evidence that their neighbours and relatives prefer it. And there is no evidence that it is necessarily cheaper than the alternatives. In fact, the evidence suggests that community care is cheap only because it is inadequate, and because the inadequacies are easy to conceal. There is evidence that imposing an incapable

old person on a household increases the strain and morbidity among the 'carers', and that the inadequacy of services to the elderly seriously disrupts other parts of the NHS' (91).

Summary

This Chapter provides detailed evidence of the conceptual diversity of community care policies. Community care, even in terms of its primary meanings (its superstructure), cannot be described as a single, simple policy. The meanings attributed to community care have changed through time, have varied by client group and have different organisational, professional, social, moral and financial implications - reflected in the complex substructure of community care. Alongside this inherent diversity, community care has been promulgated in official literature in the form of banner goals (92) - statements of a high order of generality which are universally perceived as 'good' (see pp3-4). The association of community care with these banner goals means that;

- community care is best understood as an umbrella term representing a wide range of policies which vary in emphasis;
- community care is capable of multiple interpretations, reflecting these different policy emphases and the values, rationales and objectives associated with them;
- community care is assured of continued support, because it can be interpreted so broadly.

Thus, for example, the professional endorsement of community care banner goals may disguise a less pleasant reality; that this endorsement may only amount only to the support for one particular interpretation of a policy at a given point in time. The less likely alternative is that banner goal support amounts to the endorsement of all community care policies and thier associated values, rationales or objectives; certainly, something not borne out by the historical analysis undertaken in Chapter Two (pp29-31). Accepting this general argument, there would seem to be virtue in identifying the particular meanings of community care being applied in each context and the implications of those meanings. In this way it may be possible to understand why different groups do or do not lend support to any particular community care policy.

Chapter Four continues to examine in more detail community care policies particularly as they have been applied to the needs of elderly people since 1970. The Chapter shows that contemporary community care policies have remained diverse and complex and that the successful implementation of community care has been closely related to the effectiveness of collaboration between agencies providing community care.

CHAPTER FOUR

Contemporary Community Care Policies (1970-1982)

This Chapter, as with Chapters Two and Three, seeks to further illustrate the diverse nature of community care policies as applied to the needs of elderly people. It also shows in some detail how these policies have been promoted as a collaborative strategies; policy success being viewed as dependent upon the effective co-ordination of contributions from several professional groups and their employing organisations as well as with other non-statutory carers. The Chapter is split into three historical sections; 1970-73, 1974-78 and 1979-1982.

Policy Developments (1970-1973): Developing community care partnerships

The main recommendations of the Seebohm Report came into force in 1970 through the creation of local authority social service departments (SSDs). Seebohm gave expression to Bayley's 'pure' notion of care by and with the community (see pp36-37); the Report promoted community involvement and participation embodying 'a wider conception of social service', where statutory, voluntary, neighbourhood and family carers were to work much more closely togther (1). The role of voluntary services and their relationship with statutory services was further examined by the Aves Committee in 1969 (2). This Committee supported the main thrust of the Seebohm Report, expressed in Parliament in 1971; 'We have to accept our responsibilities, and by that we mean not only more public expenditure for care within the community, but more participation by all of us in the community in that care' (3).

Local authority services were expanding and new powers enabling them to provide services specifically for the elderly came into force in 1971 under the 1968 Health Services and Public Health Act. The Act required local authorities to ensure adequate domestic support for elderly people; empowering them to provide home help, social work, warden, laundry, home visiting and housing adaptation services (4). In addition, services for the frail and handicapped elderly were extended under the provisions of the 1968 Chronically Sick and Disabled Persons Act; as the government was later to observe, these two Acts encouraged the trend towards care in the community (5).

The effective growth of health and local authority services demanded more sophisticated collaborative activity. Yet prior to 1970, Glennerster asserts that, for elderly people, 'there was a conspicuous failure to achieve any <u>means</u> for achieving a full range of care across the administrative boundaries at local level' (6). The 1971 Consultative Paper on Reorganisation of the NHS recognised this; 'Services of mutual concern have to be identified and arrangements made between authorities to plan, develop and operate them so that they

satisfy mutual needs' (7). The Working Party on Collaboration, set up to explore some consequences of NHS and local government reorganisation, noted that collaboration between health and social services would need to be firmly established 'if the community is to receive comprehensive care' (8); improving collaboration with the voluntary sector was also important (9). In terms of the statutory services, however, encouraging such collaboration was no simple task - the Working Party noted that the health and local authority services pursued 'separate objectives (either at policy or operational level or both), which do not add up to a coherent strategy for social policy' (10). In addition, in 1972 the DHSS admitted with respect to services for elderly people that there were 'difficulties' in specifying the aims and objectives of such services (11). Yet in the same year the need for closer collaboration was reinforced by the 1972 Local Government Act which consolidated and further expanded community care services.

The 1971 White Paper on Services for the Mentally Handicapped reflected negative views on institutional care and positive sentiments about community care. The document reflected work conducted by Jack Tizard in the 1960's who linked the care provided in large, impersonal institutional settings with a range of negative effects on handicapped children. These effects, he argued, could be ameliorated by provision of small, family-type non-segregated care (12). The White Paper enshrined the principle of normalisation, advocating minimal segregation of the mentally handicapped from the 'general life of the local community' since the care provided by family, neighbours and voluntary groups was 'immensely important' in 'preserving or re-establishing...personal contact with ordinary life' (13). The document endorsed the provision of 'homelike' care, support from 'friends, neighbours and from the community at large' which would 'help the family to maintain a normal social life and...give the handicapped member...as nearly normal a life as his handicap...permit' (14).

As well as suggesting this re-orientation of services, the White Paper emphasised the need for the 'proper co-ordination of professional skills', 'close and effective collaboration' between statutory services and the production of 'co-ordinated plans to which hospital and local authorities will work' (15). With the exception of a less significant role for the voluntary sector (16), the document as a whole reinforced Seebohm's principles but urged the rapid implementation of existing policies (17) rather than the formulation of new policies.

In 1972, a DHSS Memorandum to Area Health Authorities (AHAs), "Services related to Mental Illness in Old Age", clarified the responsibility of hospitals in relation to certain categories of mental illness affecting the elderly; an important issue since long term

hospital beds would be available to a 'smaller proportion' of such groups, The memorandum encouraged increased local authority residential provision, domiciliary and day care and 'experiments' in local health services designed to reduce admissions to, and increase discharges from, hospitals (18),

Overview: policy developments 1970-1973

As in the 1950's and 1960's, despite the encouragement to increase the range of health and welfare services through statute there were wide variations in local services which were often poorly co-ordinated, Attempts were made to remedy this; the DHSS set norms indicating ideal service levels for, amongst others, elderly people, Co-ordination of services became an increasingly important theme in legislation from the early 1970's onwards; collaboration was viewed as one means for ensuring that elderly people in the community received appropriate support from a growing range of service providers, Community care policies were expressed both as a reaction against institutions in general (in the field of mental handicap), and hospitals in particular, (in the fields of mental illness and mental handicap) thus suggesting a shift in resources away from the NHS to the newly created SSDs, As a philosophy, community care policies were expressed through a growing body of humanitarian ideals such as normalisation, individual freedom and choice,

Policy Developments (1974-1978)

Whilst the late 1960's and early 1970's were times of comparative resource and service growth for health and social services authorities, from the mid-1970's onwards the financial climate grew worse, forcing more selective development of services (19), In 1974 reorganisation of local government and NHS services gave separate responsibility for health and welfare services to the AHAs and SSDs respectively, Under the 1973 NHS Reorganisation Act, the need to link these two service providers was acknowledged; a duty was placed on AHAs and SSDs to 'co-operate with one another to secure and advance the health and welfare of the people of England and Wales', The Act also made compulsory the introduction of Joint Consultative Committees - joint health and local authority fora - established to make joint arrangements for collaboration, and to plan services of 'common concern' (20),

In 1975, Barbara Castle, then Secretary of State for Social Services, urged health authorities to "regard co-operation with the local authority as a high priority for without it the concept of community care will become an empty cliche" (21), But as the U,K, economic crisis deepened, the Government embarked on local government expenditure cuts, In this context Mrs Castle remarked that "if we cannot provide services to the community on the scale

we would wish, at least we should do all we can to help the community provide services for itself (and so)...strengthen and support action by the community for the community' (22). However, despite the emphasis on community care, the 1975 White Paper on Services for the Mentally Ill described non-hospital care as 'rare' and 'minimal' (23). Community care policy was dependent on a shift of resources from health to local authorities, and yet as the White Paper stated, statutory services 'no matter how comprehensively they are planned, cannot by themselves provide a complete answer' since the 'general aim of enabling the mentally ill to participate as fully as possible in the life of the community will only be achieved if other members of the community recognise and support it' (24).

At a time when statutory, voluntary and private sector welfare provision was being undermined 'with equal severity' by cutbacks in government expenditure (25) and the capital building programmes placing priority on domiciliary rather than residential care. But as independent sector residential provision dwindled, pressure grew to increase part III accommodation (26) thus making the shift to direct community-based services more difficult. Amidst these pressures, a 1975 report by the Personal Social Services Council (PSSC) reviewing residential care spoke of 'no overall co-ordinated policy in the provision of residential care...lack of co-ordination between the provisions for different groups and between services...a lack of fundamental ordering of priorities...no fundamental philosophy upon which to base provision ...The aims and objectives of particular establishments and their relationship with other services are often unstated if not unknown...with the result that...the expectations of staff and residents are confused or lacking in specific purpose' (27). (At the time, these criticisms could have applied with equal validity to community care policy and services (28)). The document noted how residential care could be pursued from different value bases - economic or social care perspectives which produced 'incompatible' aims (29).

More generally, a 1976 DHSS/Social Work Service report of a joint seminar noted that problems in organising services for the elderly arose from the fact that there was 'no coherent policy for them' (30). For example, the report noted that in terms of day care services, there was 'little consensus' about who should receive them (31) reflected in the fact that there were 'strong divergent' views as to their functions and 'no generally agreed (day care) policies' (32). Thus, across a wide range of services in the field of community care vague, conflicting or non-existent policies were reported.

In March 1976, the consultative document 'Priorities for Health and Personal Social Service' was published. This followed the publication of a public expenditure White Paper (33) which

applied the 'strictest test of priority' to all government spending, scaling down the anticipated growth of local authority spending (34) until 'a sound economic base can be achieved (when) some growth in spending should again be possible' (35). The priorities document attempted this exercise within the health and personal social services. Future service developments were to be a 'co-operative enterprise' (36) between central and local government. The government set national priorities to influence local health and welfare authorities in the context of local needs (37). Co-ordination of local services for elderly people was emphasised. Joint planning structures were to be 'fully used' (38) in conjunction with joint finance. Indeed, without the latter, the priorities document suggested that 'the highly desirable switch from hospital services to community care...will be greatly reduced' (39). Securing this shift in the balance of care was central to the priorities document. More specifically, the document emphasised 'the role of primary care in helping to relieve pressure on hospitals and residential services by caring for more people in the community' (40); community care would reduce demand on hospital and residential services (41). On the other hand, however, community care was also to be pursued as part of a longer-term preventative strategy to keep people out of institutions in the first place (42).

The priorities document promoted the growth of preventative and community-based provision over 'general and acute hospital services'; specifically stating that 'the general aim of policy is to help the elderly maintain an independent life in their own homes as long as possible' (43) to be achieved by 'expansion in all sectors of care' (44) - domiciliary, residential and some forms of hospital care (45), with the voluntary sector having 'a particularly important role' to play (46). In practice, the document admitted that existing provision for the elderly was inadequate. Statutory services were in 'serious need' of improvement; inadequate domiciliary services could cause 'misuse' of hospital beds and place 'unnecessary' demand on part III homes (47). Such shortages of services and their consequent misallocation was likely to pose serious difficulties for the development of joint plans.

The priorities document viewed voluntary sector effort as representing 'better value for money than directly provided services' (48), necessitating their involvement in joint planning. This incentive to develop non-statutory provision led to 'hard judgements' between needs which it was 'essential' for the statutory sector to meet and those which 'individuals and families must themselves be left to cope with' (49). Emphasis on voluntary work and self-help was expressed in the launch of the Good Neighbour Campaign that same year. David Ennals introduced this Campaign as a means to improve community care whilst keeping within public sector budgets. Similarly, he saw it as 'vital' that 'every possible step' was taken to

ensure 'effective co-operation' between health and local authorities (50) - joint finance was to stimulate co-operation envisaged in earlier legislation (51). In 1977, a joint planning Circular HC(77)17/LAC(77)10 enshrined such ideas, referring to effective joint planning as 'vital to the government's overall strategy of developing community-based services so that wherever possible people are kept out of hospital and other institutions and supported in the community...Only by collaborative planning in partnership can health and local authorities devise and implement effective and complementary patterns of services' (52).

Also in 1977, the Secretary of State produced a background paper for a conference on the care of the elderly which reaffirmed the primary objective of government policy for the care of the elderly as being 'to enable old people to maintain independent lives in the community for as long as possible' (53). Pursuing this objective, he argued, had implications for a very broad spectrum of services (54) which needed to be 'as sensitive as possible to individual need' and which should 'include hospital, residential and community care' (55). The emphasis on voluntary sector input, and collaboration, was even more pronounced than in the 1976 priorities document; 'voluntary effort was 'vital' to the care of elderly people and it was asserted that voluntary organisations should not be considered as junior partners or as a cheap alternative to the statutory services but as a crucial element in a developing partnership' (56). In general terms, the background paper signalled a movement away from residential care in favour of domiciliary services and sheltered housing (57) together with the development of the 'most economic and effective pattern of hospital provision' (58). There was, however, considerable uncertainty expressed about the role, and future development of, certain forms of care. For example, increasing demands made on domiciliary services would require 'a more informed judgement to be made on the levels of dependency and the circumstances in which domiciliary care provides an economic, feasible and acceptable alternative to long-term care in hospital or residential home' (59).

A new priorities document, 'The Way Forward', was published in 1977, repeating the prime objective to constrain public expenditure (60), and restating national priorities which, as before, were to guide local planning (61). Emphasis was placed on encouraging greater personal responsibility for health (62); self-help being part of a continuing commitment to community care which embraced 'a whole range of provision, including community hospitals, hostels, day hospitals, residential homes, day centres and domiciliary support... (and) health care...whether provided by health authorities, local authorities, independent contractors, voluntary bodies, community self-help or family and friends' (63).

'The Way Forward' emphasised the development of fieldwork and domiciliary services rather than residential care, although residential care would 'continue to consume a high proportion of resources' (64). Beyond this, the kind of services promoted in 1977 remained much the same as in 1976, except for a change of emphasis within the health services (65). Voluntary services were to develop (66) alongside domiciliary and residential services, in the context of improved joint working (67). However, it was acknowledged that the shift to community care would be 'gradual and slow' (68) - more of a long term goal than a short term reality because of financial stringencies. For example, one outcome of this financial context was that the development of community hospitals was 'likely to be slower than originally hoped' (69).

In 1978 the PSSC/Central Health Services document 'Collaboration in Community Care' was published. It too emphasised that community care depended on 'co-ordination and collaboration among various individuals, organisations and professional groups' (70). This publication cited the necessity of collaboration between a much broader range of agencies - housing, education, environmental health, employment, training services, police and the then Supplementary Benefits Commission - as a 'prerequisite for community care' (71), repeating the thinking of the earlier Seebohm Report. The report described community care as more than a simple movement away from institutional care. It was 'a philosophy in which the starting point of the service is the patient/client and his needs rather than administrative boundaries and needs of organisations' (72). In practice, however, it was noted 'there is often a lack of contact between health and social services' (73) due to 'certain fundamental organisational differences' which were thought to 'impede if not prevent collaboration' (74). Because client needs did not 'conveniently stay within departmental boundaries' collaboration was vital. The financial climate exacerbated this situation; economies in one service would 'seriously affect others' (75), a situation aggravated by differences in organisational structures, planning styles, priorities, professional values and models (76).

In another 1978 PSSC document, this time on residential care policy, the elderly mentally infirm were identified as a group who had particularly suffered due to the poor range, level, quality and co-ordination of services (77). The document discussed the development of alternatives to residential care but admitted that pursuing such developments would be difficult in practice because of 'insufficient communication and co-ordination' between intra- and inter-agency services which caused parts of the 'care system' to 'operate in isolation from each other'. In particular, the document spoke of a 'failure to define the roles and inter-relationships of various forms of care, such as domiciliary services, sheltered housing, residential and hospital care' (78).

To gauge the strength of feeling about contemporary and future policy issues affecting elderly people, the DHSS published a discussion document in 1978; 'A Happier Old Age'. Responses to the document were expected to influence a forthcoming White Paper on services for the elderly planned for the following year. In the foreword to the document, David Ennals, Secretary of State, outlined three aims which were to inform government policy;

1. To ensure that retirement does not mean poverty;
2. To keep old people active and independent in their own homes; to enable them to return to home as soon as possible after admission to hospital;
3. To allow old people to make their own decisions about their own lives by giving them the fullest possible choice and a major say in decisions that affect them - aiming to meet dependency in ways which maximise the use and enjoyment of individual powers, no matter how limited they are (79).

Ennals proposed that future demand from elderly people could be borne by the community; 'Although family links are irreplaceable we cannot assume that the family can carry the whole responsibility for caring for growing numbers of very old people. We may therefore need to look increasingly to the wider community to give more support of the kind traditionally expected of the family...the aim is to encourage community involvement' (80). Thus, 'volunteers and other informal support' could play a 'major part' in meeting practical and personal needs of the elderly (81). Overall, effective care for elderly people depended on 'the extent to which people worked together' (82), and on joint working with the voluntary sector (83). The document emphasised active treatment and rehabilitation of elderly people and a continued commitment to community care (84), but made the depressing admission that the continued development of community care services 'may not be practical' while 'the numbers of very frail elderly are increasing' (85). The implication was that the community would have to make up any deficit in statutory community care services.

A 1978 DHSS publication, 'Social Care Research', repeated much of this thinking. The DHSS described community care as 'a portamanteau phrase for a complex and varied concept...a convenient way of summarising developments that have taken place in a number of different fields and have important common themes' (86). For the mentally ill, the DHSS stated that community care involved health and social services, the family, voluntary bodies and 'the whole community itself...active participation from the community as a whole will be necessary if the concept of community care is to be fully realised' (87). For the elderly, desired service developments (88) and banner goals were repeated; Departmental policy was 'to enable old people to maintain independent lives in the community for as long as possible' (89).

Overview: policy 1974-1978

This period was dominated by concerns about the national economy, in the worst economic crisis since the war. The government tried to reconcile social priorities with the need to restrict the growth in public expenditure. Broadly speaking the outcome was;

(i) the shift to community care was maintained by shifting the burden of care further away from the state to the family and the wider community, increasing the need for effective co-ordination despite evidence of barriers to that co-ordination;

(ii) the emphasis on collaboration was maintained, expressed through the encouragement of joint planning, which together with joint finance, was to ensure the efficient use of public sector services in general and de-hospitalisation in particular;

(iii) the development of statutory 'community care' services - primary health care, domiciliary and residential services, 'community' and day hospitals - was slow, characterised by the sporadic development of local services and a lack of clarity as to the core roles of key local services;

(iv) growing emphasis was placed on the statutory provision of domiciliary rather than residential or hospital care;

(v) the emphasis on setting norms to standardise local service provision disappeared - services were to be planned in the light of government priorities/guidelines and local needs - a prescription for increasing local service variations;

(vi) the frequent emphasis on community care banner goals in government documents; yet the community care policies pursued in this period reflected, at different times, all three primary forms of community care identified in Chapter Three.

Policy Developments: 1979-1982: Developing alternatives to statutory care

The newly elected Conservative government came to office in May 1979 pledged to reduce inflation; and as a result pursued stringent public expenditure cuts. The government sought to broaden its service base; privatisation, voluntarism, informal care and self-help were vigorously promoted as appropriate substitutes (rather than supplements) to the statutory caring services. In its manifesto, the Conservative Party stated that 'we must do more to help people to help themselves, and families to look after their own. We must encourage the voluntary movement and self-help groups working in partnership with the statutory authorities' (90). Patrick Jenkin, Secretary of State for Social Services, referred to the governments' first priority as being to restore the nations' economic health, upon which the improvement of state services 'entirely depends'. To make optimum use of state services, Jenkin advocated working with the voluntary bodies 'and all sorts of community groups', thus seeking to destroy the myth that 'as state services grow,,,the community can safely entrust

their cares and concerns for the elderly, the handicapped and others in need, to Townhall and Whitehall and need not themselves bother over much'. In stark contrast to Castle in 1975 (91), Jenkin reinforced personal responsibility for the needy: 'it is through our families, through our neighbourhoods, through the voluntary bodies in all their manifestations that we can best express that responsibility...it does seem to me very important that we should put the responsibility back where it firmly belongs - into the communities in which elderly people live...the statutory agencies have...an important role as a back-up to this informal and formal voluntary effort...The primary responsibility rests on the community; the statutory services are there to provide a framework, a back-up and special help in particular circumstances. It really is not and can never be the other way round' (92). The new government thus promoted non-statutory care on both moral and economic grounds. Indeed, three months earlier Jenkins spoke of the 'squeeze' on local authorities enabling them to legitimately pursue 'lower cost alternatives' to care (93).

The Royal Commission on the NHS, reporting in 1979, recognised 'the present policy of the health departments is that wherever possible, care should be provided in the community rather than in institutions' (94). The rationales given by the Commission for supporting community care policy were that it was:

(i) preferred by patients;

(ii) a means to relieve pressure on hospital services, and;

(iii) a potentially cheaper solution.

In practice, it was realised that community care was 'especially dependent on co-operation between health and personal social services...(the) two separate authorities must be prepared to work together...If the necessary change in emphasis (to community care) is to be achieved' (95). The Commission noted that services were not developing sufficiently quick to meet the 'immense burden' of the growing elderly population on health and local authorities - 'inevitably', the Commission reported, 'the community as a whole will have to share the responsibility and cost of caring for the elderly at home' (96). But progress in implementing community care would 'be slow...unless additional resources are made available', despite the fact that 'the emphasis is on community care' and that 'everything possible should be done to assist old people to remain independent, healthy and in their own homes' (97). In this context, there was some doubt as to whether this latter goal could be achieved (98).

In 1981, the government published a new priorities document, 'Care in Action'. Introducing the document, Patrick Jenkin spoke of health authorities having greater freedom to plan services than in the past; 'local initiatives, local decisions, and local responsibility are

what we want to encourage' (99), reflecting government emphasis on de-centralisation (100). The document defined four priority groups and three priority services (101) as needing improvement. It added that 'further progress cannot be rapid and will depend mainly on skilful use of innovative approaches, including greater use of what the voluntary and private sectors can contribute' (102). The voluntary sector was able to 'complement, enhance and extend the statutory contribution' (103); mutual support between the statutory and voluntary sectors was welcomed (104), as was more effective co-ordination between them (105). A separate chapter was devoted to promoting links with the private sector, perceived as a key future provider of health care.

Whilst increasing the range of service providers, the handbook emphasised community care - 'a major policy objective for many years' - the aim of which was stated as to 'maintain a person's link with family and friends and normal life, and to offer the support which meets his or her particular needs' (106). For the elderly, the emphasis was on care by the 'community'; 'The whole community should be involved in providing adequate support and care for elderly people. Public authorities will not command the resources to deal with it alone' (107). Statutory authorities were to 'strengthen the primary and community care services' and together with neighbourhood and voluntary support would enable elderly people to live at home (108). As before, domiciliary services were 'to enable elderly people to return to the community from hospital where possible' (109). But pressure on personal social services meant that 'development of preventative work, particularly through supporting and stimulating caring networks in the community, has been slower than hoped for' (110).

Care in Action was supported by the publication of three special study documents (111). One of these studies examined community care and explored the role of self-help, the voluntary sector and private sector and their relationships with the statutory services. This was in the context of

(i) 'some uncertainty about the general policy objectives underlying the concept of community care' (112);

(ii) uncertainty as to whether, in the light of resource constraints, a shift away from long-term institutional care was 'realistic' (113);

(iii) concern about progress in implementing such policies (114);

(iv) the need to explore the relationship between private, voluntary and statutory sectors and the family in providing community care;

(v) 'continuing concern over the cost-effectiveness of community-based,,,care as opposed to long term hospital or residential care' (115).

The implications of these concerns were that growing numbers of mentally and physically frail elderly people were not being cared for in the community (116); in a context where the growth of community based provisions was 'slower than envisaged' (117). By the end of the 1980's it was anticipated that;

1. geriatric in-patient beds would only reach 80% of their target level;
2. the number of residential places for the elderly (amongst others) would fall 'considerably short of what is desirable';
3. home helps and meals on wheels 'may not keep pace with the growing numbers of very elderly people' (118).

In the context of this somewhat depressing scenario, the report reinforced familiar collaborative ideals and identified the 'essential' role of the family, friends and neighbours and voluntary organisations (120); 'the option of home based care is often only available where voluntary and informal effort provides the major contribution to caring for people' (121). The report supported community care policy which would provide 'for people's needs in a flexible way which maintains links with ordinary life, family and friends, wherever possible, and offers greater choice' (122). However, the choice to remain at home was qualified by reference to the individual's frailty, and the wishes of, and burdens on, carers (123). The report also suggested that not all the objectives of community care could be met 'given current and forseeable resource constraints' (124).

In 1981 the government published a consultative document 'Care in the Community' (125) which started from the premise that community care 'is what most of (the patients) want for themselves and what those responsible for their care believe to be the best' (126), and argued that 'there are many people in hospital who would not need to be there if appropriate community services were available' (127). The document listed legal, administrative and financial 'obstacles' to transferring the burden of care from health to local authorities (128), suggesting that discharging patients would 'require positive collaboration between health and local authorities' and would depend 'on making better use of what is already available, including the,,,voluntary and private sectors' (129). Thus, the document explained the failure to achieve community care banner goals in terms of broad structural issues.

Later in 1981 the government finally published its White Paper 'Growing Older' on services for elderly people. In the introduction, Patrick Jenkin stated that 'The White Paper recognises that the primary sources of support and care are informal and voluntary,,,It sees the role of the public authorities as being primarily to sustain and develop such support and

care, and concludes that only an informed effort by the whole community will ensure that the challenges and opportunities presented by the growing numbers of older people are adequately met' (130). Glennerster remarked cynically that 'The document contained not a single new policy proposal, target for provision, nor even administrative incentive to encourage good practice...It was difficult to avoid the conclusion that the government...did not want to publish anything because of the possible spending consequences and did the next best thing - they published a document with no contents' (131).

In the foreword to the White Paper it was clear that improved services for the elderly were entirely dependent on the successful containment of inflation and the increase of economic prosperity. Hence the need to call on human resources and good will, by encouraging 'irreplaceable' voluntary effort and informal care (132). The public authorities' role was repeated as 'an enabling one' (133); to sustain and develop not replace non-statutory support (134). This was justified on moral grounds (135). The primary function of the State was 'helping people to care for themselves and their families by providing a framework of support'. Professional skills were for 'care and treatment not otherwise available' (136). If family care was not available, elderly people 'should look for support to friends, neighbours and the wider community' (137). The White Paper continually referred to the contribution 'everyone' could make to caring for the elderly; it was right for the 'whole community' and 'the whole of society' to be involved (138). Thus, statutory services were to develop a partnership with evolving informal care networks; the needs of 'increasing numbers of elderly people simply cannot be met wholly - or even predominantly - by public authorities or public finance. This will be a task for the whole community, demanding the closest partnership between public and voluntary bodies, families and individuals' (139). The emphasis of the White Paper was summed up in the oft-quoted phrase in which the government enshrined what was to be the guiding light of its future social policy for the elderly; 'Care in the community must increasingly mean care by the community' (140).

The White Paper encouraged self-help, mutual aid and reinforced the notion of the residual role of statutory services (141). The overall aim was 'to enable elderly people to live independent lives in their own homes wherever possible - which reflects what the majority themselves want' (142). Community services played a 'vital role' in achieving this aim and 'in preventing or deferring the need for long term care in a residential home or hospital'. Community services were 'very important' in supporting families of elderly people'; 'The aim is to provide the care best suited to the needs of the individual, in the most effective and economical way possible. Collaboration between services is thus an essential feature' (143).

Overview: Policy developments 1979-1982

This period was shaped by the economic doctrines of a new Conservative government intent on restoring national prosperity partly through control of public expenditure. As a result, the expected growth of statutory community care provision was limited and slow despite the continued emphasis of community care banner goals. The solution to this disparity between policy intention and financial stringency was to encourage the search for alternative care providers. Indeed, public expenditure constraints were to some extent used by government as a lever to place emphasis on other community care providers; the voluntary sector, the family, the community and the private sector. The movement towards a 'mixed economy' of welfare was consistent with wider government objectives; to preserve the rightful place of informal care; to emphasise the enabling role of the State (to underpin and encourage personal or community responsibility for such care, rather than replace it); and to tap into the enterprise and resources of the private sector. Both intra and inter-agency collaboration were advocated to achieve cost-effective community care - particularly collaboration with non-statutory carers - and thereby as a means, in the words of the Minister of Health, to pursue the 'perfectly worthwhile and desirable social aim' (144) of reducing local government spending. Yet, in moving towards a broader range of care providers co-ordination became a more complex and organisationally demanding task. Moreover, the tendency to develop services in the light of local priorities and needs (reflecting the government emphasis on the devolution of power), encouraged a broader range of community care services at local level; and thus a liberal interpretation of what community care, in practice, should look like at local level.

From economic and ideological perspectives, community care was pursued in three ways - as,

i) a low cost alternative to hospital and residential care;

ii) a means to shift responsibility within the statutory sector from NHS to local authority services;

iii) a means of transferring the burden of care from the State to the family, the community, the voluntary and private sectors.

In terms of the last of these three, community care - represented as 'care by the community' - was viewed both negatively (perceived as a means of providing care cheaply) and positively (perceived as as a policy to provide support more cheaply but more appropriately through those with the natural obligation to care in 'normal' home settings).

Community care definitions adopted in government documents were again expressed in general terms, although revealing assumptions about the role of the state and the 'community' as care providers giving some clear preferences as to the location of care (outside residential

establishments, especially hospitals), and emphasising how care could be provided by developing partnership arrangements. Despite the intention to develop community care, economic constraints, professional and organisational barriers to community care to collaboration led to the slow and limited growth of formal statutory care services. The 1981 DHSS study on community care and the 1981 "care in the community" document clearly raised fundamental issues relating to the financial and organisational barriers to developing community care services; thereby explaining the disparity between the continued emphasis on community care banner goals and the realisation of those goals.

Overview of Section I

This Section has reviewed community care policies over a period of 170 years, to examine the historical and conceptual diversity of this policy movement. In focusing primarily on official literature, a number of the original assumptions made in connection with this policy (pl) have been revised. Namely that community care is,

- not simply a post-second world war policy movement; whilst community care *in name* has largely been pursued explicitly by governments in this post-war period, policy themes recognisable as similar *in nature* to contemporary community care policies have existed a long time prior to this (noting that the phrase "community care" was probably first officially used in relation to the care of the mentally subnormal in the 1929 Wood Report - see page 17). Furthermore, community care cannot be reduced to anti-institutionalism;
- officially - and explicitly - described in general terms as banner goal statements of intent which can be broadly interpreted and are commonly perceived as 'good';
- essentially diverse in nature rather than a simple, easily defined or coherent policy. As a result, community care is best understood as an umbrella term representing a range of policies and policy themes which in turn reflect many rationales, values or objectives (any of which may be implicit in banner goal statements), but which are not necessarily related or congruent;
- officially regarded as dependent upon collaboration as a means to the effective implementation of community care, particularly since the 1950's;
- potentially vulnerable not merely because of resource constraints but also because of the acknowledged barriers to collaboration.

Addendum: Key issues in community care, 1983-1989

So great has been the interest shown in community care by the government since 1982 that very brief mention is made here of very recent policy issues and developments since they reaffirm

the emphasis placed on the pursuit of community care banner goals, and the existence of profound barriers to the achievement of such goals and to collaboration in general.

The first document to note is the 1984 Report of the Social Services Committee on Community Care. This Committee Report made, in terms of this Thesis, some very interesting comments on the meaning of community care, stating that 'the phrase "community care" means little in itself. It is,,,used by some descriptively and others prescriptively,,,It has in fact come to have such general reference as to be virtually meaningless. It has become a slogan, with all the weaknesses that that implies,,,The stage has now been reached where the rhetoric of community care has to be matched by action,,,Beyond the general recognition that the days of the large hospitals are over there is no consensus on community care. None of those who submitted evidence to us were opposed to the principles of community care; but we heard a chorus of deeply-felt anxieties, protests and fears,,,The caring professions have also made it clear that, while broadly behind the general thrust of community care, its implementation to date is not satisfactory' (145). The many ways in which the term community care had been used in evidence led the Committee to contemplate abandoning the term altogether (146). However, seeing this as impractical, the Committee sought to eliminate confusion by defining the basic principle underlying community care as 'Appropriate care,,,provided for individuals in such a way as to enable them to lead as normal an existence as possible given their particular disabilities and to minimise disruption of life within their community' (147).

This Report was eclipsed by the subsequent report 'Making a Reality of Community Care' published by the Audit Commission (148). In the summary of this Report the Commission noted 'slow and uneven progress and services out of balance in many areas'. For elderly people, 'In spite of the community care policy initiative, there has been virtually no change in the balance between residential care overall and domiciliary and day care'. The summary Report identified fundamental barriers which combined 'to make it extraordinarily difficult to arrange the transition (to) community care'. In this context, the Report anticipated 'a continued waste of scarce resources,,,If nothing changes, the outlook is bleak,,,unless radical changes are made, community care will remain far from a reality for many of the very people it is intended to help' (149).

With growing evidence of significant barriers to the development of an effective community care service, and in direct response to the Audit Commission Report, the Government commissioned a further study of community care by Sir Roy Griffiths. His subsequent Report represented an 'agenda for action' (150) to make community care policies more of a reality.

The Report was published in February 1988, The governments' response to it did not come until a press statement in July 1989 (151), This promised action in the form of a White Paper in November 1989 - "Caring for People" - which adopted many, but not all of the proposals made in the earlier Griffiths Report (152), This White Paper on community care services, in a similar way to the introduction of the Hospital and Health and Welfare Plans in the early 1960's, will be implemented alongside far reaching reforms of the Health Service embodied in the Governments' NHS White Paper 'Working for Patients' (153) - published in January 1989, Both these White Papers introduced a new set of incentives, controls and divisions of responsibility into the public sector; the separation of purchasers and providers of service; the purchasing of care through contracual arrangements; the devolution of power, budgets and decision-making; the explicit assessment and specification of population needs as a precursor to purchasing care; competition amongst providers of care through internal markets and the wider 'mixed economy'; monitoring of services against agreed benchmarks related to quality standards and consumer views, "Caring for People" itself put the future of traditional joint planning and joint finance arrangements in doubt given their limited success and questionable relevance to the new era of planning in the 1990's (154), But although an explicit aim of this recent legislation has been to make agencies more accountable for community care by clarifying their responsibilities in this field, the need for collaborative planning remains, although the mechanisms by which it will take place are unclear given the new market of health care involving providers and purchasers of care,

Summary and Introduction to Section II

Throughout the 1970's and into the 1980's, community care has been increasingly regarded as within the purview of health, housing and social service authorities, the independent (private and voluntary) sector, the family and the wider community of friends and neighbours, Representing the statutory services are an array of community care practitioners; each with their own priorities, values systems, models of care and roles, Collaboration has been viewed as an increasingly important means to achieving the delivery of locally responsive, flexible and integrated community care services in response to the growing range of community carers, Yet as encouragement has been given to increasing the providers of community care its organisation has become more complex and the task of collaboration made more difficult particularly given the growing evidence since the 1970's of major barriers to collaboration,

However, community care policies have not merely become organisationally complex; they are also conceptually diverse (see Chapter Three); the expression of community care in terms of banner goals has encouraged a multiplicity of interpretations of community care, Yet despite

this complexity and diversity the literature in this first Section indicates that broad support for community care banner goals has remained robust. On the face of it, this would seem remarkable given the growing recognition of barriers to community care service developments in general and collaboration in particular.

Three possible explanations for this continuing support are suggested; first, that community care policies have retained their political and professional popularity because they are expressed as banner goals which by virtue of their generality will generate widespread support. For example, if a community care policy enshrines the right of elderly people to remain in their own homes, community care professionals will support this policy, not because of a common understanding of its meaning and implications, but because it is perceived as inherently good. This support may evaporate at operational level given the different professional interpretations of when, how and why people should enjoy this right. Thus, so long as the operational implications of community care banner goals are not specified - the policy remains broadly supportable across interest groups (see p50) which in turn implies that the collaboration necessary to implement this policy can be realised. Second, it may be that community care policies have remained robust, irrespective of any agreements as to what they actually mean because in practice collaboration is not essential to delivering community care. Thus, although local practitioners may disagree about how to apply community care policies, this may not matter because community care can be satisfactorily implemented by community care providers operating in relative isolation. Third, collaboration may be achieved irrespective of whether professionals agree on the basis on which to collaborate! Thus, consensus may be unimportant to collaboration compared to other considerations which provide the incentives to engage in collaborative community care activity despite any disagreement on key policy issues.

Section II begins to explore the relationship between the complexity and diversity of community care, inter-professional consensus and collaboration; mapping in more detail the different perceptions of some community care practitioners on some specific issues associated with the policies and practice of community care. Thus, some appreciation may be gained for the extent to which these groups have similar understandings of, and approaches to, key issues relating to the provision of community care for elderly people. This in turn, may give some indication of how easy or difficult inter-professional collaboration is likely to be in this particular policy arena.

SECTION II

CHAPTER FIVE

Professional Perceptions of Community Care through Time: 1961-64, 1971-74 and 1976-82

Introduction

Chapter Four indicates that 'official' community care policies for elderly people have, particularly recently, been expressed as banner goals and pursued as collaborative strategies despite their complexity and diversity. This Section - Chapters Five and Six - explores the extent to which statutory community carers from separate agencies have congruent perceptions of the meanings and implications of community care policies, given that they are expected to collaborate to implement them. Perceptions are compared firstly on the basis of an analysis of professional journals, and secondly (in Chapter Six) on the basis of an analysis of responses made to the 1978 document 'A Happier Old Age'.

A number of journals are reviewed in this Chapter; two principal journals for four groups - representing the interests of medical, nursing, housing and social work practitioners. Each journal chosen was analysed over one periods 1961-1963, 1971-1974 and 1976-1982. These periods were chosen because of their different policy and resource backgrounds (see Chapter One and Appendix). The contents of each main journal were reviewed under three headings;

a) community care policy in general and as applied to elderly people;

b) the general care of elderly people, and,

c) collaboration between carers of elderly people.

These selection criteria yielded over 1200 articles (excluding editorials, letters and other reports). All these articles were analysed and the perceptions of individual groups on similar issues within the same time period were compared. By no means all of the material analysed and categorised can be presented here. Instead, three issues have been selected to illustrate professional responses to specific aspects of community care policy for elderly people. These issues were; general support for, and views of community care and elderly people; the organisation and delivery of community care; the care of a marginal group - the

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Footnote: *the referencing system used in this Chapter is unique to the Thesis. References are made in a way to facilitate a ready appreciation of the source - by professional journal - of comments or views expressed. So it is possible to distinguish the source of perceptions held as the Chapter develops, rather than forcing the reader to refer continually to the Appendix just to determine which professional journal made a given point. Thus, references followed by 'S', 'H', 'M' and 'N' refer respectively to social work, housing, medical and nursing journals. A 'G' prefix refers to a general reference outside of the journals.*

elderly mentally infirm. This last issue was a means of examining how community care as a policy and concept was applied to the needs of a marginalised group.

The journal contents analysed represented spontaneous responses to a range of issues at particular times and thus contrast with, and create a context for, responses to 'A Happier Old Age' in Chapter Six which provides a snapshot of perceptions on pre-selected questions formally raised by this government.

Community Care (1961-1963)

Of the three time periods covered in this Chapter, this period yielded fewest journal contents for analysis. This is perhaps not surprising given the early development of community care policies. About 50 separate journal sources are directly referred to in this section of the Chapter. The majority are from medical and social work journals, with a small number (about one-fifth) from housing and nursing journals. The key government policy documents published in this time which gave expression to community care policies were the 1962 Hospital Plan and the 1963 'Health and Welfare Plan' both referred to in Chapter Two.

(A) General Support for, and Views of, Community Care and Elderly People

Four articles expressed general support for community care - in the nursing, housing and social work journals - although for different reasons. One article stated that 'elderly people are happiest in their own homes (1N); another remarked that community care policy was 'both humanitarian,,,and,,,the most economical way of giving help' (2H); and two social work articles stated, respectively, that community care was simply 'more humane', since 'one of the worst things you can do to patients is to institutionalise them' (3S). These views reflect some of the rationales for developing community care identified in Section I.

The medical journals expressed no positive support for community care. On the contrary, these journals voiced considerable concern about the practicality and desirability of community care services which were 'still in their infancy' (4MN), under-resourced (5MS) and which 'barely give a service' (6M). This lack of provision was attributed to the difficulty in shifting resources from hospital care to local authority domiciliary care as envisaged in the Hospital and Health and Welfare Plans (7M). Given this pattern of resource allocation it was hardly surprising that one commentator stated that in respect of community care 'Criticisms are more reportable than acolades' (8M). In similar vein, three social work commentators referred to community care as 'a distant goal', a policy with unclear implications, and one which was superficially practiced (9S).

Some criticism and scepticism associated with community care was targetted at specific applications as a social work article stated, this policy 'has different meanings to different people' (10S). For example, several articles commented on the implications of this policy on the different providers of care; the state, the family or the wider community. Thus, several social work articles described this policy movement as, respectively, 'finally dependent on the family', involving 'active community participation'; indeed, 'community care could not flourish if individual members of the community did not actively care' (11S). This latter expectation would, one author remarked, produce the 'transfer of defenceless souls from skilled care to less skilled care - or no care at all'; fostering 'unsupported family care' (12S). The acceptability of this possible outcome was questioned in both a housing and a medical article (13HM). Moreover, within the social work journals there was some disagreement about social workers focussing their efforts on facilitating care by the community rather than providing direct statutory support (14S).

Several medical articles suggested that under-funded health care for old people was at least partly related to doctor's negative attitudes to elderly patients; 'we cannot directly treat much of what we see in older patients,,,(thus) there is an obvious danger of thinking that there is little to be done' (15M). This type of prejudicial view was encouraged by clinical judgements of 'success'; defined in terms of achieving short-term cures using acute, high technology medicine (16M). In keeping with this medical model of need was the 'progressive patient care' model which relied on the classification of patients according to their medical and nursing need - as these needs changed, so the patient should be moved so as to 'place the right people in the right beds' (17M). By contrast, some (non-medical) journals referred to the need to develop positive, holistic models of care of elderly people (18NS), which included consideration of the wishes of the client and the family (19SH).

(B) The Organisation and Delivery of Community Care

Some articles voiced a range of fears and concerns regarding the desired shift in services from hospital and institutional care to community-based care. This pessimism is reflected partly above - in views expressed on the limited achievements of community care policies. But, in addition, two articles expressed the view that local authorities could not deliver community care (20NM).

Others articles were sceptical as to the viability of inter-agency co-operation for the elderly especially at the boundaries between statutory services (21MS) evidenced in the 'misplacement' of elderly people in NHS residential settings (22M) and gaps in services

(23M). A housing journal referred to co-operation between health and local authorities as 'indispensible'. Yet other housing articles saw such co-operation as hindered by disagreement as to the roles of various services. The development of sheltered housing brought to the fore unclear distinctions between community services. One housing article stated, 'there can be a danger that (sheltered) dwellings become classed as,,,Old People's Homes for the senile, infirm or physically handicapped,,,or people in need of care and attention' (24H).

(C) The care of the elderly mentally infirm

There were strong views expressed within social work journals regarding the shallowness of community care policies, both for elderly people in general and the (elderly) mentally infirm. Thus, community care was described cynically as 'a slogan, a magic and pseudo-therapeutic phrase' which gave the false impression that 'a large, warm and benevolent neighbourhood, full of love and kindness' existed for disabled people (25S). Such care could amount to 'community neglect' on the basis that 'the glib acceptance and superficial practice of community care' could result in discharge home 'without adequate care or help for himself or the community in which he lived' (26S). These views reflected the broader concern that neither the family nor the community at large could or should carry alone the burden of care for such people. Therefore, whilst one nursing article expressed positive support for the ideal of keeping the mentally infirm at home (4N), other medical and social work articles disagreed because of the social cost of providing this support (28MS).

Amidst these kind of views, it was not suprising to find journals referring to serious discontinuities in services for the elderly mentally infirm - sometimes exacerbated by negative attitudes to old people as referred to above (p72). One article argued that the hospital was not always the ideal place for the 'irremediable' psychogeriatric patient reflecting the 'erroneous professional view that morbid mental changes' were 'normal and inescapable in old age' (29M). One nursing article referred to the 'steadily more confused' position regarding the care of such old people, in which 'the senile old person appears to be no-one's responsibility' (30NM). As this last quote indicates, service co-ordination in this field sometimes left a lot to be desired; the elderly mentally infirm too easily fell between stools (31N).

Summary: 1961-63

Whilst some nursing, social work and housing articles could be found which gave general support (albeit for different reasons) to the movement towards community care, medical journals expressed no such support. There is some evidence to indicate that this lack of medi

cal support reflected anxieties about territorial erosion; community care policies would direct resources away from acute services and so threaten acute medical practice.

In terms of the application of community care policies, whilst non-medical articles gave credence to the theory of community care, medical articles gave critical consideration to its practice in terms of the overall quantity and quality of care delivered. Social work journals were critical of the likely impact of community care on the family - views supported in the occasional housing and medical articles. Nursing journals were, by comparison, virtually silent on most aspects of the theory and practice of community care. Medical articles provided evidence of a general barrier to the positive development of services to elderly people in general - attitudinal barriers to working with elderly people within the medical profession. It was remarked that the medical model which underpinned clinical practice tended to devalue the care of elderly people. This narrow model contrasted with more holistic approaches propounded in other journals which suggested that community care was about meeting a wider range of needs consistent with providing people with choices and greater freedom.

The organisation of community care prompted most reaction from medical and housing journals. Articles in both sets of journals discredited the effectiveness of collaborative community care activity by reference to gaps and overlaps in services; both also doubted the capacity of the local welfare authority to deliver community care. Thus, even in this early period there was evidence that community care was undermined by poor co-ordination.

The desirability of pursuing community care policies for the elderly mentally infirm was questioned, particularly in the social work journals, because of the social costs borne by families and informal carers. There was evidence - across the journals - of organisational and professional barriers to achieving effective community care for the elderly mentally infirm; gaps in services for this group were mentioned, and reference was again made to negative stereotypes of old age amongst medical practitioners which mitigated against the positive treatment of this group. Gaps between services were particularly evident for this group, reflecting poor inter-service co-ordination and unclear responsibilities for care. All journals expressed disquiet as to the practicality and desirability of pursuing community care policies for this group.

1971-74: Community Care Under Financial Constraints

There are approximately 125 separate journal sources directly referred to in this section of the Chapter; considerably more than in the 1961-63 period reflecting a greater interest in

community care services for elderly people. In comparison to the previous period, the percentage and number of nursing journals drawn from increases substantially. Between them, nursing and medical journals account for approximately 70% of the journals referred to; indicating a very intense health service interest in community care issues. From an organisational perspective, this period was dominated by local authority and NHS reorganisation in 1970 and 1974 respectively which sought to shift resources, first away from the NHS to the personal social services, and, second, within the NHS, away from more expensive NHS acute services to community based services.

(A) General Support for, and Views of, Community Care and Elderly People

Positive statements in support of community care policies for elderly people were a comparative rarity in this period; seven statements (in four nursing and three housing articles) endorsed this policy movement, largely because it reflected the preference of old people to remain in their own homes, thereby increasing their happiness (32NH).

On both a general level and on specific issues, concerns were expressed about the practice of community care. An editorial from the medical journals commented that as a result of the shift to community based services 'the acute services are on the point of collapse' (33M); another commentator argued for the maintenance of 'high-cost NHS resources' to treat elderly people (34M) rather than the continued development of low-technology community support. The questionable quality of community support provoked one comment which questioned the assumption that the 'current religion' community care would save 'costly acute beds' - 'We are assured that patients will be much happier and much more humanely treated in their own homes and that such care will be cheaper without reduction in quality. We wonder'. On similar grounds, two further sources questioned the rundown of long-stay institutions because of the inadequacy of community support (35MS). Thus, the shift away from long-stay hospital care did not generate universal support. In this context, it is interesting that three articles chose to include hospital services in their definition of community care (36MN). Certainly, across all but the housing journals there were authors who were critical of the overall quantity and quality of community care provision (37MNS).

As in the previous time period, there were a number of comments made in relation to the role of informal carers. A social work article viewed community care as 'the wooliest of panaceas' because at worst it gave the government a rationale for 'throwing the burden of caring firmly back to the public' - a perception shared in three further medical and social work journals

(38SM). By contrast, one correspondent in a nursing journal suggested that families ought to take more responsibility for their elderly relatives (39N).

Reflecting the priority of acute medicine, and attitudes to elderly people in general were a series of comments made in journals relating to the low status of geriatric medicine and geriatric nursing. In terms of the former, *The Lancet* commented that the specialty of geriatrics 'deals with those patients that no other doctor wishes to care for' (40M). In this context, three other articles (41M) sought to promote the image of geriatric care. A fourth article referred to the inappropriateness of setting the acute goals of 'curing and discharging patients' in a chronic unit, especially given that 'the whole spirit of chronic care differs from that of acute care' (42M). In contrast to the prevalence of this acute medical model, was the practice of progressive geriatric medicine which encouraged 'total patient care' rather than just clinical diagnosis and disposal (43M). This holistic approach was upheld in several other articles seeking to convey positive views of geriatric medicine (44M) amidst evidence of negative medical attitudes to this specialty (45M). In geriatric nursing, there was a similar juxtaposition of views. Four articles made reference to disincentives to establishing careers in geriatric nursing. For example, the view that 'greater length of service in geriatric nursing' was a 'bar to promotion prospects' (46N); a reality to be contrasted, in eight other articles, with encouragement to develop positive nursing approaches to the care of elderly people (47N).

There were few social work articles in this period concerned with the care of elderly people. Indeed, in 1971, it was commented that in ten months since the launching of one social work journal, there had been 'a disproportionate preoccupation with the needs of the young', despite the important role of geriatric social work (48S). As with some medical articles there were advocates of making individual responses to 'the total situation of the client', rather than a satisfaction with simplistic general solutions (49S). Thus, three other social work articles asserted that social workers could and should help to provide support to elderly people (50S).

Nursing (and to a lesser extent social work) journals reveal a greater interest in some more detailed implications of community care; for example, the relationship between the rights and wishes of elderly people (notably their right to independence) and decisions about resource allocation. Several nursing articles supported the view that elderly people should be accorded the right to remain at home rather than live in institutions; 'How much better if we could,,,(keep) them in their own home,,,to live with independence and dignity even if

grubbily, in their own homes' (51N). The notion that it was acceptable for old people to live 'grubbily' at home was one indication of the extent to which a persons' quality of life could be perceived by others as undermining their right to remain at home experiencing a lifestyle which others might find unacceptable. Nursing and social work articles referred to a number of other factors which could determine the extent to which the independence of elderly people might prevail over professional or carers views of need - the pain suffered by the elderly person; the home environment; the stress and wishes of family carers; the risk of leaving people without 24-hour support; enjoying a "reasonable" quality of life (52NS). One of the factors influencing decisions taken about the future of elderly people was the relative weight given to the rights of informal and professional carers and the old person. Nursing journals particularly expressed concern about the paternalism implicit in the influence which professionals and carers exerted on decision making processes affecting elderly people. Old people were potentially 'pawns in games that adults play', a situation which could, for the old person concerned, produce 'misery,,,instead of the expected benefit'. For example, securing admission to residential care could be a 'salve to the conscience' of carers rather than a reflection of the wishes or needs of the elderly person (53N). So it was that a nursing article advised nurses to take a 'slightly pro-patient and therefore anti-relative bias' in making decisions about patient care (54N). Similarly, another author suggested that although a patient might 'be misguided or even foolish in everyone's eyes' the job of professional health workers in such circumstances was 'to advise, not dictate' (55N).

Likewise, a social work article recognised that 'very often presenting problems are made up not of the elderly client's perceptions of his situation, but of the perceptions of family friends and neighbours' (56S). A separate article made reference to the potential clash between the rights and wishes of the old person and their carer(s) which presented 'a dilemma of conflicting values' to social workers (57S), especially given the great weight accorded to individual rights in social work ethics (58S). This reluctance to discount clients rights explained social workers' tolerance of deviant behaviour (59S), a tolerance which attracted some criticism where social workers were perceived to ignore cases of self-neglect (60N). Overall, the different attitudes and approaches to people's needs, wishes and rights reflected what one nursing article identified as the influence of psychological, medical and social models of care. These models posed a dilemma; 'which (model) makes more sense of what is going on, which is more honest and protects the rights of the so-called patient'; the means by which resources were allocated created similar problems (61N).

(B) **The Organisation and Delivery of Community Care**

The management of community-based services could be affected by many of the issues raised in the previous section; perceptions of the benefits and priority of community-based services vis-a-vis hospital or institutional care; attitudes to the rights of elderly people and the responsibilities of their carers; holistic or clinical models of care; perceptions of the cut-off points of community care services. Some journals already referred to in this period suggest the existence of financial, professional organisational and attitudinal barriers to the development of community care services. As in 1961-63, one perceived barrier to the organisation of community care was the fact that the local authority was responsible for providing community support. In this context, one medical editorial referred to the 'woeful failure' to translate the 'trumpet call' of community care into 'some sort of reality' (62M).

References were made to service roles and their impact on the organisation of community care. One article ascribed a vague role to residential care, stating that 'residential homes should only be resorted to when community living is no longer practicable' (63M). This kind of loose definition was particularly evident in terms of the role of sheltered housing. There were mixed perceptions of the role and importance of sheltered housing; one Geriatrician described sheltered housing as 'by far the most significant advance in the health and well-being of elderly people in this country' (64H); although the same Geriatrician later reported that research showed that the majority of elderly people did not want to live in sheltered housing (65H)! There were certainly several housing articles (and one social work article) which emphasised the drawbacks of moving old people to alternative (sheltered) accommodation (66HS). Six further articles gave different views as to whether accommodation for elderly people should be integrated with "normal" housing, and the normal community or not (67H). The benefits of particular types of sheltered housing were thus unclear and perceived in different ways, most notably within the housing journals themselves.

More generally, reference was made to 'administrative divisions' between sheltered housing, part III and hospital accommodation which 'have become blurred', as a result of which in many areas 'conflict is engendered which perpetuates rigid divisions (between services). There are difficulties of transferring elderly people from the community into the caring system and they often become stuck at various points within the system' (68S); two medical articles also referred to the misplacement of elderly people because of alleged shortfalls in various services (69M). Lack of clear service roles, and shortages of those services, were perceived as barriers to the achievement of effective community care.

As well as organisational discontinuities and overlaps between types of community care services, reference was also made to inter-professional disputes which disrupted collaborative activity deemed essential to the achievement of community care. For example, one nursing source report referred to the 'extraordinarily bitter public warfare' between doctors and social workers that had undermined past and present attempts to 'work harmoniously together' (70NS). Another nursing article referred to 'paranoia' existing between social workers and health visitors - a point supported in housing and medical journals (71NHM). Another article suggested that social workers were 'so jealous of the importance of their emerging profession' that they were 'anxious to manifest their independence by a failure to consult with their health service colleagues' (72N). In 1974, one medical journal published a series of articles reflecting doctors' impressions of the social work profession (73M). These articles revealed;

(i) G.P's criticism of social workers, notably in the mental health field;

(ii) G.P's and social workers' uncertainty as to each other's roles;

(iii) that there was little systematic communication between the two professions;

(iv) that the responses of the groups to similar needs could widely differ.

Overall, these articles refer again to major professional, organisational and attitudinal barriers to collaboration and community care.

(C) The care of the elderly mentally infirm

Many criticisms of community care policies voiced in sections (B) and (C) were raised in connection with the care of the elderly mentally infirm. In terms of overall philosophy, several nursing articles agreed with the sentiment that; 'it is now the aim to maintain as many as possible of the elderly mentally infirm in the community' (74N), although the extent to which the elderly infirm person had the right to remain at home was not clear (75N). For example, it was argued that it was 'obviously better for the patient to stay in familiar, safe surroundings' (76N); since this was preferred by elderly person and carer alike and represented 'money well spent' (77N). By contrast, two articles suggested a more flexible, individualistic approach could be taken; it must not be 'blindly assumed that all infirm, elderly people should remain in their own homes till they die. For some, an institutional environment may be therapeutic - each case must be assessed individually' (78SNM).

Other articles expressed doubt as to the benefit of keeping such people in the community (79NM) often in the context of harsh criticisms of the practice of community care for this group. For example, although 'very few' quarrelled with the concept of a community based service, the concept was described as 'largely mythical'; the community was at best 'a vague

concept and as such cannot provide a basis for worthwhile services involving the life and happiness of fellow humans'. Thus, it was argued that community care, even though 'bolstered by wishful thinking, bland assumptions and professional ideology' should not replace existing services (80NM). In terms of community care practice, a nursing article spoke of patients being 'virtually imprisoned in hospitals, not because they are unfit to be in the community, but because at present the community is unfit to care for them' (81N); in addition, community psychiatric services were perceived as 'often inadequate, unsatisfactory and distressing for the patient and the family' (82N). A social work article made similar criticisms, as did a letter in a medical journal; the former referring to the present scale and quality of community care services for the mentally infirm as 'grossly inadequate', the latter considered that 'community care (for the mentally infirm) was almost non-existent' (83SM).

The quality of family support was described as 'a critical factor' in determining comprehensive community care (84N). Yet reliance on family and community support produced some misgivings about pursuing community care for the elderly mentally infirm, because of the strain on informal carers which resulted (85M). Hence a nursing article asked whether pursuing community care should take into account 'the impact an elderly psychiatric patient has on those around him'; an adverse impact could necessitate the 'removal of the patient from his familiar surroundings to hospital may be necessary' (86N).

Attitudinal barriers were again perceived to hinder the delivery of care to the elderly mentally infirm; hospital specialists were said to perceive them as 'unacceptable' patients, giving 'the impression that the bed rather than the patient was the important subject at issue' (87M). Another medical article referred to the elderly mentally infirm as a 'rejected group...The elderly as a whole...tend to be rejected by the medical profession, which means the psychogeriatric patients are doubly rejected' (88M). On another negative note, a medical author was speaking of mental infirmity in old age when he said 'No other condition generates so much crisis, irritability and inter-professional friction' (89M).

In terms of appropriateness of care and support to this group of elderly people, the point was made in a medical source that their disposal was often seen as more important than their care prompting another source to comment that the care received by such people from the health service was arbitrary (90M). This group of elderly people seemed more likely to fall between stools since doctors, on the basis of clinical judgements, 'have tried hard to define patients (as) suitable for existing institutions' on the basis of clinical judgements. This approach - to compartmentalise needs - resulted in 'strict lines of demarcation to which all

parties adhere' (91M). In accord with some of the remarks made earlier in this section, the inadequacy of community services led to the questioning of the rundown of long-stay hospital beds for the mentally infirm (92M); although one prominent psychogeriatrician advocated the shifting of large numbers of these patients out of hospital care (which 'very few' needed) into residential homes (93M). These perceived shortcomings of community care policies and differences in attitudes, definitions of need and responses to need led one social work article to refer to 'a degree of mutual hostility' between the medical and social work professions providing community care for this group (94S).

Summary: 1971-74

A smaller proportion of articles registered positive support for community care policies in this period than in 1961-63; some medical and social work articles questioning the shift away from long-stay hospital care. All but the housing journals (which expressed no view on this subject) contained critical commentaries of community care practice - referring generally to the poor quality of community services, and the social cost of community care policies on informal carers. There was therefore greater inter-professional consensus on the overall shortfalls of community care than its benefits. As in 1961-63, community care policies were perceived in medical journals as a threat to acute hospital services, and made apparent the differences between the clinical model of medical practice and a more broadly based holistic approaches to care and support. The conflict between these two models showed itself in the ambivalence in medical and nursing journals to the care of elderly people. Similarly, in social work journals an indifference to the needs of elderly people was reported, despite advocacy of social work intervention for old people.

In general, greater attention was given in this period to some detailed applications of community care philosophy, notably issues surrounding the right of elderly people to maintain independent lives. Interestingly, the nursing journals engaged heavily in discussion of this issue, and some social work articles explicitly judged the "success" of intervention in terms of safeguarding against possible infringment of client rights. Crudely, community care was treated as a proxy for a client's wish to live an independent "normal" life. Yet the same articles defending client rights, cited dilemmas concerning the relative priority of carers and clients needs; the point at which a person's rights came second to other considerations such as the quality of life for carer or client, and professional views of appropriate care. The different stances adopted in the journals to these considerations were clearly a source of conflict, most notably between social workers and medical practitioners, a conflict which was illustrative of the separate models of care and value systems adopted by these two

groups. There was disagreement both within the nursing and social work journals and across these two sets of journals and the medical journals as to the importance, weight and implications of considering people's rights in relation to decisions affecting the care of elderly people.

In terms of service roles, housing journals devoted considerable space to the future of sheltered housing. Yet there was dissensus within housing journals as to the benefit and importance of different types of sheltered housing, reflecting different views about preserving "normal" lives for elderly people and integrating them into, or segregating them from, the wider community.

All the journals generally agreed on one point in terms of the organisation of community care; that there were gaps and overlaps in services; that elderly people, according to various definitions of need, were misplaced. Similar negative perceptions were also evident in the 1961-63 period. However, it was apparent that in addition to these organisational barriers and difficulties were professional conflicts, most notably between social workers and general medical practitioners. Such conflicts partly centred on disagreement surrounding specific details of community care practice.

In terms of community care for the elderly mentally infirm, nursing and medical journals (and to a lesser extent social work journals) emphasised the poor quality of community care services, with medical and social work articles referring to inter-professional friction resulting from the attempt to provide co-ordinated (medical/social work) support for this group of elderly people. Nursing and medical articles also questioned the wisdom of expecting informal carers to bear the brunt of the responsibility for social care and support to this group of elderly people. These misgivings contrasted with the minority belief, expressed particularly in some nursing articles, which suggested that community care could and should be pursued for this group. On balance, however, the consensus of views across all journals (except housing journals which were silent on the issue) was that there were serious difficulties in pursuing a general strategy to keep the elderly mentally infirm in their own homes. Thus, the notion of community care as a panacea for all ills was strongly disputed, perhaps exemplified in the views that the quality of care and level of support offered in permanent residential care may be more appropriate than keeping such people at home. These doubts raise questions about the support for community care banner goals; suggesting that the wide support for such goals was lacking particularly for marginal groups such as the elderly mentally infirm. Lastly, as with elderly people in general, there was in this context some

disagreement in the nursing journals as to the weight to be given to the rights of the elderly mentally infirm.

1976-1982: Community Care under Financial Restraint

In this last section of this Chapter, the largest number of individual journal sources (over 200) are directly referred to; of these one-half of the sources are from social work journals. Of the remaining half the majority were from nursing journals. Thus, for the first time, social work journal sources came into prominence, outnumbering the number of housing, nursing and medical journal sources quoted put together.

In terms of key public policy developments, the Government introduced its first national priority planning documents to identified "priority" health and welfare services and targets for growth which local authorities were to take into account in their expenditure plans. Similar "priority" documents were introduced between 1977 and 1981 in the context of increasing public sector financial constraints. In addition, in 1978 and 1981 two policy documents - "A Happier Old Age" and "Growing Older" - were produced which sought directly to develop community based services for elderly people (see Chapter Four) (96G).

(A) General Support for, and Views of, Community Care and Elderly People

Although the "priority" and policy documents in this period were intended to generate a shift away from long-stay institutional care to community care, many articles (especially in social work journals) questioned whether this policy was achievable, given what was generally perceived to be the poor track record of community care policy - poor quality community services, premature discharge and inadequate after-care, inappropriate accommodation (97SMN). Hence, some of these government documents were regarded with some scepticism in the three main sets of journals (98SMN). Some medical sources, as before, went further and questioned the desirability of the shift to community care as represented in the 1976 "priority" document; the emphasis placed on the "Cinderella" services rather than the acute hospital sector was regarded as 'defeatist' (99M). In 1978 the BMA looked back on this reaction noting that it had been 'highly critical of the strategy to shift the balance of priorities in favour of the elderly' but remained 'particularly concerned' about the policy to slow down expansion of acute services (100M). Reflecting this medical antipathy, some nursing journals put the blame for failing to shift resources to community services on the 'omnivorous hospital services' which continued to 'swallow up' NHS resources (101N).

Despite what one social work author described as 'a general commitment to the concept of community care', there were also perceived to be wide variations in community care services, reflecting the 'serious lack of an overall national policy' and, more generally, the 'vast' gap between the 'theory and practice of community care' (102S). One explanation given for this policy gap was that community care was 'ambiguous' and thus prone to wide interpretation (103S); concern about the vagueness of community care policies was expressed in six other social work articles in this period (104S).

Some journals in this period recognised negative attitudes to the care of the elderly as a major professional barrier to developing community care policies for elderly people. For example, it was stated in a letter to a medical journal that the 'all pervading acute-bed and teaching hospital ethos,,,leaves us short of sympathy for the elderly and short of a philosophy for coping with their chronic illnesses', because the medical model treated healthiness as normal, the elderly were seen to be abnormal and unresponsive (105M). Two other letters stated that for some medical practitioners elderly people were 'still treated as if they were an uninteresting commodity, their disability a fait accompli'; work with elderly patients was regarded by some doctors as an 'unwelcome chore accepted with resignation rather than enthusiasm' (106M). Many other medical sources illustrate this attitudinal bias, for example, it was commented that geriatrics were frequently taught 'in second class accommodation with second class equipment and by second class doctors' (107M). Equally, it in the nursing profession was claimed that 'Age prejudice and stereotyped views of older people and of ageing are frequently found within the nursing profession' (108N); nurses' attitudes to geriatric medicine were described, in one of eight articles on this theme, as ranging 'from reluctance to frank repugnance' (109N).

Social work articles also admitted that elderly people were 'rarely accorded high priority'. Social workers adopted 'traditional solutions' to their needs 'out of ignorance, lack of resources or shortage of time'. These traditional solutions tended to 'minimise choice' and were concerned with 'effective "disposal" rather than high quality social work practice' (110S). Thus; 'Social casework with the elderly has become virtually non-existant,,,since the introduction of the generic concept,,,the elderly were given lower and lower priority', a point made in four other social work articles (111S). Five further social work sources gave examples of the limited extent of social work practice with elderly people, for example, work with elderly people 'tends,,,to focus on the practical and go no further' (112S). This position was reflected in the fact that (unlike during the period 1971-74) although there were regular articles on care of the elderly in social work journals, they were largely

written by non-social workers. The emphasis of the majority of these articles was to restore some credibility to social work for the elderly (113S).

A wide range of views were expressed, most notably in the social work journals, as to the virtue of community care policies; elderly people might be happier if supported at home, or prefer such care at home because community support was more acceptable, more appropriate or therapeutic than alternative (residential) forms of care (114SMN). Set against these positive views of community care policies were other nursing and social work sources expressing disquiet at the poor quality of life for people living in the community (115SN), referring to the negative origin of such policies which were perceived as based on the movement away from institutions rather than on the documented benefits of care at home (116SN). Thus, one article questioned whether old people were happier at home (117N).

As in earlier times periods, the concern about the strain on informal carers resulting from the pursuit of community care policies was widely expressed; one social work author suggested that it was time to call a halt to the statement that "community care" was good; although there was 'no doubt' that it was 'often appropriate' to keep the old in their neighbourhood, there was also 'no doubt' that community care meant 'intolerable strain on those providing the care' (118S). Similar sentiments were found in many other social work and nursing journals (119SN). Some social work journals viewed community care as dependent on ethics of self-help and mutual aid, which social workers were expected to foster rather than undermine through their direct intervention; This latter expectation was also perceived as unrealistic, and another source of policy vulnerability (120S).

The primary focus of community care services - whether on the client or the carers - raised issues relating to people's rights and wishes. One article argued that 'Health and social services should support the supporters with the same enthusiasm as they support the elder herself' thereby giving strong support to caring for carers (121S). By contrast, a nursing article was wary of placing too much emphasis on the needs of carers because, for example, old people wouldn't 'want to stand the changes of going in and out of various forms of care to provide relief for the family' (122N). Yet another nursing commentator was 'distinctly unhappy' about nursing old people at home if this meant that 'some relative has to stay at home to look after them, when she might be doing useful and productive work of her own choice outside the home', thereby questioning assumptions about the virtue of informal care (123N). The latter position was adopted by other authors in the face of heavy burdens placed on carers due to the dependency level of the elderly person concerned (see references 118-119).

On the more general topic of the right of elderly people to remain at home, one nursing article argued that 'If a man or woman wishes to remain in familiar surroundings, and if the people around them are not put at risk, then that decision must be respected. People are not things to be manipulated' (124NSH); a stance supported in another nursing article which stated that 'Even if the patient chooses to live in a squalid situation full of danger his wishes should be respected' although it might contradict any philosophy of engagement in society, be misunderstood by the public and other professionals, or create a conflict of interests (125NS). The sanctity of an individual's right to stay put was discussed in other sources; this principle could be rebutted, it was suggested, if it infringed other people's rights or wishes (126S) or if the individuals put themselves at risk or caused distress through their behaviour, but there was general agreement that the principle should not be rebutted for reasons related to bureacratic convenience or to minimise professionals' or carers' anxieties (127MNHS).

Although in general the nursing journals quoted immediately above show a great awareness of the need to uphold the wishes of elderly people, it was claimed that social workers put a 'much higher weight than is common among professionals,,,on the consumers' view of needs' (128S); for example, one author stated that 'to widen people's area of real choice and enable them to exercise choice seems,,,the only proper goal of any social work intervention' (129S). However, in contrast to this explicit approach, the medical journals rarely discussed patients' rights or risk. It was suggested that old people's ill health, their self-neglect, unreasonable behaviour, or the stress this placed on carers all might lead to hospital admission irrespective of the patient's wishes - although it was questioned whether some of these reasons were in themselves sufficient grounds for gaining access to acute care (130M).

Alongside the complex debate regarding the extent of old people's rights to independence, was the issue of the risks associated with such independence; as a nursing article recognised 'elderly people choosing to remain independent increases risks for them' (131N). Yet, as with the issue of rights it was remarked that 'The extent and nature of social workers' duty to protect old people is unclear' (132S); especially given that the death or demise of old people in their own homes in adverse circumstances 'does not appear to be always acceptable to public opinion and the law' (133N). The adoption of acceptable risk levels led to restrictions being placed on elderly people (134N); although it was noted in a nursing article that it was 'not reasonable to expect that old people should be guarded against every possible danger at all times,,,old people should not be discouraged from accepting the risks of every day living' (135N).

(B) **The Organisation and Delivery of Community Care**

The previous section identifies a range of issues which are inextricably linked to the organisation and delivery of community care; professional attitudes to elderly people and the virtue of community care policies in general; perceptions of how resource allocation might be bounded by the rights, wishes and risks associated with individuals pursuing independent lifestyles in the community. The ambivalence surrounding community care policies was associated with the failure to deliver comprehensive services on the ground and the different attitudes, priorities and models of care adopted by key professional groups.

In this context, perhaps unsurprisingly, references were made to 'professional jealousies and demarcation lines which must be broken down in the interests of the elderly person' because for elderly people 'co-ordination, collaboration and speedy and effective communication between all concerned,..are essential' (136HN). Hence it was argued in a social work article that if community care was to remain the preferred strategy to institutional care 'then much more thought needs to be given to the political, organisational and professional difficulties which confront it' (137S). Yet, as in the previous two periods, there was some doubt as to the capacity of local authorities to finance and deliver adequate community care - doubt expressed this time within social work rather than medical journals (138S).

Professional role conflict was also perceived across all journals as affecting collaboration; the 'dilemma' of caring for old people in the community was, according to one nursing source, that nurses, health visitors and social workers 'do not always combine successfully,., (leading) to fragmentation of care because of poor communication' (139N). Indeed, reference was made elsewhere in nursing journals to 'mistrust, suspicion and prejudice' between these groups (140N). In addition, it was argued that the work of home help staff overlapped with that of social workers and the district nurse (141S); the sheltered housing warden with home helps and district nurses (142M); the health visitor with social workers (143N). Overall, health and social services (particularly doctors and social workers) were 'in conflict with one another rather than collaborating in the achievement of common goals'. One reason cited for these difficulties in inter-professional collaboration was the delineation of 'artificial boundaries' between services and their clients rather than the establishment of 'close working relationships'; boundary problems which extended to housing and social service authorities as well as to medical, nursing and social work professionals (144NSHM). Even within social service authorities a 'conflict of values' between different social service workers was viewed as providing 'the most basic dilemmma in collaboration' (145S). In this context, several articles referred to the need for greater inter-professional and inter-

organisational consensus on a number of issues related to the delivery and management of community care, as a means to ensure more effective collaboration and thence better quality community care services (146SNH).

An example of one area of inter- and intra-professional disagreement was in respect of the role of residential care. Thus, within the social work journals several articles argued, for example, that residential homes should be phased out to 'free the resources necessary to expand the community support which would enable the elderly to remain in their own homes' (147S). From an alternative standpoint, social work articles regarded residential homes as an asset; a "community resource...a focal point for a range of services to the local community' (148S). Far from phasing out residential care in favour of community care, the former was perceived as 'a cornerstone of community care instead of an alternative to it' (149S). This latter view challenged the stereotype that institutional care was "bad" and that community care necessarily better; the adoption of the resource centre model of residential care would 'more and more obscure' the demarcation line between residential and community care (150S); as was stated elsewhere, the issue was 'one of deriving appropriate forms of (residential or community) care and ensuring that they were delivered to those who most need them' (151S).

In terms of the clientele of residential homes, one social work article, whilst asserting that residential homes had 'no clear role' and 'have roles thrust upon them by all other services', suggested that fit elderly people 'should not go into old people's homes' (152S). Although, generally speaking, medical articles supported calls for more part III beds, there was confusion as to who should fill them; people discharged from hospital, the elderly mentally frail or the chronic sick? (153M). A nursing article recognised that although old people's homes increasingly housed elderly people requiring nursing care, such care was rarely available, hence the remark that 'health care provisions in residential homes for the elderly are inadequate', prompting the statement that 'The aims of residential care are in urgent need of re-evaluation' (154NS). However, just as there was no clear consensus as to the role of residential homes, equally there was some confusion as to who the 'community' could cater for; 'What should families and informal helpers reasonably be expected to cope with? What disabilities and circumstances should be considered too much for them?' (155MS).

As with the role of residential care, the journals reveal different perspectives of sheltered housing; as was stated, 'The tenant, the warden, the housing manager, the area Social Services director, all have different perceptions and views about the role (of) sheltered housing' (156HS). A further housing article maintained that the increasing dependency of old

people in sheltered housing meant that it had 'slowly but surely been drifting towards residential homes in the needs it attempts to meet and in the role it is seen to play' (157H) - a view expressed in several other places (158SHM). Indeed, the perceived shortage of part III homes was described as changing the role of sheltered housing 'mainly by default' (159H).

Social work articles in particular were sensitive to the discontinuities in care and inconsistencies of perception relating to key services. They also perceived more general problems relating to community care service management. For example, one social work article made reference to the fact that each service had its 'own priorites and professional interests' (160S); another article similarly suggested that different parts of the care system functioned according to different models and criteria, pressures, procedures and goals (161S). These disparities together with shortages of accommodation and domiciliary services produced what one further article described as the 'substantial misallocation between various forms of care' with 'major forms of service provision' developing in an 'unco-ordinated manner without the benefit of a considered framework of policy and practice'. So despite the high profile given to the humanitarian philosophy of community care, difficulties such as these meant that the care old people received was 'to a major extent, fortuitous' working according to 'chance rather than choice' - such sentiments were expressed in other professional journals (162SMN). Not surprisingly, it was also argued that too often 'too many old people are in the wrong place, at the wrong time and for the wrong reason' (163S).

Views on the general principles of resource allocation were expressed across a broader range of journals. Whilst one medical article asserted that 'Help should be taken to the elderly and not the elderly to help' (164M), some social work articles acknowledged that often elderly people were instead fitted into the available resources (165S) despite a medical objection that this was 'not...reasonable or acceptable' (166M). The idea that elderly people could be moved through different services in sequence as their dependency grew was viewed as over simplistic across many journals (167NSH) as well as potentially 'psychologically and physically damaging, disrupting established family and friendship networks' (168S).

(C) The care of the elderly mentally infirm

In 1979 the policy to close mental hospitals and discharge mental patients came under fire in the medical journals; the 'full implications of community care (were) not appreciated', yet community care remained 'an attractive concept, an admirable goal' (169S). Indeed, several sources supported the essence of the latter sentiment, for example, one nursing author stated that 'it is clearly vital that as many families as possible are helped to care for their own

dementing relatives at home' (170NSM). However, there were strong reservations expressed in other nursing and social work journals concerning the appropriateness of community care policies in terms of providing good quality support to elderly mentally infirm people and their carers (171SN). In terms of informal care, for example, a social work article viewed the cost of caring for confused relatives at home as being 'considerable stress and difficulties' for the family (172S). In the words of another social work article, community care 'remains in our imagination to inspire future ideals, to support our fancy that what we are currently doing is in the best interests of all, to deaden our anxieties about the hurt that this policy may cause patients and their families'; a view which was broadly shared in medical articles (173SM). Certainly, medical correspondents questioned the "cut-off" point beyond which an elderly mentally infirm person was no longer fit to remain at home; if the person suffered from severe mental disorder or physical illness, then they should be admitted to hospital due to the higher risk of self-injury and greater stresses caused in providing care at home (174M). One medical source indicated that for this clientele there was some doubt as to who had the prime responsibility for responding to needs as the question was asked, "Whose responsibility are they?" (175M). Indeed, reference was made to 'a battle between the two main professional groups (i.e health and social services) involved with the mentally ill' in terms of implementing community care policies. This article viewed community care was caught up in the conflict between professional groups and their models of care (176S).

Summary: 1976-1982

The number of articles analysed in this period show community care policies to be of considerable concern to professionals (notably social workers). But there were surprisingly few statements of general support for these policies expressed in the journals; and the viability of community care for the elderly mentally infirm was frequently questioned. Whilst there were some references in social work, nursing and medical journals to the potential benefits of community care policies, comments on these benefits were outweighed by wide-ranging criticisms of these policies. Of the journals analysed, social work journals were most damning and frequent in their criticisms, being highly sceptical of the actual or potential achievements of community care policies for elderly people - views supported in nursing and some medical journals. As in the previous two time periods, medical authors were anxious to avoid disinvestment in the acute sector and from this perspective also questioned the desirability of community care policies.

On a more general level - and compounding the negative attitudes to community care - were negative attitudes to caring for elderly people in general. The journals gave clear signals that the nursing, social work and medical professions found it difficult to engage enthusiastically with elderly clients/patients. The status of geriatric care, and perceptions of the needs of elderly people did not appear to offer the necessary incentives to any of these three professional groups to provide more than marginal care or support. This propensity to withdraw from elderly people would appear to explain some of the perceived barriers to inter-professional collaboration referred to below. More fundamentally, the heterogeneity and type of needs presented by elderly people seemed not always to fit well with professional models and priorities, and thus their investment of time and resources.

On matters of specific operational principles associated with community care policies, such as the right of elderly people to remain in their own homes, there was a multiplicity of perceptions expressed within and across all the journals. Thus, for example, some nursing articles were more reluctant than others, in principle, to support elderly people at home where this placed undue stress on carers. On the more general issue as to the cut-off point for community care (the point beyond which elderly people should not be encouraged to remain at home), there was no consensus within any of the journals. Social work articles tended to emphasise the rights of the elderly person to choose their destiny, but as with nursing journals, were not able to agree on the extent to which such rights should be allowed to adversely affect the lives of others, produce heavy consumption of resources or contravene professional judgements or standards. In terms of the last factor, for example, the instances of elderly people dying in apparent squalor were often perceived by the public as an indictment on the caring professions, although to the social worker this may represent the right of people to live and die as they chose. In the medical journals, there was some indication that clinical considerations were viewed as rightfully taking prominence over patients' rights in determining patient outcomes - this paternalism was not endorsed in nursing or social work journals. All groups agreed that elderly people should not be removed from home merely on the basis of organisational or professional convenience. Similarly, different views were expressed on the subject of the risks which elderly people should be allowed to take, particularly within nursing journals where there was recognised conflict between imposing constraints on elderly people's freedom, to minimise the risk of falls and injuries, and the rights and quality of life of the patient. The accountability of professionals for the demise of patients/clients whether through neglect at home (a social work concern) or through allowing greater independence in supervised care (residential homes and hospitals) clearly posed dilemmas for professionals.

Collaboration was acknowledged in housing and nursing journals especially to be of great importance to providing effective care for elderly people. But attitudinal, financial, professional and organisational barriers such as mentioned in this summary were perceived in social work articles as interfering with collaborative activity and undermining community care policies. Inter-professional rivalries and conflict were recorded in all journals, and intra-organisational conflicts within social services departments themselves were recognised in social work articles as affecting the delivery of care to elderly people. The journal literature as a whole indicates that disagreement regarding the roles of key community care professionals were a particular hindrance to collaboration; giving rise to a variety of boundary disputes relating to who should do what for whom. Similar differences of perspective existed in terms of the role of key resources such as residential homes and sheltered housing. Indeed, it was notable that social work journals were divided as to the purpose and future of residential care - as an alternative to, or part of, community care services. Such a disparity could only heighten the concerns expressed elsewhere about the boundaries of community care; if residential care was a community resource, then the "community" might be expected to cope with frail elderly people in a different way than if such care was the antithesis of community care provision and to be avoided. The debate about who should occupy such homes, or warden-aided dwellings further illustrated the difference of views held by the four groups as to the particular roles of such resources, and therefore their responsibility to support elderly people in them.

The conflicts between the theory and practice of community care, and the perceptions of service/professional roles and responsibilities was most evident in the comments relating to the care of the elderly mentally infirm. In general terms, whilst some nursing, social work and medical journals expressed the view that elderly mentally infirm people should have the option to be supported at home, a number of social work and nursing articles warned of the social cost of providing such care, and regarded the quality of support available to such elderly people as not commensurate with their needs. Beyond such general conflicts around the right of elderly mentally infirm people to remain in the community there was a recognition in a medical article that these people often fell between stools; not being viewed as the responsibility of any key community care professional group. The negative attitudes to the care of elderly people registered above and the difficulty of balancing the needs of carers against the needs of the elderly people also undermined support for pursuing community care for this group reflected in inter-professional conflicts surrounding their needs.

Overall Summary

This section seeks to summarise the findings about professional perceptions of community care policies for elderly people both across and within the four "professional" groups selected and across the three time periods analysed. At a general level, it is noticeable that the interest shown in community care shifted through time away from a preponderance of nursing and medical interest in 1961-63, to heavy ownership (and criticism) of these policies by the social work profession in the 1976-82 period.

In all three periods medical articles opposed the shift of resources from health services to local authority community care services. Other journals showed remarkably little support for community care policies in any of these time periods. Indeed, by 1976-1982 any support for the supposed benefits of community care banner goals had been virtually overwhelmed by a tide of criticism levelled at the practicality of community care policies.

Growing doubts about the virtue of community care policies were inextricably related to a number of practical issues; the strain on carers; quality and quantity of service provision; poor service co-ordination; professional role conflicts; the disagreement about how to interpret community care principles such as the "right" of elderly people to remain at home. Certainly an issue raised across all three periods, and which caused groups to question the appropriateness of community care, was the burden of care shared by informal carers. In 1961-63 social work articles expressed concern about possible strain placed on carers as a result of the emphasis on community care. Concerns grew in 1971-74 in nursing and medical journals, and re-surfaced again in 1976-82 particularly in nursing and social work journals. There was a general consensus that community care could disproportionately, and thus inappropriately, shift the burden of care onto carers and away from the statutory sector. Juxtaposed against these concerns were views about the inviolability of the rights of elderly people to remain in their homes.

Attitudes to elderly people themselves, their needs and priority as resource consumers were also mixed. Medical articles in 1961-63 reveal the priority placed on the clinical model of treatment, short-term acute high technology medicine, which accorded low status to elderly people. Accordingly, geriatric medicine was under-resourced and de-valued. This position was confirmed in 1971-74 and 1976-82, although the contrast and conflict between a narrow curable, ill-health model and a more holistic caring approach adopted in some nursing and social work journals was given greater recognition in these later periods. Equally, in 1971-74 nursing and social work sources (and in 1976-82 social work sources only) showed great

prejudice against elderly people despite their broader models of care and user-friendly value-bases. In 1971-74, nursing journals indicate that this prejudice was a consequence of medical bias and resource investment; to have a career in geriatrics was to work in a second-class health service. In social work journals, limited resources and the increasing priority of child care work meant that social workers had little time other than to "fix" services for elderly people. These circumstances ensured the continual marginality of elderly people to these key community care professionals' work.

Other community care issues provoking comment were the boundaries of community care and the rights of elderly people to stay at home. Such issues came to the fore in 1971-74 and 1976-82. In 1974 nursing sources stated that elderly people should, in principle, be supported at home, but articles in the same journals disagreed as to when that right should be rebutted. Both nursing and social work journals opposed the move-on of elderly people for reasons of professional convenience or to appease carers. Yet the emphasis which social workers placed on the rights of clients to remain at home clashed with nursing and medical perspectives which centred on more pragmatic considerations related to the availability of practical support and the coping capacity of informal carers. In the 1976-82 period, nursing and social work articles still agonised about these issues. The case of the isolated elderly person with deteriorating health and living in squalor being one in which these two professions seemed caught between societal expectations and standards, individual rights and professional judgements of need. All four sets of journals haggled over the dangers of applying the rights argument too far, on the one hand, and the dangers of professional paternalism, on the other. The debate in nursing and social work journals on the acceptable level of risks further revealed the conflict between allowing individual freedom and the accountability of statutory carers for people's demise. These perceptions reveal how support for a community care banner goal - such as maintaining the right of elderly people to stay at home - could mask considerable disagreement about how to apply that right in the case of dependent elderly people who may be on the boundary of community care and institutional services.

The second area of journal interest surveyed - factors affecting the organisation and delivery of community care - showed a series of long-standing concerns which had not been resolved by successive local government reorganisations or changes in government policy and planning processes. In 1961-63 boundary disputes were already registered in medical and nursing journals reflected in debates about the 'misplacement' of elderly people and gaps in provision. Even at this stage housing articles recorded their concerns about the role of sheltered housing overlapping with that of the part III residential home. Such views about

divisions between services, role blurring and the misplacement of patients were repeated in social work and medical sources in 1971-74, Adding to this unsatisfactory position was the existence of inter-professional disputes about key statutory carers roles (such as the roles of the community nurse, health visitor, G.P. and social worker), These disputes were fuelled by the organisational context described here and the attitudinal context reflected above,

Although articles in all four sets of journal across all three time periods recognised collaborative working as essential to caring for elderly people, the same organisational barriers to community care as witnessed in 1961-63 and 1971-74 were referred to in 1976-82, Indeed, references to inter-professional conflict grew in 1971-74 and further still in 1976-82, In the latter period, instances of such conflict were expressed in all four sets of journals, Amidst this experience, calls were made for greater agreement as to core values and priorities to be owned by health and welfare providers alike,

The role of residential homes was perceived in numerous ways within social work articles - from being antithetical to the spirit of community care to being integral to the same, Housing and medical articles also expressed diverse views of part III homes, Overall, all three sets of journals reported views in this area which failed to identify a clear clientele for part III homes, Moreover, the different approaches resulting from professional models of care suggested that different ways in which resources should be utilised; a holistic approach suggested a flexible means of resource allocation; a narrower medical model suggested that there were, or should be, clearer dividing lines between health and welfare services associated with the same clients,

In the third area analysed - community care for the elderly mentally infirm - community care policy had significantly failed to impress all community care practitioners, Even in 1961-63 social work, nursing and medical journals were ambivalent as to whether to pursue community care for these elderly people, Benefits and drawbacks of community care for this group were juxtaposed with each other in the same three sets of journals, Nursing and medical articles reported some confusion as to where elderly mentally infirm should be cared for, and by whom, In 1971-74 there was a similar mixture of optimism and confusion in the nursing journals particularly regarding the desirability of community care for the elderly mentally infirm, Nursing articles supported the principle of keeping such elderly people at home, but shared no clear sense of when such care was no longer appropriate, Indeed, nursing, medical and social work sources to tended to advocate individual rather than general solutions to the needs of elderly mentally infirm people, However, these same sets of journals indicated that

the poor quality and quantity of services in this field effectively denied people any real choice as to whether they could stay at home or not. On another front, the stress on carers was perceived within nursing and medical articles as a major reason to question the desirability of pursuing community care for this group of people.

In 1971-74 the elderly mentally infirm were perceived as an unattractive group to the medical profession; there was a tendency to regard the needs of this group of people as unworthy of health investment. Medical articles associated this perception with the avoidance of professional responsibility for this group and a recognition that medical care for these elderly people could be arbitrary rather than consistent, planned or related to need. This kind of alienation within the medical journals again reflected the clinical model of care; a model which was recognised within medical and social work journals as bringing doctors into conflict with social workers.

In 1976-82 views for and against pursuing community care for the elderly mentally infirm were again expressed in nursing, medical and social work journals. As in 1971-74, social work journals reported inter-professional conflict between doctors and social workers in this field; and as in 1961-63 the medical journals expressed a lack of clarity as to the limits of community care for this elderly sub-group, suggesting that it was unclear as to which authority or profession had the lead responsibility for caring for the elderly mentally infirm.

Overall Summary

Consensus and community care banner goals

There were comparatively few positive statements of support for community care banner goals within any of the journals across the three time periods. As such, consensus within and across nursing and social work journals on the virtue of community care banner goals was minimal and dissipated through time, with social work articles being particularly critical of community care in the 1976-82 period. In the case of medical articles, such consensus did not exist at all; community care was perceived as a threat to acute medicine and as such was scorned.

Earlier Chapters of this Thesis have suggested that the consensus surrounding the virtue of community care banner goals might be robust. Therefore, this Chapter casts some doubt on this assumption based on professionals' limited expression of, and waning confidence in, community care banner goals.

Consensus and specific community care issues

It has also been suggested that the historical complexity and conceptual diversity of community care policies - and the promulgation of community care in banner goals terms - may predispose community care professionals to disagree as to the meaning and implications of community care policies (p50, 68). There is some evidence to support this suggestion. For example, the role of the family in community care provision evoked different responses in professional journals; nursing articles expressed mixed views suggesting, at one extreme, that families could and should provide significant levels of care to their elderly relatives due to their moral obligations; and on the other hand, that the cost of caring on female kin was so high that they should not be expected to provide social support. Medical journals adopted a more pragmatic approach, tending towards individualistic rather than moralistic solutions; each case should be decided on its merits, and according to practical circumstances and clinical judgements. Social work articles emphasised the rights of elderly people to make choices, and along with some nursing journals, expressed disdain for the way in which elderly people's wishes could be ignored, and so be rendered powerless in decision making processes. In general, there were similar differences of view as to the extent to which elderly people's rights to independence and self-determination should be pursued. Social workers clearly stood at one extreme, expressing a common view that elderly people should not be the victims of other people's judgments and priorities. Nursing articles, as intimated, were divided on this issue. Housing journals expressed some interest in this issue, because it would have had implications for a "move-on" policy in which elderly people moved from one form of accommodation to another as their dependency grew. Although medical articles were comparatively silent on this issue, the assumption in many articles that health care resources should be allocated by reference to clinical judgements placed emphasis on the power of professionals both in determining care and supporting patients.

Another set of views surrounded the future role of key community care services and practitioners. Mention has been made in this section of the interest within housing journals in relation to the role of sheltered housing. Certainly, within the housing journals there were disparate views as to the nature of sheltered housing which should be developed, revolving around the demands made on wardens and the balance between segregated and integrated housing policies for elderly people. Other journals seemed to be in favour of developing more sheltered housing but justified this stance in terms of negative arguments related to the high cost and inflexibility of more traditional institutional services. On the future role of part III homes, social work articles expressed a considerable diversity of views; at one extreme criticism of over-developing such services because of their

institutional nature; at the other, there were arguments put forward in medical and nursing articles for developing nursing support in such homes, so expanding their role. Other social work articles suggested using such homes as community resource centres to be used for day care, short-term or shared care, rotational care and assessment purposes.

In terms of practitioners' roles, there were clearly misunderstandings surrounding the role of social workers, other local authority domiciliary staff and the primary health care team, notably health visitors and district nurses. The role of the warden was unclear given the lack of consensus as to the future role(s) of sheltered housing. The different perspectives on these roles became more obvious especially in the 1976-82 period, and clearly affected the way in which 'gatekeepers' such as doctors and social workers inter-related. However, in so far as the issues in this Chapter reflected different perceptions of need, rights, priority and resource allocation, the quality of collaboration was affected by all the issues mentioned in this summary. Certainly, despite the views that inter-agency and inter-professional consensus was desirable, the barriers to generating positive working relationships seemed considerable.

The care of the elderly mentally infirm also provoked disagreement across community care professionals; their rights to remain in the community and their access to various types of care and support were contentious issues. Many of the differences of views between professional groups on this subject and others were attributable to differences between professional models of care, organisational constraints, professional attitudes and priorities.

Consensus and Collaboration

Clearly to maintain elderly people in the community - particularly those people with multiple needs - it was acknowledged as essential that professionals and agencies work together. However, this Chapter provides some evidence that one possible stimulus to collaboration - consensus across key community care providers on both policy aims the means of achieving those aims - could not be assumed. It is unclear, given this pattern of disagreement, on what basis professionals and agencies could collaborate to provide community care.

The pattern of disagreement surrounding specific issues related to community care policies is further explored in Chapter Six. The relationship between apparent disagreement on issues related to the policy and practice of community care and collaboration is subsequently explored in Section III of this Thesis.

CHAPTER SIX

Responses to 'A Happier Old Age': A Snapshot of Perceptions of Community Care

Introduction

In 1978 the Labour government produced a discussion document on services for elderly people; 'A Happier Old Age'. According to the foreword, the document was intended to stimulate responses from professional and organisational bodies, and 'especially...from old people themselves'. The document sought responses to 'key issues and problems' to ensure that the governments' first White Paper dealing solely with the needs of elderly people (planned for 1979) was developed within 'a process of consultation'. In fact the discussion document bore very little similarity to the White Paper, 'Growing Older', which was eventually published by the newly elected Conservative government in 1981 (see p58, pp62-63).

Nevertheless, 'A Happier Old Age' was a deliberate attempt to develop a joint approach to social policy - to achieve greater coherence and consensus across a wide range of issues, including the development of community care services and policies. As such, the responses to the document provided an ideal opportunity to examine the diversity - or unanimity - of opinion about community care policy for elderly people. Having gained permission from the DHSS, access to these responses was gained. The data the responses yielded contrasts with that provided in Chapter Five, in several respects;

(i) the government chose the issues and questions and initiated a response;
(ii) these issues and questions were more specific and the same for all respondents;
(iii) the responses were made at one time (the summer of 1978);
(iv) the respondents were usually national committees of the principal interest groups;
(v) responses reflected a general, national, consensus viewpoint of these groups.

There were over 1400 responses to the document including a total of 156 from major national bodies listed by the DHSS. Of these 156, 23 responses are analysed in this Chapter. These 23 were chosen because they represented all the medical, nursing, social work and housing interest groups except the many responses from voluntary and private sector groups such as housing associations (see Appendix 1). These 23 responses are divided into 11 health service and 12 local authority interest groups. They are not divided into the four professional groupings because of the comparatively few housing and nursing groups amongst this sample;

1. **Health Service Interest Groups (Total = 11)**

British Medical Association (BMA)

Royal College of General Practitioners (RCGP)

Royal College of Physicians, Geriatrics Committee (RCGC)

Royal College of Psychiatrists (RCP)

British Geriatrics Society (BGS)

Central Health Services Council (CHSC)

Health Visitors Association (HVA)

Royal College of Nursing (RCN)

Royal College of Nursing, Society of Geriatric Nursing (RCGN)

Association of Chief Administrators of Health Authorities (ACA)

Central Health Services Council (CHSC)

2. **Local Authority Interest Groups (Total = 12)**

Personal Social Services Council (PSSC)

Association of Directors of Social Services (ADSS)

Institute of Social Welfare (ISW)

British Association of Social Workers (BASW)

British Association of Social Workers, Special Interest Group on Ageing (SIGA)

Geriatric Special Interest Group - Social Services' and BASW staff (GSIG)

Institute of Home Help Organisers (IHHO)

National Council of Home Help Services (NCHH)

Association of County Councils (ACC)

Association of District Councils (ADC)

Association of Metropolitan Authorities (AMA)

Domiciliary Services Organisers of 10 County Councils (DSO)

The Issues Analysed

A detailed analysis of these 23 respondents' comments on 16 issues raised by the document was initially undertaken. The 16 issues were chosen because they related to the sections of the discussion document relating to community care. The 16 issues are listed below along with the paragraph or paragraphs of the discussion document to which they relate together with the questions raised by the government under each paragraph (shown in italics);

1. Family Support and Inter-Generational Contact (para 2,7); *Are there ways in which family links can be strengthened and the exchange of help and support between elderly people and their relatives encouraged?*
2. Good Neighbour Campaign and Community Support (para 2,8); *How can this kind of community support be provided on a wider scale?*
3. Dying at Home (para 2,11); *Would patients prefer to be in their own homes during this time, if so what additional support do they and their families need?*
4. Bereavement (para 2,12); *What can be done to help old people to adjust to it?*
5. Balanced Communities (para 5,5); *What steps can or should be taken more generally to achieve better balanced communities?*
6. Sheltered Housing (Para 5,6a); *Is the pattern of housing provision,,,on the right lines, and where should the emphasis lie between public and private provision? What kind of facilities are of greatest importance to elderly people? To the extent that resources permit, are changes desirable in the existing structure of grants and loans in order to provide better assistance to enable old people to effect any necessary improvements in their housing, or their landlords to do it on their behalf?*
7. Housing Provision (para 5,6b); (questions as above),
8. Role of Residential Care (para 5,8); *If suitable housing and domiciliary services were available, to what extent would they offer an alternative solution for those now living in residential homes? Is there, in the long run, a place for residential homes for long-term care? If so what kinds of homes and for what kinds of residents?*
9. Residential Accomodation; Short-Stay Provision and Day Care (para 5,11); *What scope is there for the development of these and other arrangements designed to provide care for people who are not long-term residents, and what are the main limiting factors?*
10. Residential Accommodation; Separation of Lucid and Confused Residents (para 5,14); *What are the views of residents and staff about these arrangements? To what extent should confused and lucid residents be grouped together?*
11. Domiciliary Services (para 6,4); *What examples of good practice and the imaginative use of resources deserve to be more widely shared? What scope is there for improving the present effectiveness of domiciliary services within the resources available?*
12. Role of Social Work (para 6,5); *Views would be welcome on the place of fully trained social workers, knowledgeable about the ageing process, and the effect of physical and mental disorders in old age, in providing the counselling necessary to enable some people to reach decisions acceptable to themselves,*
13. Services for those living at Home (para 6,6); *What is the scope for adjusting the roles of community nurses and for expanding the help provided by auxiliary staff within the district*

nursing service?

14. Psychiatric provision; mental infirmity (para 7.12) *What more needs to be done to ensure a more effective service for dealing with the growing numbers of elderly people likely to suffer from mental infirmity? Are nursing homes needed? If so, how can adequate staffing standards be maintained?*

15. Co-ordination and Collaboration; General (paras 8.2 & 8.3), *How might authorities of all kinds be encouraged to extend,,,collaboration and generally to develop wider perspectives when considering how best to serve the needs of old people? How far in practice do these differences* (in the roles and responsibilities of professionals and organisations) *give rise to difficulties in communication and co-operation, and how can they be overcome? What adjustments might be made in the basic and the in-service training of the various professions involved to enable members to develop an appreciation of the importance of teamwork and co-operation at all levels?*

16. Voluntary bodies and collaboration with statutory authorities (para 8.4) *What further use could be made by statutory authorities of the provisions which enable them to give financial and other forms of help to voluntary bodies providing local services?*

The Form of Analysis

The data produced by the 23 respondents under these 16 sets of issues was analysed across and within the two interest groups, firstly on the basis of the 16 issues listed above, and secondly, under similar headings used to analyse journal articles in Chapter Five;

i) views of, and support for, community care policies;

ii) the organisation and delivery of community care services;

iii) the care of the elderly mentally infirm.

1. **Views of, and support for, community care**

(a) **General perceptions of community care policies**

Health Service Interest Groups

Health responses showed a tendency to preserve and promote the role of the health service in the development of community care. There was a broad consensus that primary health care services should be improved, together with domiciliary (nursing, health visiting, physiotherapy and occupational therapy services) and day hospitals. These views repeated an undercurrent of feeling in the responses which indicated that community care was seen as a threat to health services. For example, the ACA stated it would 'deprecate any measures which resulted in the diversion of resources from the NHS'.

Despite such anxiety, there was common support for the overall policy of community care for elderly people; 'We endorse the objective to help old people to continue to live in the community' (BPS); 'The majority of frail elderly people are best accommodated in their own homes' (RPGC); 'The prime objective should be to help the elderly enjoy the amenities of their own home for as long as possible, to encourage independence and reduce dependence' (BMA); 'The declared aim of care is the maintenance of old people in their own homes' (RCGP); 'The majority of frail elderly people are best accommodated in their own homes' (RCP).

Local Authority Interest Groups

These groups emphasised the need to improve service provision, and levelled more criticism of the availability of community care services. For example, GSIG stated that 'geriatric beds are very difficult to obtain...district nursing services are stretched to the maximum...part III accommodation is increasingly in demand...suitable housing may be unavailable for many months'; 'the provision which has been and is (available) is ad hoc, unsystematic...and grossly variable across the country' (SIGA). The AMA felt that owing to public expenditure cuts 'it is impossible to see how local authorities can do other than "scratch the surface" in their efforts to meet the demands which will result from an increasing elderly population'; the ADC added that 'it is only acceptable for the elderly to remain in their own homes if adequate nursing, chiropody, meals on wheels and home help services are available'.

Community care was viewed as a policy which, in theory, enshrined the right of elderly people to make choices or express their wishes or preferences. Thus, ISW noted that there was 'some evidence' that elderly people 'have a preference to remain at home'; the PSSC believed that 'the starting point' of keeping people independent at home was the 'availability and choice of services'. But, the consensus was that choices were undermined rather than enhanced by the limited availability of community care services. So ADSS saw community care as not only the current 'expectation' of many people, but 'in practice, the only hope for the vast majority of old people' - i.e there was no practical alternative, but to stay at home. It was argued that 'real choice' of services didn't exist - as a result, ADSS argued 'it would be quite wrong to place too much reliance on community care'.

However, despite these criticisms many respondents still positively supported community care policies; 'we endorse the Government's intention that...services should be to enable people to remain independent in their own homes whenever possible' (PSSC); 'the essential objective is to help people to remain independent as long as possible...The Association...accords with the accepted policy of trying to keep the elderly as members of the ordinary community as long as

possible' (AMA), 'The well-known principle of retaining elderly people in their own homes where possible has been,,,accepted by the Association for many years' (ACC); 'The objective of the elderly maintaining independent lives in the community for as long as possible is strongly supported' (ADC); 'the expansion of services to enable elderly people to remain in the community is welcomed' (SIGA).

Comment: Both health and local authority groups positively supported community care policy at a banner goal level. However, both groups (particularly local authority respondents) were concerned at the quantity of such care available; local authority groups questioning the virtue of community care policy if, in practice, it denied choice and freedom.

(b) **Perceptions of need, rights and priorities**

Responses made to the subject of 'Dying at Home' are examined in this section; to illustrate differences between perceptions of need, rights and priorities.

Health Service Interest Groups

Many respondents defended the right of old people to die at home; 'old people wishing to die at home should be enabled to make this choice' (HVA); 'patients and relatives should have the freedom of choice whether to remain at home or be admitted to hospice or hospital care' (RCN); 'If home care (for the dying) is wanted, then every effort should be made to provide it' (BMA). As the RCP stated, 'many people would prefer to die in their own homes'. But on examination there were many factors to be taken into account in the provision of terminal care. For example, the view of the BMA was that 'every effort should be made' to provide terminal care at home given the 'strong feeling' that home was the 'natural place to die'. Yet the BMA cited a number of potentially conflicting factors involving the view and circumstances of informal/professional carers and the cared for, which could influence a decision to provide terminal care at home;

- 'involving relatives,,,is perhaps the most important factor';
- 'The primary factor,,,must be the patient's own wishes';
- the 'adequate provision of attached nursing staff';
- subject to 'certain unmanageable complications arising in the home';
- according to 'medical and nursing needs';
- the principle that old people should not 'die alone, or in unrelieved pain, or as victims of squalor, incontinence or neglect';
- on the basis of 'consultation with the patient's own doctor,,,to assess the suitability of the patient's home circumstances for terminal care';

- subject to 'the demands this may make on the general practitioner and other members of the primary health care team';
- in the light of 'the qualities and attitudes of the relatives who would be providing care at home';
- unless 'care at home imposes intolerable strains' on the family, and thus subject to 'the well-being of the family'. If the family suffered, 'Hospital care may then be found to be the right course' (BMA).

Other health respondents referred to focusing terminal care services on the family; the RCN advocated more support for families who maintained their elderly at home. Likewise, the BMA 'strongly commended' the establishment of services for carers which would 'provide much needed relief at times of crisis' or 'as needs arise and before they reach breaking point'.

Local Authority Interest Groups

These respondents made similar points to their health service counterparts. Thus, BASW said it would 'commend...positive efforts to allow more people to die at home' although SIGA believed that 'Extra resources will be required if people are allowed to exercise choice as to their place of illness and death'. The exercise of choice as to where one died was viewed as 'advisable' by ISW. BASW was more forceful on this point: 'We are concerned at the continuing articles in the press expressing outrage where the elderly die in squalor at home...there should be a campaign of education about the rights of the elderly to make choices for themselves even when this means that they live and die in conditions which the public may find unacceptable...The key issue...is choice...we are concerned at the extent to which...choices are sometimes diminished or denied. Priority is often given to the needs of relatives, neighbours, caring professionals and the public themselves...when decisions are made, the elderly person himself is all too often excluded or overruled'. Similarly, ISW believed that 'at all times the wishes of the client should be paramount'.

This tension between rights of elderly people and their carers, and the judgements of professionals was recognised elsewhere: 'Many people would prefer to die in their own homes... it is families, G.P.s and nurses who are anxious to get them in hospitals and homes' (SIGA); 'throughout...the needs and wishes of the client should be of primary importance, however great the pressure to give priority to other considerations'. The GSIG stated that 'It was felt that many old people would prefer to die at home and that this was their right, provided that they are aware of the risk being taken and that they are not over-riding other persons' rights' - if strain on carers was too great then access to hospital should be sought. A more general stance

was adopted by the ADC which stated that 'It is only when the community can no longer provide for their welfare that,,,(the elderly) should transfer into residential accommodation or become a National Health Service responsibility' (ADC). Other groups suggested giving more weight to the rights and wishes of carers in taking decisions (PSSC, ACC, SIGA, DSO).

Comment: Health service groups supported the right of old people to live - and more especially to die - at home, as did local authority groups. But there was a difference of views within and across the two groups as to the circumstances in which such rights should be forfeited. Health groups (notably the BMA) gave a range of incompatible criteria determining the circumstances in which terminal care at home was practical or desirable. Local authority groups as a whole clearly placed greater emphasis on the right of elderly people to die at home, but also made reference to other factors - notably the stress placed on carers, and the support available to them - affecting decisions about whether terminal care could be provided at home or not.

2. <u>The organisation and delivery of community care</u>

(a) The Role of Sheltered Housing and Residential Care

Health Service Interest Groups

The BMA argued that the use of short-term care/day care in residential homes 'should be extended' because such arrangements were of 'considerable benefit' to the family - a view broadly supported (RCN, RCP, RCGP, BGS). For example, in the case of terminally ill elderly people and their carers, short-term care in residential homes, and other forms of respite care were advocated (BMA, HVA). In general, however, health groups were less clear as to the overall role of residential homes. Thus, the RCN was 'alarmed by the inappropriate use of residential homes' (also RCGN) arguing for the removal of 'sick elderly' patients from part III homes unless their care could be provided by 'a competent or caring relative'. Similarly, the BMA although advocating an 'expansion programme' of residential homes (along with the BGS) recognised that such homes provided 'nursing home type accommodation' - a 'wrong use' of these resources intended for 'those who do not normally require any medical or nursing care' except that available from the primary health care team. On the other hand, the CHSC believed there was 'value' in being able to care for ill elderly people in a residential home. Lastly, in terms of relocating people into part III accommodation, the RCN said 'No pressure should be exerted,,,to sway the individual one way or the other'. But, by contrast, the HVA suggested that elderly people should be encouraged to move to appropriate accommodation; 'relatives and professionals should exercise foresight and encourage the removal to more supported accommodation while the elderly people concerned are still sufficiently flexible in attitude'.

There were also diverse views on the role of sheltered housing. Some respondents saw sheltered housing as an alternative (with domiciliary services) for residential care; reducing admissions to part III homes (RCGN) and containing pressures on hospital services (BMA). This development of sheltered housing was also supported on philosophical grounds; sheltered housing was 'preferable' to 'passive and total support in residential accommodation' (BMA) and thus should 'increase as quickly as possible'. By contrast, the RCP thought it 'doubtful' if sheltered housing could provide an alternative to part III homes because even the best sheltered housing couldn't cater for mentally infirm elderly people. More generally, there was a lack of support for sheltered housing of certain kinds; 'we do not favour the development of large blocks of housing solely for elderly persons' (BGS), such developments were 'not desirable' (RCN). The BMA, however, acknowledged that on this point 'views differed'. BGS was more candid; 'we do not know the most appropriate balance of different types of (housing) provision'.

Local Authority Interest Groups

These groups gave most positive support to the greater development of short-term care and day care in residential homes. BASW commended such developments as did SIGA, NCHH, ACC and PSSC. Yet amongst these views, NCHH and ISW raised other considerations; 'what about...other residents in homes?...Is it bad for elderly people to be uprooted into temporary care?' (NCHH).

Views about the overall role of residential homes varied although there was general agreement that 'there will always be a need for (them)' (SIGA). But as for the emphasis placed on developing homes, while IHHO believed such services should be provided on a reduced scale, the PSSC saw the planned development of residential services as 'too slow'. The clientele of residential homes were described as those whom the community could 'no longer provide for' (ADC and ACC); as frail elderly people 'not able to lead independent lives without constant supervision...the very elderly and accordingly frail and/or handicapped' (ISW and ADC, BASW). The ACC stated that 'residential homes are not nursing homes' but the AMA accepted that such homes, in practice, were indistinguishable from nursing homes, and the NCHH stated positively that the future of residential homes could be 'nursing homes, staffed with nursing aides for total care of dependent people who are not treatable in hospital'. In general terms, ACC summed up its view; 'no adequate solution had emerged' as to the role of residential homes. Finally, BASW noted that when admitting to residential homes, 'There is often insufficient consultation with the elderly person himself...this is sometimes avoided because of other pressures such as the need to empty a hospital bed or to relieve strain on relatives. These situations do present a dilemma for social workers in determining who is the client since it seems impossible to respond to the wishes of both the elderly person and caring relatives'.

In terms of sheltered housing, the AMA 'strongly endorsed' the policy to provide as much sheltered housing 'as economic circumstances permit', BASW referred to specially designed buildings as 'commendable' and the ADC saw a 'continuing and expanding role' for sheltered housing. But alongside this, the DSO group remarked that 'the grouping together of elderly people in special housing sometimes produces isolation and serious and depressing disadvantages', Another criticism was voiced by the PSSC which pointed out that there was 'considerable evidence' that moving people to sheltered housing can have 'harmful effects'; BASW agreed, arguing that sheltered housing should not be seen as 'the start of a progressive movement into more dependent relationships', These views were not appreciated by ISW; 'the elderly should be able to move through a spectrum of housing accommodation from complete independence to residential homes as disability increases'; the AMA added that more should be done 'to encourage elderly people to move to accommodation better suited to their needs',

The PSSC spoke of 'confusion' surrounding the role of sheltered housing and called for an 'urgent review' of its objectives, since it tended to be viewed by social service authorities as 'a major alternative to residential care for incapacitated elderly people' but by housing authorities as 'a preventative provision for relatively fit elderly people', The AMA's view was that 'Elderly people that used to be in residential accommodation are now...in...sheltered housing', The ADC, however, identified the need to develop hybrid sheltered housing 'to fill the gap between the type of sheltered housing...designed for elderly people who are still able to cope for themselves reasonably well, and the residential home which is now mainly designed for the very frail elderly needing constant attention'; to 'alleviate pressure on residential accommodation', The ADC argued that sheltered housing 'should not be used as a cheap alternative' to residential accommodation, although, in practice, there was 'no clear dividing line between the elderly residents in each', Elsewhere it was felt that the idea that sheltered housing would remove the need for long-term residential provision was 'ill-founded'; reducing residential care on this basis would be 'deplored' (PSSC),

Comment: The responses from health and local authority groups to the roles of sheltered housing and part III are mixed on both sides, Both health and local authority groups argued for an expansion of the use of residential homes for short-term, respite and day care, But neither of the groups were clear as to who should be long-term residents in homes; some health groups saw such housing as preferable to part III homes, some were unsure of the clientele for sheltered housing; others remarked on the damage sheltered housing produced by creating geriatric ghettoes, Local authority groups provided a similar range of views, There were mixed views put forward by health and local authority groups as to the virtue of a "move-on" policy which would

match elderly people to accommodation according to their dependency level, and the allocation criteria by which housing resources should be utilised.

(b) **Professional Roles**

Health Service Interest Groups

The bulk of health group comments relating to professional roles concerned the health visitor and social worker. In the case of the former, HVA thought that a 'considerable increase' in health visitors was needed to enable them to extend their work to the elderly; RCP viewing the possible 'shrinkage' of their role with elderly people with 'grave concern'. The RCN saw the role of the health visitor in terms of assessing the 'nursing needs of the elderly'. However, medical groups saw them as having a 'key role in assessing needs and counselling patients and relatives' (BGS); as undertaking 'the counselling and surveillance of the elderly supported by the social worker' since they worked 'most effectively as counsellors for the elderly' (BMA); to be 'widened' to enable them to keep elderly people 'fully informed of entitlements to medical and social benefits' (RCGP). As for social workers, they were to 'act as specialist advisors to general practitioners in order to help in difficult casework with the elderly' (BMA). In general, there were calls for more specialist social workers to work with the elderly (RCP, BGS, HVA, RCN) although the RCP felt that 'much work' except 'complex and subtle casework' could be done by untrained social work assistants.

Local Authority Interest Groups

The role of social workers was the principal focus of local authority responses. BASW referred to the 'considerable value of trained social workers being involved in work with the elderly'; 'the elderly no less than other client groups have a need for,,,skilled social work intervention' (ACC). Yet social workers spent 'little time with the elderly' (NCHH), 'low status' was accorded to work with the elderly despite the fact that it was 'important' for old people and their families to have 'ready access to skilled assessment and counselling' (PSSC). Social work training in the care of the elderly was said to be 'inadequate' and amounting 'to a major cause for concern' (BASW and SIGA). Thus, social work assistants picked up elderly caseloads, although supposedly only under 'very close and careful supervision' (BASW and ACC). Due to this lack of social work involvement NCCH argued that 'the job of home help organiser could be developed to include the counselling of this group of clients' - it was the role 'they already (but unofficially) play as advisers to the elderly'; likewise, the DSO advocated using home helps in rehabilitation and the re-learning of skills for elderly people.

SIGA described the social work role with the elderly as to 'help people reach acceptable personal decisions'; BASW identifying an 'essential role' in respect of admissions to residential homes; 'the counselling that is often needed when old people are taking this major decision,,,they can provide support during the settling in period'; there being a 'strong case' that they should be involved in 'initial referrals and assessment' and 'at points of transition,,,points of trauma and crisis'. More generally they had 'a vital role in the organising of services and resources,,,(a) co-ordinating and enabling role' (BASW).

Comment: Health interest groups looked for an expansion in the numbers and role of health visitors to enable them to undertake casework-type responsibility with elderly people functions (general assessment and counselling). Social workers, it was argued should have a more specific role and specialise in working with elderly people. Local authority interest groups acknowledged that social workers should work more with elderly people, but in practice were unable to do so, this lead some to call for greater home help involvement in elderly casework. The input of social workers to the care of elderly people was described as being at times of crisis or for reaching key decisions such as admission to part III. The unclear responsibility for elderly people reflected in these comments clearly hindered the co-ordination of services.

(c) Collaboration and co-ordination

Health Service Interest Groups

The BMA recognised that the 'interdependence' of services for the elderly demanded 'effective joint planning without which it is impossible to achieve an appropriate balance of services'. Whilst respondents emphasised the need to improve links between the primary health care team and social services staff, hospital services and the voluntary sector particularly when admitting and discharging elderly people from hospitals, the separation of health and social services had produced 'increased problems in caring and duplication of service provision' (RCGP). Closer liaison between these services was described as a 'top priority'. Even in the case of the primary health care team reference was made to the 'ineffectiveness,,,that is caused through a lack of understanding of the individual roles of (team) members' (RCN).

Local authority interest groups

Inter-professional collaboration was long overdue; it was alleged that there had been 'some confusion in health and social service departments over who is to provide what and for whom' since 1974. Experience indicated that 'the priorities of the various professional workers often differ fundamentally' (PSSC). Yet despite this, mutual support was said to be 'of the greatest importance,,,a joint approach is vital,,,(because of the) increasing danger of duplication', it

was argued, 'there should be clarification' of the roles of social service and health service community workers (ACC). Teamwork and co-operation were 'highly desirable' (ISW); joint planning could counter 'overlap and duplication' of services (ADC). But although SIGA viewed collaboration as 'vital', there was a general dissatisfaction with the quality of collaboration between organisations and professions. For example, ADSS was 'not happy' with the level and effect of collaboration, and ISW was 'very dissatisfied' with attempts at collaboration.

Comment: Clearly both health and local authority groups saw the need for formal and widespread collaboration; but both groups acknowledged this was some way from being achieved.

3. <u>The care of the elderly mentally infirm</u>

Health Service Interest Groups

Overall provision for the elderly mentally frail was generally thought to be poor; 'progess is slow' (BMA); 'the greatest deficiencies lie in psychiatric services for old people' (RCGC) since they were accorded 'low priority' and suffered 'neglect' (RCP). In service terms, HVA admitted that on the matter of providing specialist accommodation for this group of elderly people, 'opinion was divided'. Whilst, it was argued that 'wherever practicable, demented patients should be cared for at home' (BMA); that 'more of this group could be kept at home' if community provision was adequate (RCGN), the RCGC argued that mentally infirm old people could not be cared for at home 'since it is impractical to provide round the clock domiciliary care'. Similarly, people with established chronic brain syndromes needed '24 hour supervision and care' (RCP). The latter point was made by RCGP which argued that patients with 'irreversible brain failure should be cared for in a residential home'; a matter on which BGS and RCGC agreed. On a similar basis, RCP argued for specialist homes for this mentally frail group; the BGS argued that the lucid and confused elderly should live in separate homes; the BMA argued that separate homes were 'not always desirable'. The RCN stated that 'a mixture of people' was 'part of normal social interaction' and was in general against separate provision; the RCGP thought integrated provision was possible given 'careful selection' of residents.

Local Authority Interest Groups

The care for mentally infirm elderly people was described as 'abysmal' (SIGA), eliciting 'different views', requiring 'urgent attention' (ACC). The vast bulk of comments made by respondents related to the nature of residential care for these people. One group believed that 'it is important to avoid placing mentally handicapped and physically handicapped people together' (IHHO). Another argued both ways; 'the overriding feeling,,,is that there could be separate accommodation for the mentally confused' since their presence among the lucid elderly

caused 'considerable distress and irritation'. But equally it was 'criminal' that such people should be 'shut away without a chance of rehabilitation' (ISW). The majority of respondents were unsure whether there should be separate accommodation for the elderly mentally infirm or not - BASW believed that 'further research' into this 'dilemma' was needed. SIGA saw the mixing of residents as 'helpful and stimulating' for the mentally frail but 'worrying and depressing' for the fit elderly (also ACC). On similar grounds the FSSC emphasised 'the need for caution on this issue'. The ACC therefore came closest to the truth when it suggested that there was 'no general agreement' about whether homes should cater for the elderly mentally infirm.

Comment: There was a recognition from health and local authority groups that support and accommodation in the community for the elderly mentally infirm was poor. Whilst some health service interest groups thought it practical to support such people in their own homes, others did not, and by implication neither did local authority interest groups given their preoccupation with issues related to residential care. There was no consensus from either group regarding the appropriate housing or social support which should be available to this group.

Overall Summary

Consensus and community care banner goals

The issues on which there was general consensus across both groups, tended to be banner goal statements of a high order of generality. For example,

that elderly people should stay at home for as long as possible;

that elderly people should have the choice of remaining at home to die;

that inter-agency or inter-professional collaboration was good;

that elderly people should not require nursing care in part III homes.

There were also negative issues on which both groups held the same view, notably that community care services for the elderly mentally frail were very poor. It was notable that both health and local authority groups supported the need for improved collaboration, although recognising that in practice such collaboration was hard to achieve.

Consensus and specific community care issues

Although there was support for these banner goal statements, comments made by both health and local authority interest groups show that it was unclear to what extent, in practice, these banner goals would be pursued. For example, in accepting that elderly people should be accorded the right to stay at home, the extent to which their wish to remain at home should be paramount was unclear; should such a wish take precedence over professional judgements, the wishes of carers, bureaucratic procedure? In general, respondents seemed more capable of supporting a

theoretical ideal than a set of procedures, values or priorities based on that ideal. This is hardly surprising given that lending support to a community care ideal is unlikely to have a great impact on the work of a community care practitioner; but, having to implement a procedure or set of working practices based on that ideal may have a profound impact on a practitioner.

Across responses as a whole, there were issues on which there was disagreement within and across the two groups;

the function of sheltered housing developments;
the overall role of part III accommodation;
the identity of the main counsellors/advice givers to elderly people at home (health visitors, specialist or generic social workers, social work assistants or home help managers);
mixing of mentally frail and mentally fit elderly people in part III homes;
the extent to which "marginal" elderly people (such as the mentally infirm or terminally ill) could be cared for at home.

Taken together, the disagreement on these issues represents a serious obstacle to co-ordinating and delivering community care services particularly if support is provided a) by a range of statutory community carers, or, b) to dependent elderly people on the margins of services.

As suggested in Chapters Three and Five (p50, 68 and 96), it may be possible to understand why consensus on an issue breaks down by reference to the rationales which underpin any particular policy or policy; these rationales appeal to different professional value-systems, models of care and priorities (see pp42-43). In these responses analysed here it was possible to identify four such rationales;

i) *An organisational rationale* - concerned with optimising and the practicalities of providing services in particular ways. Emphasis might be placed on continuity of care, prevention or crisis intervention, service co-ordination, elimination of client risks. Each of these objectives has its own separate implications.

ii) *A resource-based rationale* - concerned with resource availability and usage, cost-effectiveness and appropriateness. A resource-based model tends to fit people to the available services according to definitions of service role.

iii) *A humanitarian rationale* - a non-directive approach to decision making, presenting clients with options and allowing them to make informed choices. The rights perspective matches available services to the people.

iv) *A needs-based rationale* on the basis of defined need, services would be allocated.

Thus, as with iii) resources were matched to the individual, but unlike iii) the criteria for allocation of resources were determined by the professional carer's judgement of need. Definitions of need varied by profession.

Consensus and Collaboration

Identifying the rationale(s) underpinning any particular community care policy (and thereby the values, priorities and objectives of each policy) may explain any differences of view amongst community care practitioners in relation to that policy. For example, although there was consensus on the right of elderly people to die at home; the responses made on this issue indicate that terminal care in the community was justified on the basis of any of the four rationales listed above. This in turn may explain the difficulties in providing such care on a collaborative basis; the rationales underpinning terminal care may impinge on the value-systems and priorities of professionals in different ways, affecting their willingness to collaborate.

Introduction to Section Three

Content analysis of the journal articles and responses to 'A Happier Old Age' indicates that;

- there was mixed support for community care banner goals in the journals but universal support in responses to "A Happier Old Age". Nevertheless, consensus tended to exist on issues of a high order of generality;
- there was little consensus across groups on the same specific features of community care and several features which seemed to provoked disagreement over time, across and within groups (for example, the care of the elderly mentally infirm, the role of part III homes);
- there is variable support for specific aspects of community care policies. This partly reflects the association of community care with the different rationales underpinning these policies, which in turn received mixed support given the various value-systems and priorities of the interest groups (see p67).

Given these findings, the next Section continues to explore more critically the links between consensus, collaboration and the implementation of community care by posing three questions;

In practice, is collaboration an essential prerequisite of community care?

If not, why not? If so, is consensus a prerequisite of collaboration?

What factors determine the pattern of consensus or the extent of collaboration?

SECTION III

CHAPTER SEVEN

Case Study 1: Integrating Local Services for Elderly People

Introduction

Chapters Two to Four have illustrated the historical and conceptual diversity of community care policies for elderly people. In particular, Chapter Four highlighted the importance placed on collaboration as a prerequisite of community care as well as raising general issues about the links between the nature of community care policies, inter-professional consensus and collaboration given the complex and diverse nature of these policies (pp68-69). The evidence presented in Chapters Five and Six gives further cause to question the basis on which community care policies are supported by the practitioners are expected to jointly implement them. Given the findings from Sections I and II, some of the assumptions made about the linkages between consensus, collaboration and community care are critically examined in this third Section by exploring three questions;

In practice, is collaboration an essential prerequisite of community care?

If not, why not? If so, is consensus a prerequisite of collaboration?

What factors determine the pattern of consensus or the extent of collaboration?

Three fieldwork studies were undertaken which shed light on these issues. Chapters Seven and Eight examine in detail the origins, planning and development of two projects which attempted to improve local community care for elderly people. The remaining 'control' study, reported in Chapter Nine, explores the nature of day-to-day relationships between community care practitioners with responsibility to support elderly people in the community in three adjacent city centre and suburban localities. The research methodology for these three studies is described in Appendix 1 and briefly introduced in Chapter 1.

The findings from the first two project case studies are presented in four sections covering the description of the projects, their planning and operation, and lastly, the interactions between professions or agencies related to the project. This structured analysis then allows some responses to be made to each of the three questions raised above.

1. Scheme Description: The 'Core' Scheme

This first study examines an initiative to replace a former Victorian Poor Law institution (functioning as a part III residential home for elderly people) by an innovative combination of community-based 'core' services. The new services planned were built on the site of the part III home and were first introduced in March 1983. These 'core' services were to serve

elderly people living in a rural, relatively inaccesible district council area within an English Shire County. The project explicitly sought to enable elderly people to live at home for as long as possible, through the direct provision, or co-ordination, of a range of services and facilities comprising the following;

i) a range of on site 'core' services; a 6 bedded short-stay residential assessment unit, 38 sheltered housing units, a 20 place day centre, a home-help laundry and meals-on-wheels kitchen, office accommodation and a reception area;

ii) a range of 'core' site professional support; social work services; an occupational therapist (and thus aids and adaptations); a domiciliary services manager; 24-hour, 7-day-a-week warden services; and care assistant support; ambulance transport;

iii) ready access, by direct referral, to the local primary health care team (G.P.s and Community Nurses); domiciliary social service support (home helps, home care aides and meals-on-wheels); relevant housing services (mobile warden services, housing lettings and other housing maintenance support);

iv) should it prove necessary, access to long-stay social service residential accommodation or, alternatively short-term acute hospital care. The services and facilities under i) to iii) inclusive were to be jointly allocated on the basis of local joint assessment processes, joint management and funding arrangements.

a) The Philosophy behind 'Core' Services

From 1979 onwards, a series of papers outlining the philosopy and purpose of the proposed core services were drafted (see section 2 below), the earliest of which attributed the development of these services to the fact that 'Too many elderly people are in the wrong place at the wrong time for the wrong reason' (First draft SSD paper, 'Integrated community services for the elderly', January 1979). In response to this situation the Director of Social Services stated that core services were to be 'tailored to the needs of individual tenants' (Letter, Director of Social Service to Carnegie Trust, 20.12.79); a view reflected in a later paper which described the project as 'an alternative to traditional and separate services' which 'encourages the fitting of services to people and discourages fitting people to services' and which was 'attractively cost-effective' (Third draft SSD paper; 'Integrated Services for the elderly', 1979). A subsequent paper on core services confirmed that 'all elderly people should have access to services appropriate to their assessed needs', encapsulating much of the thinking behind the core project in the following passage;

'Services for elderly people are provided by many statutory and voluntary agencies,,,For the most part there has been no significant joint planning or sharing of resources. The needs of each individual elderly person are split up amongst the various agencies with

consequent confusions, ineffectiveness and inefficiency,,,Furthermore, the services are organised in such a way as to shape each individual's needs to available services, rather than the other way around. And for the most part all but the most basic services cannot be provided in or close to the elderly person's own home. The results are enforced separation, disorientation, and poor prospects of eventual rehabilitation for many old people. It is with these shortcomings in mind that the replacement provision has been planned as a joint venture,,,providing integrated local provision for all elderly people in the catchment area' (Paper by Deputy Director of Social Services, "Integrated local services for elderly people", 18.10.82).

These document extracts indicate that core services were based on three main rationales:

i) ***Humanitarian*** - the core model was regarded as beneficial to, and preferred by, the consumer; increasing self-determination, empowering elderly people to make informed choices about their lives and future. Thus, service packages were to be tailored to the individual needs and wishes of elderly people, retaining their independence in the community and thus improving their quality of life.

ii) ***Financial*** - core services would, to some extent, reduce demand for more expensive part III and hospital care. Multi-disciplinary assessment of need and drawing on a wider pool of services should enable care packages to be developed which were aimed at providing rehabilitative and preventative care to elderly people.

iii) ***Organisational*** - avoiding service duplication, overlap and gaps in provision; improving the continuity of care through locally co-ordinated, jointly allocated services; improving inter-professional co-operation through joint needs assessment and the flexible deployment of jointly managed and pooled resources; improving services to people on the margins of traditional services, who, typically, were not the responsibility of a single service manager.

Thus, the core philosophy was underpinned by many of the rationales attributable to community care policies in Chapter 3 (pp42-43) as well as being rooted in the need for collaboration heavily associated with community care policies (see Chapter Four). The nature of the core service model is represented by diagram 8 below, which can be contrasted with the more 'traditional' model of care which pre-existed it (see diagram 9). In this traditional model services were compartmentalised; each service was separately managed allocated and staffed, each with their own administrative systems and professional gate-keepers. The main shortcomings of this model were that it relied on boundaries being drawn between services, each with its own pre-defined cut-off point. Thus, there was potential for general

disagreement about when services should be provided and by whom, resulting in service discontinuities, avoidance of clear professional responsibility for clients and crude attempts to fit elderly people to available resources.

Diagram 8: Core service model

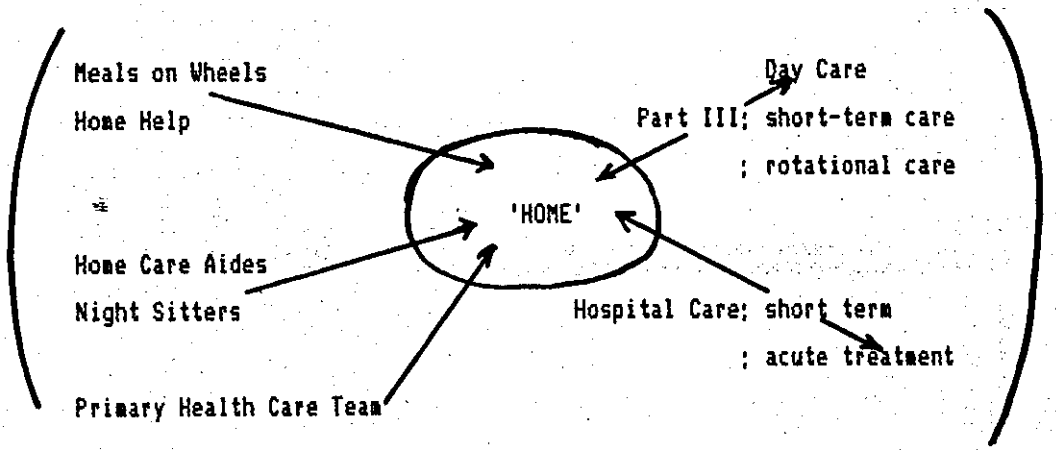
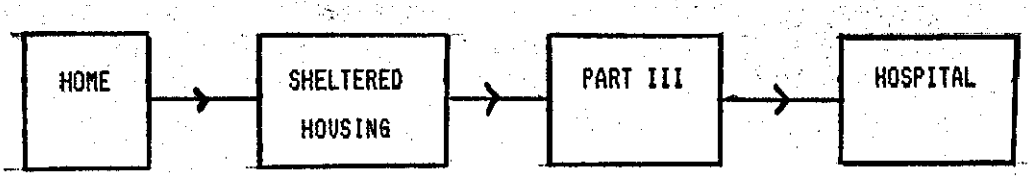


Diagram 9: Traditional service model



Highly Independent,....+,....+,....+,....+,....+,....+,....+,....+,....+,.Highly Dependent

b) Management Structure

i) ***Project management structure***

The core scheme provided services traditionally managed by three organisations - the Community Services and Residential and Day Care Divisions of the County Council Social Services Department (SSD), the local District Health Authority (DHA) and the local District Council Housing Authority. Core services were co-ordinated on a day-to-day basis by a 'core team' (CT) comprising of staff employed by these three agencies, who were in turn managed by a Joint Management Group (JMG) of more senior officers from those same agencies:

Joint Management Group:

Assistant Director of Housing

Senior Nursing Officer

Area Social Services Officer (SSD)

Area Residential Homes Supervisor (SSD)

As the diagrams in part (ii) of this section below indicate, JMG members were direct, or ultimate, line managers of all core team staff, who are listed below,

Core Team:

Chief Housing Assistant (District Council)

Co-ordinator of Warden Services (District Council)

District Nurse (Health Authority)

Office Clerks (Community Services Division, SSD)

Patch Co-ordinator (Senior Social Worker, Community Services Division, SSD)

2 Social Workers (Community Services Division, SSD)

Occupational Therapist (Community Services Division, SSD)

Domiciliary Services Manager (Community Services Division, SSD)

Warden, Deputy Warden and Assistant Warden (Residential Services Division, SSD)

ii) ***Staff structure and services; line management arrangements***

The new on-site core services were provided to a large measure by staff from the part III home it replaced, who remained under the management of the Residential Division of the SSD; care assistants were merely tranferred across from one service to the other; the matrons of the part III home became the new wardens, retaining day-to-day management of the care assistants. The management of wardens through the SSD was atypical and unique in the County Council at that time; in this area, as elsewhere in the country, wardens were usually employed by housing authorities, not social services departments. However, the appointment of the previous matrons to the warden posts was necessitated by the no-redundancy policy of the County Council and led to the continuation of previous line management relationships. Other SSD (Community Division) staff employed were recruited afresh to the area; two whole time equivalent (WTE) social workers, one WTE occupational therapist and one WTE domiciliary manager, together with secretarial staff. Lastly, housing and health staff were released to work on the project as required; no new posts were directly employed on the core scheme from these two authorities. The line management arrangements for all core team staff are shown diagrams 10-12 below (an asterisk indicates those staff interviewed for the research). As diagram 12 shows, Social Services' responsibilities for different elements of the core service were shared; the senior warden had day-to-day management responsibility for the services provided within the building; the short-stay residential unit, the day centre and the sheltered housing units. The Patch Co-ordinator had overall responsibility for community-based social services. This diagram also gives an indication of the complex geographical division of management responsibilities for community services within the SSD.

Diagram 10: Housing authority staff line managament structure

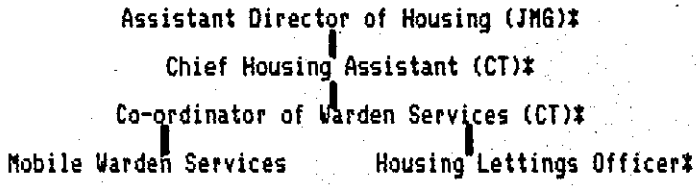


Diagram 11: Health Authority staff line management structure

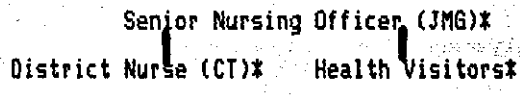
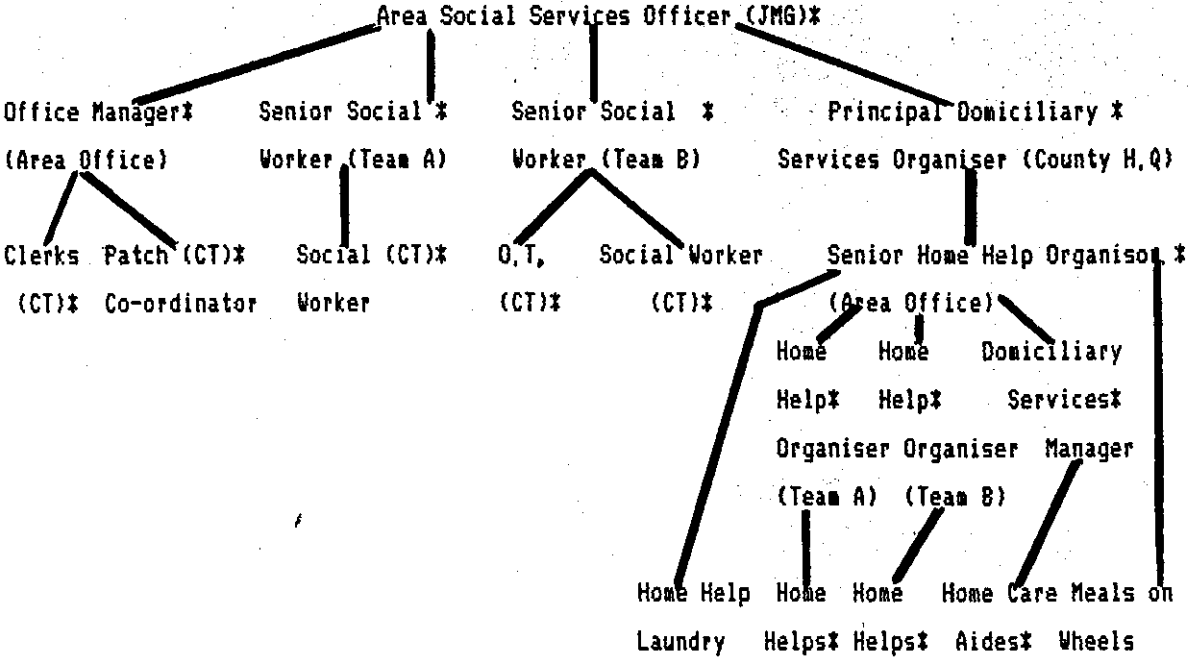
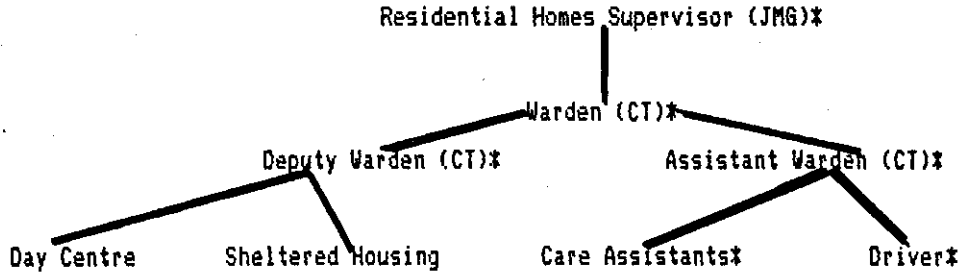


Diagram 12: Social Services staff line management structure:

(a)COMMUNITY SERVICES DIVISION



(b) RESIDENTIAL SERVICES DIVISION



c) Funding Arrangements

The core scheme was capital funded by the District Council and the County Council Social Services Department. The former funded the sheltered housing units, car parking areas and surrounding gardens; the latter funded the day centre, residential unit, office accommodation and reception areas. The Housing Authority took responsibility for maintaining the fabric of the buidlings. The County Council provided most of the revenue funding; paying for the 24-hour warden and care assistant service to the building and the fieldwork and enhanced domciliary services. The Health Authority continued to fund community nursing services.

2. The planning of the Core scheme

In 1978 the Director of Social Services met with a local Director of Housing to discuss plans to replace a part III home in the latter's catchment area. Both Chief Officers agreed that some combination of accommodation, day care and community services should be provided locally to enable elderly people to stay longer in their own homes. Given this broad agreement and commitment from the two Chief Officers, other officers of the two authorities met in 1979 to discuss the type and combination of services which could be provided; producing a series of draft documents referred to in section 1 (a) above. In one early planning meeting it was noted that 'there was some concern expressed about the philosophy consistent with each element of the provision on the site, and some different views were expressed as to the degree of integration of services, and the ways in which both staff and buildings could be used as a resource to meet the widest need in a cost-effective way' (Note of a meeting, dated 17.2.78). Indeed, some 18 months later, a number of issues relating to the service mix to be provided, the clientele to be served, building design, service management and operational procedures were noted to have provoked 'heated' discussion (Meeting Note, 20.12.79) despite general agreement on the virtues of integrating services as implied in the core philosophy.

In 1980 the SSD's Consultant on Elderly Services recommended that a Steering Group be established to take the project forward (Letter Consultant to SSD Assistant Director, 9.7.80); some ten months later this same officer wrote that 'A lot of work remains to be done in relation to operational policies, organisation and management. If it is to be run as part of an integrated service for the elderly, commitment in the planning and operational guidelines will be necessary from the Health and Housing Authorities' (Letter to SSD Assistant Director, 28.5.81). Following this, the SSD's Deputy Director set up and chaired an internal SSD ad-hoc Working Party to finalise the detailed plans for the project based on the essential features of the core philosophy expressed in the earlier draft documents on core services. However, the Deputy Director left the department in 1982 following which there were

fundamental disagreements amongst SSD operational managers regarding Divisional responsibilities for the project and the basis on which it should be implemented.

The Deputy Director was one of several core project advocates who left the SSD between 1980 and 1982. Thus, at this mid-point of the project planning process two SSD officers remarked that the project was effectively orphaned; 'no-one else "owned" it,,,there was a lack of commitment to resolve any issues'; 'part of the problem is,,,whose baby is it ,,,no one person had or would have personal responsibility for it'. The dilution of middle management ownership of the project was associated with a lack of commitment to implement the project as set out in the draft plans on core services. As two other social services officers stated; 'many people won't accept that core was established to implement a new type of service,,,a project trying to straddle traditional lines'; neither of social services' operational divisions would 'stick their neck out for core - they're not committed to that type of service provision'. Reflecting this situation and following the departure of the Deputy Director, an Assistant Director of Social Services wrote that in the former's absence 'it is impossible to identify someone with the time to properly oversee and co-ordinate the various developments within this project' (Letter Assistant Director to SSD Director, 23.12.82).

Eventually, in January 1983, a few months prior to the completion of the site building works and several months after the Deputy Director had left, a Joint Management Group (see section 1 (b) above) was formed to oversee the project until it became fully operational. In the absence of any formally agreed detailed project plans, the JMG had to write job descriptions for core staff, define the role and functions of project services and prepare the basis for assessing people for those services. This, a JMG member argued, was 'very, very late' in the day. Accordingly, when the project opened in March 1983, there was widespread ignorance of the likely impact of the project outside the JMG. Indeed, it came as a surprise to some social services managers, G.P.s and community nurses when the JMG began to implement the core project on the basis of the philosophy described above.

Overview; the nature and planning of the Core Project

The core project represented a radical approach to community care; it sought to formally restructure all health and welfare services available to elderly people in a large geographically isolated area to improve the range, quality and efficiency of community care services. The project relied on close co-ordination of services and intensive inter-professional collaboration; with the SSD as the lead agency. The core philosophy was formally developed from a very eary stage in the 5 year core planning process through a succession of

draft papers; being repeatedly expressed in banner goal statements, which sought to promote the independence of old people in their communities by appealing to the virtues of organisational efficiency, cost-effectiveness and humanitarian values. Although these core banner goals were written down and used as a basis to formally negotiate capital and revenue funding, it was apparent that after opening the scheme the implications of this philosophy were not understood or accepted by key service managers and community practitioners. Moreover, the limited ownership of the project made it vulnerable; the project was perceived and treated as if in a no-mans land, with senior SSD managers being reluctant to preserve the integrity of the project as originally planned. The section below amply illustrates the ambivalence interviewees felt towards the core scheme.

3. <u>Operationalising core services: the gap between theory and practice</u>

One of the striking features of this case study was the contrast between interviewees' common support for the core philosophy and their widespread reservations about the operational impact of the project. As one G.P. stated, 'With regard to the philosophy and principles of core we agree with these, but unfortunately in practice there are problems'; and in the view of a social services officer, 'Conceptually, if you talked to anyone in the department they would be committed to the philosophy, but it's jumping to practical service provision that's the difficulty'. For example, the following statement of positive support for the core model by a housing manager was by no means atypical; 'The project is within our continuing philosophy of community care for the elderly. It's consistent with the philosophy of extending services to more elderly people...It's consistent with providing services to elderly people in an acceptable manner, and dying in a civilised manner without unnecessary recourse to part III or geriatric wards'. Yet, in explaining the poor implementation of the core project, many practitioners and managers cited similar problems;

'Core has a philosophy which the organisation is not conducive to carry out - the philosophy is hard to apply...it is still wrongly seen as an alternative form of residential accommodation with all that means' (Senior Social Worker).

'It was clearly to be a different style of service provision - an attempt to move away from the traditional services...Beyond that, it's clear that people in the Department have different understandings of the project and different abilities to adapt to it' (SSD Assistant Director A).

'most interested parties would agree that core is a better way of looking after the elderly, but the mechanism to achieve core principles is not agreed' (Residential Homes Supervisor).

'I would not want to change the philosophy or the principles of the core scheme...but we have not been able to fulfill these principles in many areas and I think this is because some

of the core team do not fully understand what the philosophy and principles mean in practice' (Occupational Therapist).

'I'm sure a place like this can give the ultimate in care for old people,,,it's fine on paper, but in practice it doesn't work,,,I think we all approve of the idea which core represents, but it does seem to be unrealistic at times' (Warden)

'Those who have thought about the philosophy are committed and so are the senior managers, but there's no pathway from these people to those who deliver the services which cause them to understand the principles - so they stay where they are, People in the system who have nor formal responsibility for core influence staff to stay where they are' (SSD Assistant Director B).

This disparity in perceptions between the theory and practice of the core project and its philosophy is similar to that reported in Chapter 6 (p113). The next section examines some examples of specific issues which undermined either the collaborative nature of the core project or the overall implementation of the core project.

4. Operational problems: Challenging Organisational structures and policies

a) Warden Services - Residency and Role

The core building design incorporated a residence for the senior warden adjacent to the sheltered housing units; at the time, DoE capital loan sanction was conditional upon such accommodation being provided. In addition, warden residency reflected local imperatives; first, the need to have ready (24 hour on-call) access to the warden as manager of the on-site services; second, the acceptance of conditions of employment for both wardens employed by the local housing authority and officers-in-charge of homes employed by the SSD. Thus, the residency of the warden was included in the legal "heads of agreement" signed by the SSD and Housing Authority. However, despite this formal agreement, the senior warden appointed was not resident, because County Council policy for officers-in-charge of residential establishments had changed, no longer necessitating residency.

It was unclear whether this decision affected the implementation of core services. But it demonstrated a unilateral decision-making process to accord with a change in County Council policy. As a housing manager commented, the County Council 'took it for granted that their policies would apply and I took exception to that presumption. We were anxious to play a full role in decisions rather than have them made on the basis of presumed principles. Unthinking acceptance of existing policy ran contrary to the spirit of the new project'. Clearly, the SSD, in taking its decision, effectively treated the wardens in the same way as its officers-

in-charge; and in opposing this stance, the Housing Authority referred to the need to treat core wardens as all other wardens in the Housing Authority. Both these approaches to the issue showed a tendency to pursue a solution which suited the respective organisations rather than a joint perspective based on the core project philosophy.

b) **Allocation of sheltered housing units**

In 1980, the Director of Social Services described the proposed core service as a 'hybrid' between a residential home and sheltered housing (Letter, Director to *The Times*, 9.7.80), reflecting an early commitment to avoid unnecessary admissions to traditional part III homes and the difficulties associated with moving increasingly frail elderly people on from sheltered housing. Thus, from an early stage the Housing Authority and the SSD sought to negotiate a mutually acceptable points system for allocating core sheltered housing but found this difficult because each agency held different definitions of priority needs and perceptions of staff utilisation. The solution adopted was both formal and informal. The formal position was that the Housing Authority formally retained the sole right to allocate the housing units. However, for these units a separate points system was devised to reflect social need, and the allocation of units was jointly agreed in meetings between the Area Social Services Officer and Assistant Director of Housing.

c) **Domiciliary Service Management**

This third issue was central both to the core project community care philosophy and the nature of collaborative working. The core philosophy emphasised the need for jointly managed, locally deployed staff. The core domiciliary services manager (DSM) was therefore intended to manage and co-ordinate home help and home care aides in the core catchment area; as one social services officer remarked, it 'would be stupid to have two management structures side by side' for these groups of complementary staff. Yet this arrangement ran contrary to existing SSD policy where home helps were managed by local domiciliary teams and home care aides through the area office (see Diagram 12 above). Moreover, differences in County Council pay scales and conditions of employment for home help and home care aide organisers meant that, as one officer remarked, 'we would be breaking a procedure in combining the responsibilities which could have caused ripples for other organisers'. As a result, a compromise was reached when the DSM was appointed to the project; the postholder co-ordinated both sets of staff in liaison with the relevant home help organisers and the senior home help organiser (based at the area office).

A less flexible arrangement was agreed in relation to the management of the meals-on-wheels kitchen and home help laundry which were traditionally managed by three managers;

i) kitchen assistants were managed by the Senior Home Help Organiser;

ii) the resourcing of meals-on-wheels kitchens was undertaken on a county-wide basis by the Principal Domiciliary Services Officer (PDSO) based at the County H.Q;

iii) the home helps by the local Home Help Organiser.

County Council policy assumed that all services within a residential establishment were the prime responsibility of the officer-in-charge - the senior warden in the case of the core project. Yet had the warden become responsible for the three services identified, then an officer in the SSD's Residential Division, would be managing Community Service Division resources and staff. This arrangement was unacceptable to senior managers in the Community Services Division; the PDSO, who had ultimate responsibility for domiciliary services in the area, was instructed in a memorandum from an SSD Assistant Director to 'only relate to a home help organiser not a warden'. So, as one SSD officer remarked, 'It became an issue of boundaries again'; the response was to opt for a more traditional arrangement of services involving least change, and preserving the status quo of local management arrangements, and ensuring that the core project staffing arrangements, in the words of a core team member, 'conform to the rest of the County'.

c) Flexible Deployment of Domiciliary and Care Staff

The nature of domiciliary and care staff support in the core project was intended to be different from the pattern elsewhere in the County. The plan of core services drafted by the SSD Deputy Director in 1982 emphasised the need to integrate resources; 'The staffing of the core team, availability of back-up and specialist staff, and the overall level of resources should ensure that irrespective of accommodation, all elderly people should have access to services appropriate to their assessed needs'. In particular, the plan included a note which defined the role of care and domestic staff (transferred from the previous part III home) as being to support the sheltered housing tenants, day care users and short-term care users. But these staff were 'not to provide services to all residents of sheltered housing. Services will be deployed according to assessed need and whenever possible normal community services will be used' (Core paper dated 18.10.82, op.cit.,). This latter reference was an attempt to ensure that core services were not delivered in the style of traditional institutional care (which care assistant staff had formerly provided). However, as an earlier core paper in 1979 had indicated, core services were 'to provide a range and level of services to elderly people which would mean that they were not forced to be admitted to part III' (First draft paper dated January 1979, op.cit.,). Thus, ex-residential staff were to provide a level of service

on a par with, but altogether different in emphasis from, institutional provision. Providing this style of care utilising residential staff proved very difficult for several reasons;

i) ***Interpretation of philosophy.*** Core services were geared to provide flexible but 'normal' patterns of support to people in a range of community settings. The sheltered housing flats were deemed part of the 'community'. To involve care assistants (residential staff) in the servicing of the flats, it was argued, could not be thought of as 'normal'. As a social services officer said, 'if tenants are to remain independent and be part of the community it would be better to have the service provided by wardens only'. In addition, the practice of allowing the care assistants to routinely monitor people in the flats was construed by some professionals (notably social workers) to be an invasion of privacy.

ii) ***Good Practice.*** Maintaining independence, respecting client wishes and rights, giving people choices and assisting people to re-learn or develop coping abilities were all implicit in the core philosophy. Yet this style of care was largely alien to the stock of experiences of residential staff. As a result, many of these staff failed to accept that this type of care was appropriate; some viewing it as tantamount to cruelty and legitimising the neglect of elderly people.

iii) ***Issues of Consistency and Precedence.*** There were county-wide implications of changing the duties of care assistant staff to enable them to work more flexibly in the development. It would have meant that staff of different grades, rates of pay, conditions of service and training (care assistants, home helps and home care aides) would provide similar services. This fostered anxiety amongst senior managers at County HQ that the Unions would either insist that care assistant staff undertaking any additional responsibilities be paid at an enhanced rate or, worse (from the HQ managers perspective), would negotiate for the upgrading of all care assistant posts to ensure uniformity of pay in the County under the same job title. Both these options were unacceptable to the SSD. Indeed, as a result of Union pressure, an SSD Assistant Director insisted that 'no attempts are made to change staff duties and job descriptions unless this is properly approved and negotiated' (Letter to Area Officer, dated 21.6.83). As a senior SSD officer remarked, 'with the Union involved the department had to bear in mind other priorities, and so there was a certain amount of inertia (to change)'. In this context another SSD Assistant Director referred to 'personal fears about regrading of staff'; the possibility of managers losing control over their staff in complying with new job descriptions or project principles led to them becoming 'defensive about how their resources are being used'.

d) **Transport Services**

The core ambulance vehicle was originally intended to provide a service not just to the project (such as day care users), but also the community as a whole. However, using this resource flexibly in this way also proved problematic. As the Area Officer commented, 'It doesn't seem compatible with some people's thinking to use the bus as a community resource. There are problems in expanding the role of the transport here - it puts pressure on the transport budget and involves more complicated admininstration. In other words it's easier and cheaper to run it on traditional lines...Yet if the project was set up to change services, people can't come along and say "Why are you trying to change services?"'.

5. **Challenging Professional roles and relationships: the impact of Core services**

Having identified some areas where the core (community care) philosophy was compromised due to a range of organisational factors, this section of the Chapter cross-cuts the information on the core service from the perspective of inter-professional relationships. In so doing, the impact of the core scheme on those relationships is examined in terms of the effect on the implementation of the core services.

This section only comments on practitioners from two of the three authorities involved in the core scheme; community nurses (Health Authority employees), and social service fieldwork and residential staff. Some observations on the work and perspective of G.P.s are also made. The work of, and relationships with, housing staff are not reported because of their limited involvement in direct patient care. The only key housing issues raised were related to the allocation and staffing of the sheltered housing units which have been explained above.

a) **G.P.s, Community Nurses and Residential Staff.**

The relationship between these groups was mutually perceived as positive and beneficial, primarily because of the historical relationship developed between them in the former part III home which the core services replaced. In the former part III home, for example, residential staff would nurse residents, administer medication and provide a range of chronic sickness, acute and terminal care. As one G.P. remarked, 'the staff were very competent and kept the residents clean even though many were incontinent. I used to leave medication with the staff so that when routine problems arose they would give medication at the outset rather than call me in...the staff were experienced enough to spot problems early and handle them themselves'. According to another G.P., 'it was inevitable that old people would deteriorate in part III and so the home became a semi-hospital, but they coped very well. We didn't have to try to get old people into hospital because the home handled most of the problems'.

In the part III home G,P,s and community nurses had a minimalist role in supporting elderly residents; the matrons and care assistants provided routine maintenance and care, obtaining specialist health support in acute crises only. Admission to hospital was a rarity. By comparison the core project didn't aim to provide the same type or intensity of personal care. So, a G,P, argued, 'Core can't meet the needs of some old people - if they're incontinent and confused or upset the other tenants - they've got no nursing staff to manage; these old people would have coped better in the old home,,,now we have a group of young people running to us every five minutes'. Similarly, the change from resident to mobile wardens in local sheltered housing schemes was viewed by the latter G,P, as 'an unmitigated disaster' since 'The old wardens used to help old people a lot more; now mobile wardens just pop in and if there's any problem they call for a doctor or nurse and walk out!'. The physical nursing care provided by the former residential staff was approved by G,P,s, minimised demands on their time and was consistent with a medical model of care which assumed elderly people to be passive recipients of care. On implementing the core project, the residential staff still deferred to G,P,s although SSD fieldwork staff did not perceive this as appropriate because of the emphasis they placed on client's rights and choices. As one core team member explained, 'wardens tend to look up to the doctors and never question what they say; "because he's a doctor he must be right"'; another core team member added that 'the wardens tend to take their (the G,P,'s) word as law, rather than feedback into the team about what to do'. A warden confirmed this difference in attitude; 'We respect the doctors, that's what we've been expected to do and it's only proper. But the other fieldwork staff don't seem to pay much attention to what the doctors say,,,my staff can't understand that. How can you expect the co-operation of doctors if you don't treat them with respect?'.

The core scheme relied on residential staff adopting a new model of care. In turn, this placed G,P,s and community nurses in a different relationship to residential staff; they were no longer supposed to offer each other the mutual support that had been provided on the basis of a medical model of care. In the part III home the residential staff were able to maintain a regime which enabled them to keep residents clean, sociable and safe with G,P,s blessing; in the core scheme independence and self-determination precluded such an approach. Thus, the style and standard of care offered in the home, was no longer acceptable. G,P,s perceived the residential staff as competent, within such the part III home, to handle high dependency patients; something not considered by residential staff or G,P,s as possible within the core scheme, although the scheme explicitly sought to avoid the moving on of frail elderly people as their dependency grew. These perceptions partly explain the negative reaction against the

core project by these carers; as a social services officer stated 'the commitment from the residential staff and G.P.s was questionable since they resented the loss of the home'.

b) **G.P.s, Community Nurses and Social Workers**

In the core scheme, social workers had an mandate to maintain frail elderly people in their own homes for as long as the client wished. The G.P. was no longer just expected to prescribe and monitor medicines, or provide a crisis intervention role to frail elderly people, as had been the case in the former part III home. The core model of care anticipated G.P. involvement in preventative and rehabilitative work to keep elderly people at home not short-term occasional intervention. Three G.P.s strongly questioned the wisdom of this approach:

> 'Patients who can no longer be maintained at home are those old people who are incontinent, confused or who need basic care for short-term acute illness. Domiciliary services and wardens can only go so far - they are thin on the ground at weekends and bank holidays; they can't provide adequate levels of supervision. The burden then falls back on to me'.
>
> 'The whole concept of core is wrong. There must come a point when an old person needs residential care, because the stress of living at home can exacerbate illness';
>
> 'Some patients aren't bad enough for hospital, but are too bad to stay at home. But because there's no part III, they have to stay at home. We need facilities which can provide old people with general care and attention and keep them clean and dry'.

So it was that in crises G.P.s felt forced either to provide more intensive home care or negotiate short-term admission to hospital; in terms of the latter situation, one G.P. argued that 'Psychogeriatrics are a great problem. We are harangued by social workers if we don't resort to dirty tricks (dialling 999 or admitting to hospital under false pretences) to get them into hospital'.

Community nursing staff expressed similar views, citing cases of people in the community who should be in part III accommodation; 'The psychogeriatric patients - those that you can't leave for five minutes without them being a danger to themselves or others. The immobile elderly - those who, if left, would be at high risk from falling or who could not cope at home without constant help...Basically anyone at risk when left alone without 24 hour cover'; 'there comes a point when home care aides and night sitters aren't enough; some people need 24 hour care. I'm not saying we want everyone pushed into a home, but there does come a point when you need more care than can be provided in the community'.

Most G.P.s and District Nurses agreed that the core philosophy was laudable; but they disagreed strongly with social workers about who should benefit from the core services, when

and why. The costs (personal, social and financial) of keeping dependent old people at home were weighted differently by the various professionals. Not surprisingly, therefore, there was considerable friction between these groups when providing community care support.

c) **Social Services' Fieldwork and Residential Care Staff Relationships.**

In the former part III home, residential staff pursued a passive model of care; elderly people were not, as a rule, asked to make decisions affecting their care, or encouraged to express their personal wants. By contrast, social workers regarded the wishes and rights of clients as paramount even when this clashed with a professional's judgement. These differences of perspective were reflected and reinforced in daily disputes. Thus, fieldwork staff complained that residential staff;

> 'do things in an awkward way. They will often take people to the loo and leave the door open,,,they've no idea about people's dignity,,,They're bothered about feeding and cleanliness,,,they won't encourage people to be independent';
>
> 'the residential staff see work on an emotional level and are quite arbitrary in their approach to individuals,,,Good clients are people with an attractive personality, are clean and quiet. Bad clients make demands, are unresponsive, unkempt etc'.

The social work approach was more akin to the core philosophy than that of the residential staff. Therefore it was not surprising that residential staff felt their approach to care was perceived as old fashioned, inflexible and inappropriate under the core model. However, they also held the view that the approach of the fieldwork staff was naive, theoretical, disrespectful and uncaring; as a G.P. stated, 'the wardens complain of being lectured by 22 year olds who are playing at medicine'. Likewise a warden admitted that 'I don't think the way the fieldwork staff expect me and my staff to care is right. They don't have sufficient experience, in my opinion, to be able to make the judgements they do'. In return, fieldwork staff described the approach of residential staff as follows;

> 'very different - their view of old people is not that they are normal people who happen to be older, but are a race apart and should be treated accordingly. If you're 65 then you need feeding, you need dressing, you need washing, you need toiletting. The wardens want to keep old people dry, tidy, comfy; they see us as hard-hearted and cruel if we try to keep them independent. But if we give back an old person their mobility, we give them back their independence and self-esteem';
>
> 'The care staff don't appreciate that rights apply to old people,,,but to explain that old people can make their own decisions comes across to the wardens as a bright idea from a text book';

'the wardens patronise me,,,treat me as a little girl,,,they think we haven't worked with the elderly very long. They see us as callous and hard, because they cannot understand that caring for someone doesn't mean doing everything for them',

The core model of care led residential staff to feel ambivalent about providing support to a range of frail elderly people; the anti-social or self-neglecting person who stayed in their own room because staff did not feel at liberty to coach them to be social or take care of themselves; those who were perceived as requiring control (the disruptive, the wandering, disorientated people who disturbed other tenants); the sick elderly who were perceived as needing more constant care than community nurses and G.P.s could reasonably provide. The dilemma of the residential staff was that they felt morally obliged to intervene in the lives of these elderly people, although 'not knowing if it was allowed' since it could compromise the client's rights to privacy, freedom and independence. For example, as two wardens commented, 'When someone gets out at 3 a.m, because we can't lock the doors, then if they get knocked down, it will be the wardens who are blamed'; 'Mary doesn't like anyone going to see her, but I feel I have to go in,,,If I didn't she would never come out of her flat'. On the other hand, residential staff were reluctant to provide other kinds of support which were more consistent with the core philosophy; notably encouraging the independence of tenants by re-learning or improving their life skills. These anxieties are well illustrated in the following quotes from two wardens relating to one sheltered housing tenant;

'then there's Ben,,,he's in need of care,,,he doesn't look after himself, and so he smells, and other tenants avoid him. At the home we could keep him clean. He needs a lot more care; he gets a bath twice a week, but that's not enough,,,in the home they wouldn't have to worry about working, shopping, washing etc,,,in the day centre we're told to get him to do things, but he just wants to talk and gossip,,,and come for a rest',

'People like Ben cause concern,,,his flat is deteriorating,,,the carpet and chairs are burnt. He spends his money very loosely. At the home Ben had a bath every day and we used to have a stock of nice clothes for him,,,Now he spends his pension on other things and can't afford clothes,,,he goes out in the same clothes all the time, and he smells so bad ,,,Ben's fine to talk to, but he wouldn't end up like that in the home. When people walk out of the doctor's surgery because he smells, it reflects badly on us, but the people don't know the procedures we have to keep to now',

6. Summary

The issues set out at the front of this Chapter examining the relationship between consensus,

collaboration and community care are addressed in this section, drawing on the data from sections 1 to 5 of this Chapter;

Community care banner goals; extent of consensus and support.

The development of the core scheme was largely opportunistic; resulting from the availability of resources in the County Council capital programme to replace the part III home; the coincident commitment of both Housing Authority and SSD Chief Officers to developing a radical community care service in the area. Indeed, a 1981 briefing paper to the SSD's senior management team noted, 'the area is not an area of priority need for the elderly. It is the phased redevelopment of the elderly persons home and the active interest of the Director of Housing, that provides the opportunity'. The kudos to be won by both authorities from developing an innovative project like the core scheme, combined with the cost-effectiveness of the proposed service reinforced the commitment of the two Chief Officers to this scheme. In terms of the latter stimulus, a SSD officer concluded, 'the one thing which brought about the change in the type of care was financial - the County Council could share the cost with the Housing Authority'. This study suggests, therefore, that consensus on the banner goals of community care - at least amongst local policy-makers - may be a necessary but not sufficient condition of successful project intitiation.

Surprisingly perhaps - given the critical views of the project expressed earlier in this Chapter - that health service carers did not undermine general support for the core scheme banner goal philosophy. Indeed, not one interviewee expressed opposition to it; consensus on this particular set of community care banner goals seemed robust. This supports the view (pp111-113) that whilst willing to support a set of community care ideals, practitioners may not support the means by which those ideals are implemented.

Consensus, Collaboration and Community Care; the importance of models of care

In section 1 of this Chapter the core model was compared to the traditional model; in comparison to this latter model, the core service sought to more flexibly deliver a greater range of community care services by means suited to individual needs and wishes rather than organisational structures or professional convenience. The differences between the two models were significant, as illustrated in Table 13 below. In the traditional model a hierarchical, discontinuous set of separately managed services are co-ordinated at the boundaries. Collaboration between agencies only took place at those boundaries. Services, in theory, were largely independent; consensus about definitions of need and organisational responsibility were only important at the margins of services, in crises, or for people whose needs did not

easily suit one service or another. In the core model, resources were pooled and jointly allocated and delivered. Collaboration was essential to core project resource management and on day-to-day operational decisions. Such decisions were to be reached on the basis of a consensus given that it was intended to jointly deploy core services. The weakness of the core model - from an inter-professional and inter-agency perspective - was precisely this reliance on formal and jointly managed community care services at so many levels, particularly in the absence of jointly accepted operational policies or procedures.

Table 13: Comparison of features of core and traditional models

SERVICE FEATURE	TRADITIONAL MODEL	CORE MODEL
Service boundaries;	Defined; tendency for gaps and overlaps in services, likelihood of boundary disputes.	Blurred, tendency to merge services, avoid gaps and any cut-off points.
Service management	Mostly Separate	Integrated
Needs assessment	Mostly separate	Deliberately joint
Resource allocation	Separate and defined by individual authorities	Joint and defined by philosophy
Staff roles	Specifically defined and separate	Generally defined; but flexibly used
Staff management	Through traditional line managers	Jointly through the JMG
Decision making process	Client fitted to available resources given professional judgement of need	Client choices & wishes determine services provided
Collaboration	Necessary at service boundaries and in crises.	Necessary on most day-to-day issues.

Consensus and Community Care

The core community care model was reliant upon a considerable degree of consensus and collaboration for its success. Yet the evidence in this Chapter shows that, in practice, consensus and collaboration amongst managers and practitioners alike broke down when the project began to impinge on the day-to-day responsibilities, priorities and procedures within which those practitioners worked. Commitment and consensus around the model of community care did not prove robust when applied to specific issues; when used to identify the <u>means</u> of providing support rather than the <u>ends</u> for which that support was provided. In particular, this study indicates that there was disagreement where;

- an existing authorities' policies were breached, setting an awkward precedent;
- the authority or control of individual service managers was threatened;
- the utilisation of particular staff or services which departed from the norm;
- support required from practitioner/managers made additional demands on their time and/or failed to validate their experience, expertise or skills;
- in the area of agreeing the means to address the needs of marginal clients, especially in crises;
- solutions to need assumed that the rights of clients took precedence over professional judgements of need;
- the style of care challenged firmly held stereotype views of elderly people.

Disagreement on core project issues was most common within the SSD itself between the Residential and Community Service Division managers and fieldworkers. Differences in the style of care associated with residential staff and community-based fieldworkers were fundamental; arguments about which part of the development was a community facility (and so to be serviced by the domiciliary and fieldwork staff) and which part residential (to be serviced by wardens and care assistants) were crucial because of the style and philosophy of care within the SSD Divisions. Thus, the boundary dispute between Divisional staff and services infringed on the effective running of the core scheme, by determining the type of care available to elderly tenants living on site according to the part of the building they happened to be in at the time, or who managed the services they received.

Power, bureaucratic and ideological conflicts between practitioners was manifest in the disagreement on project details. These three conflicts arose (as illustrated in the Table 14 below) within three sets of core collaborative relationships; intra-agency (almost exclusively within the SSD); inter-agency and inter-professional relationships.

Table 14: The Core Project - Areas of Conflict/Disagreement.

TYPE OF CONFLICT	TYPE OF RELATIONSHIP		
	Intra-agency	Inter-agency	Inter-professional
Power	Control of resources Boundary of Divisional responsibilities; who takes "lead" role,	Waiving statutory duties (housing) Control of each-others resources	Relative authority and professional domain; deference to each-other
Bureaucratic	Staff/resource policies & practices; boundary disputes; central versus local control; pressure for uniformity in agency	Inability to work jointly & outside single agency policies	Intensity of support; 24 hour versus 9am to 5pm services; resource cut-off points
Ideological	Treatment and care of elderly people; weight put on key principles - independence, rights, self-determination etc	Housing, social & medical definitions of need; definition of boundaries & roles of services	Models of care; weight put on key principles & how to interpret them

For example, in terms of intra-agency relationships, managers in both Divisions engaged in a power conflict by refusing to relinquish sole control of their resources (notably staff); in terms of bureacratic conflict, decisions about the project were often subject to the needs of the organisation or Division as a whole to preserve consistency and avoid awkward precedent. In terms of ideological conflict, there was disagreement between the professionals in both Divisions as to the validity of values and principles implicit in the core philosophy which determined how client needs should be met and resources allocated to meet them. These areas of disagreement mirror many of those noted in Chapters Five and Six above.

Consensus; impact on collaboration and community care

The SSD was functionally organised, centrally and hierarchically managed. As such, its decision making processes lent themselves far more readily to the traditional model than the core model. For these and other reasons, the SSD was poorly equipped to manage joint projects. An SSD planner noted that 'Working together on an integrated project is so new to

the department that people don't see the implications in terms of day-to-day operational management,..and communication between organisations'. Thus, as another SSD officer stated, his colleagues tried to contain the core project within a traditional model of care: 'What happens is that the various elements of the development are treated by the relevant managers ...as their domain, their responsibility and therefore they want to make the decisions and they want to control how their resources are used, and to that extent (the project was not) ...a joint venture'. Many of the implementation problems associated with the project were attributable to differences associated with the "traditional model" of care. For example, two line managers noted that 'People have got to recognise different disciplines and different people's responsibilities for different areas of the project and each other's roles within that. We have to work within our functional structure'; 'The project relies on consensus to function effectively. If there's no consensus the problems arise. That could be resolved by returning to a hierarchical structure'.

The innovative nature of the core project called upon senior managers to make decisions in the light of interests other than their own, or that of their service, or Division. But SSD managers in particular reverted to familiar boundary definitions, traditional responsibilities and lines of accountability. The core project assumed significant organisational altruism in the management and allocation of resources. Yet in practice the *status quo* was too readily defended rather than challenged and changed on the basis of core principles. This was explained by one senior manager in terms of a 'tension' between managers who ran an efficient organisation based on 'their ideas of how their staff should work, which in turn were based on traditional patterns of service' and those managers who 'take on board new approaches that assume flexibility'. The former tended to 'retreat to a traditional position when any problems arise; they can handle what they're familiar with,..it's not a risk-taking situation'. A social worker added that 'the devil you know is better than the devil you don't,..the new conception of working is a threat to the old ways of working, and no-one likes change,..it tears a hole in the blanket of security with which they wrap themselves', an attitude reinforced by 'pressure on people to keep within the Divisional policies and practices'. For these reasons, the task of the JMG was very difficult, as one JMG member stated: 'it's trying to fortify and promote (core) objectives in the face of some intransigence: 'People don't like the idea of changing policies; it threatens their divisional policies, practices and guidelines'. Another JMG member remarked that 'as we faced up to operational issues and Divisional resistance the (group) cohesion was threatened. The group falls down because people are under different pressures. We can agree on most issues, but people go away and try to implement those issues and face difficulties - they get pulled

back into different Divisional policies, That pressure varies between members,,,pressure to conform to other, contradictory principles',

In theory, a housing manager argued, core project decisions were to be taken 'in the light of core being an experimental project aimed at changing the role of those providing services and the manner in which those services are tailored to the needs of the client', If the core philosophy was to be pursued, 'the occasional need for flexible interpretation of policy, or indeed a change of policy, can't logically be excluded', One of the disadvantages of the core project was precisely that it required such widespread organisational change; the project fundamentally challenged the operation and validity of existing professional networks, systems and procedures, In practice, most changes were required within the SSD itself; in operational policies, management structures and styles, Thus, as the evidence here shows, the core project was hindered not so much by inter-agency barriers, but by those within the SSD,

Organisational and professional disagreement on the details of the core community care policy did seriously impair collaboration, Since the core project was a service which relied on effective inter and intra-agency collaboration this was all the more debilitating, However, the project was implemented against a background of poor inter-agency communication and very limited corporate planning, Had this context been different and the organisational climate been more conducive to those changes, the disagreement on particular aspects of this community care policy may have been less, Equally, it is unclear what relevance consensus would have had on the nature and benefit of those changes had the right people at the right times decided to negotiate the details of the the core model through their respective organisations,

The next case study, in Chapter Eight, looks at a more specific project which operated at a service border - the hospital/community interface - and addresses the same three broad sets of questions set out at the start of this Chapter,

CHAPTER EIGHT

Case Study 2: Improving community care for discharged elderly people

This Chapter continues to examine the three sets of questions identified at the start of Chapter Seven (p114); and is the second of the three fieldwork studies reported. The study undertaken here is of a very different 'community care' project to that examined in Chapter Seven; an after care scheme for elderly people discharged from an Accident and Emergency (A&E) department of a very busy district general hospital. As with Chapter Seven, the methodology for this study is described more fully in Appendix 1.

Background Research on Hospital Discharge

Regular research on the discharge of elderly people began in the 1970's with a report in 1972 about elderly people discharged home from Liverpool hospitals. This report, "Care is Rare", was published by Age Concern Liverpool, suggested that the hospital discharge process failed to ensure that old people received adequate care on return home. A follow-up report, written and published in the Continuing Care Project in 1975 entitled "Going Home?" highlighted further weaknesses in hospital discharge systems, stating that 'the elderly on discharge from hospital often found themselves in limbo in which their needs were poorly catered for' and advised that the best way to avoid this situation was through the establishment of after-care co-ordinators who could 'break the vicious circle of organisational and communications weaknesses' (p3) associated with hospital discharge. The research also made clear that the timing of after care was crucial; the first three days following discharge home was when elderly people were most vulnerable and needing specialist support to avoid hospital readmission or the breakdown in support provided by family and friends.

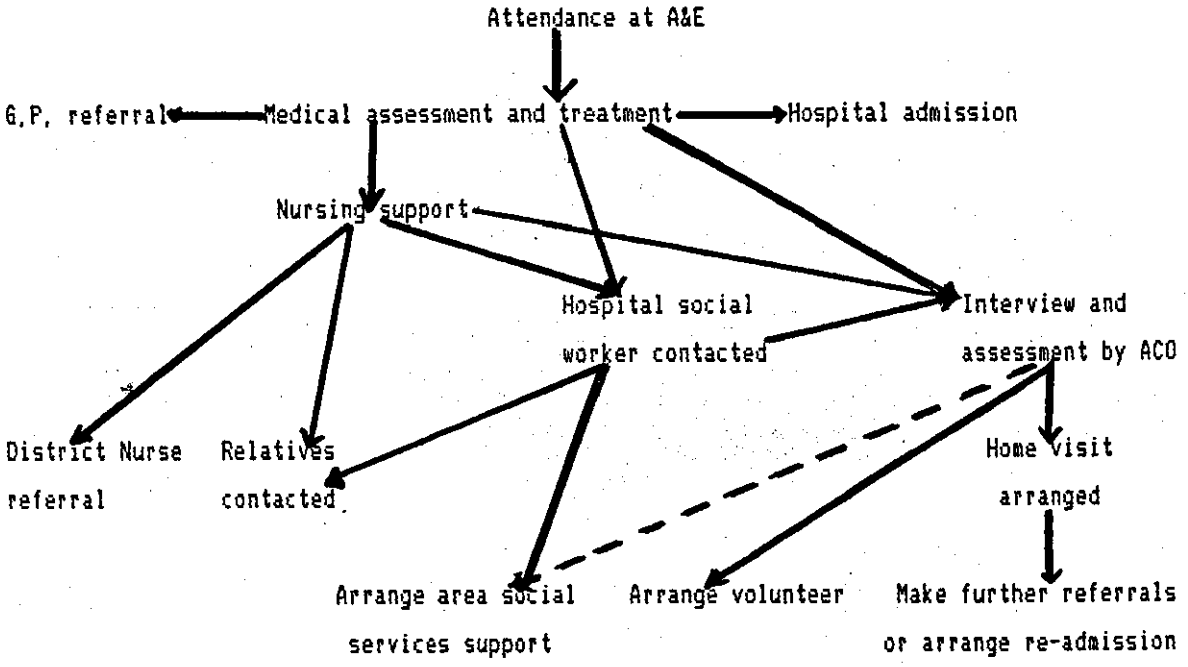
1. Scheme Description; after care within an A&E department

This case study examines an after care scheme established in 1980 based in one of the largest and busiest Accident and Emergency (A&E) departments in the country and centred on the establishment of an After Care Officer (ACO) with three primary functions;

- to undertake a social assessment of elderly people in A&E due to be discharged home;
- to arrange home support for these patients as soon as possible following discharge;
- to visit the patient in their own home within 48 hours of discharge to re-assess their need for further support in the community, or possible readmission.

The role of the ACO in the assessment and discharge process within the department is illustrated below in diagram 15;

Diagram 15. The assessment and referral processes in A&E and the role of the ACO



Key:

_____ = formal referral route ---------- = informal referral route.

The formal assessment and referral processes in A&E was quite simple; each practitioner had relatively discrete responsibility to assess or treat patients and each referred to his peers following diagnosis (doctors to doctors, nurses to nurses and social worker to his area-based colleagues). The ACO was only involved in the assessment process after a clinical decision had been made to discharge the patient and the medical assessment/treatment of the condition had taken place. The next stage was to set in train arrangements to provide necessary after care support for the patients' return home. The least simple part of this process was in arranging social support. Here, whilst the intention was that the roles of the ACO and the A&E social worker should complement each other (with the ACO co-ordinating voluntary input; and the social worker social services support), in practice, the limited availability of the social worker and pressure on the department often meant that the ACO was contacted unofficially to arrange all kinds of social support. In addition, although criteria for ACO referrals were limited to a "catchment population" of elderly people aged 70 and over living within a certain radius of the hospital, some elderly people had lived further afield than the scheme criteria allowed for. These informal referrals caused some problems particularly in the early years of the scheme (see pp149-150 below).

The assessment and referral process as a whole only relied on a limited degree of inter-professional contact and co-operation. Discharge decisions were not jointly reached, or made as a result of some case conference or departmental consensus - they were made by the doctors at the first stage of the assessment process. Following a decision to discharge, any of three other kinds of practitioners would usually be involved in determining the level and type of after care support necessary - nursing staff, social workers and the ACO. At this second stage of the assessment process, seperate referrals were made to community-based colleagues by each practitioner. In the vast majority of cases the second stage of the assessment process did not conflict with the the descion to discharge. But, on occasion, and particularly in the cases of mentally or physically frail elderly people, some of the non-medical staff could lobby clinicians to reverse their decision to discharge.

The assessment, co-ordination and monitoring responsibilities of the ACO involved her in direct contact with elderly A&E patients. Typically, the ACO spent half of each working day conducting interviews with elderly patients in A&E department, making any necessary referrals for after care; the other half of the day would be spent visiting patients discharged home in the previous 48 hours who had agreed to be seen whilst in the hospital. The ACO would become aware of elderly people in the department by two principal means; direct contact during the course of her "rounds" of the department when in the hospital and by nursing referrals recieved when she was out of the department.

The A&E department workload was heavy; in terms of elderly people alone, on average, the department dealt with 9-10,000 attendances per annum of whom the great majority would be discharged home. The diagnosis, treatment and "disposal" of this volume of patients required a rapid and efficient assessment and discharge process. At the time, A&E had no direct access to other in-patient beds to allow some patients to stay in hospital overnight if for some reason (for example, a case of head injury) their immediate discharge might be unwise. Access to in-patient beds for elderly people also presented some difficulty; A&E clinicians often found it hard to gain access to a bed for an elderly person on either geriatric, general medical or orthopaedic wards. In the department itself, it was not always possible to take the opportunity to spend time with elderly people to find out the likely home support for each elderly patient. This situation together with the overriding need to avoid 'silting up' the department with patients meant that there was a strong emphasis placed on arranging after care; getting people safely home where they could receive more comprehensive individual support from G.Ps, district nurses, home helps, volunteers or relatives to ensure a speedy recovery. In addition, work pressure on the department was known to be particularly great at

certain times of the day or week making it a priority to discharge elderly patients but very difficult to arrange after care due to the added extra workload.

a) **Scheme Aims and Philosophy**

The aims of the after care scheme were not specified in any document; written documents relating to the scheme were only concerned with the means by which the scheme should operate (such as its referral criteria and the ACO's role). However, during discussions to establish the after care scheme, many interviewees referred to a consensus amongst A&E staff and Age Concern officers alike on the urgent need to improve the quality of after care support available to elderly people. Interviewees also expressed support for the after care scheme in terms of reference to three rationales, akin to the three primary meanings of community care described in Chapter Three (see p32);

i. ***De-hospitalisation.*** The scheme was viewed as a means of ensuring that elderly were not unnecessarily admitted or readmitted to hospital. A number of assumptions underpinned this notion; that elderly people generally did not wish to be in hospital; that hospital admission increased their dependency; that home was the best place to recouperate. These views were expressed by many nurses, one of whom stated that 'we need to get old people home as quickly as we can; they are often distressed and confused...The longer they stay here the harder it is to settle them back to normal life'; aside from tending to an injury the department's aim was 'to get them home where they want to be' - in the spirit of community care.

ii. ***Good quality care at home.*** The ACO was seen as providing the means to organise adequate and timely community support services. Implicit in this notion was the assumption that community care was good; it merely needed properly organising. For example, a Consultant suggested that 'The community is often the best place to discharge elderly people provided the social support is adequate...the after care scheme ensures that such support is adequate and so facilitates the return home of elderly patients'.

iii. ***Efficient use of resources.*** The scheme sought to avoid misallocation of acute services; aborbing medical and nursing staff in the time consuming process of arranging after care; avoiding "social" admissions and preventing hospital readmission; utilising cheaper and more appropriate community support. So, one doctor argued, 'this is an acute teaching hospital, economically the worse thing we can do is to warehouse elderly people at great expense without changing their health status, when they could go home and be cared for equally well and recover better for less cost'.

b) Scheme management

The ACO was employed by Age Concern and directly line managed by the Chairwoman of Age Concern. However, Age Concern was advised in this role by the "support committee"; a group of Age Concern and hospital staff listed comprising;

Age Concern (local office)	3 (Chairwoman, Treasurer and 1 other)
Age Concern (national HQ)	1 (National fieldwork officer)
After Care Officer	1
A&E Consultants	2
A&E nurse (Sister-in-Charge)	1
Nurse Manager	1
Hospital Voluntary Services Manager	1
Principal Hospital Social Worker	1
A&E Social Worker	1

The support committee had no formal Terms of Reference, or cycle of meetings. It met on an ad-hoc, reactive basis to discuss issues relating to the overall running of the scheme as and when necessary. In practice, the committee met bi-monthly or quarterly in the first two years, but six-monthly thereafter.

c) Funding

The salary of the ACO was met through a private donation made to Age Concern (see Section 2 below). The travel expenses for the ACO were funded out of local Age Concern funds. The hospital provided an office near to A&E for the ACO to use, and met all overheads associated with this office (heating, lighting, telephone etc).

2. <u>The Planning and development of the after-care scheme</u>

The discharge of elderly people from the A&E department had been an area of concern since 1973, when hospital social workers recognised that community support for elderly people was often unavailable in the crucial post-discharge period. Despite evidence gathered to support this view, only in 1976 was the issue again formally raised, this time by a Consultant in A&E who had conducted his own survey of people aged 75 and over attending the department. The three key findings of this research were that of those attending A&E;

- The number of patients over 75 years of age had increased by 25% between 1976 and 1978;
- Approximately 50% of these elderly people attended outside 'normal' working hours - i.e. after 8 p.m. and before 8 a.m. on weekdays, and at weekends.
- That the overwhelming majority of elderly patients did not warrant admission on medical grounds, but nevertheless some of them were admitted for social reasons.

The Consultant concluded that after care arrangements were so poor that 'the outlook for the elderly and infirm who suffer acute illness or injury which is not sufficient to indicate admission on medical grounds, is likely to be bleak' (Internal Report on A&E research, 1978). These findings reinforced the need to improve after care arrangements especially outside office hours when departmental staffing levels were lower and hospital social work support (and social service community staff) did not operate except on an emergency basis.

By the end of 1979, Age Concern had received a number of complaints from carers about the poor quality of discharge arrangements for elderly people leaving A&E. In this context, representatives of Age Concern met with staff of the A&E department in January 1980 to arrange some means of co-operating so as to 'identify and assist the elderly on discharge' on a nil-cost basis (Meeting note, January 1980). These discussions were given a dramatic boost when shortly after this first meeting a private benefactor donated £20,000 to Age Concern to enable them to provide some means of overcoming these discharge problems. Thus, in February 1980, Age Concern again met with A&E hospital staff to form a "support committee" to discuss what kind of improved after-care arrangements should be funded by this donation. Within a few meetings the committee had agreed to appoint an ACO on a part-time basis, and had devised an outline job description for the post. The intention was to fine-tune the ACO job description following an autumn survey of elderly people attending the department. The ACO was appointed in November 1980, and began this survey. The survey confirmed earlier research findings: that elderly people attended A&E in significant numbers outside office hours and often failed to obtain adequate support on return home. As a result, it was agreed that the ACO would work at different times during the week, including evenings and weekends, would begin to recruit volunteers to provide immediate local support to discharged elderly people, and make contact with key community care agencies services in the catchment areas for the scheme.

Over the next two to three years, the role of the ACO evolved in three ways. First, the post edged slowly towards becoming full-time as demands on the ACO increased; second, there was a change in the criteria for referrals (such as, the age group and location of people to be referred to the scheme); third, there was clarification of the referral process (who was to refer which people to whom, in what circumstances).

Overall, the scheme was perceived as a great success. Early in 1981 it was noted that the ACO 'had established good relationships in the department, and felt as though she was regarded as one of a working team...the ACO's personal presence in the A&E department was felt to be invaluable' (Support Committee Minutes, April 1981). The scheme's success was confirmed in

1982, when the scheme won a national competition as the best example of a jointly run statutory/voluntary scheme in the health and social care field.

Overview: the nature and planning of the after care scheme

The after care scheme differed markedly from the core project discussed in Chapter Seven in a number of respects; it was a small-scale relatively simple revenue project; it was negotiated and developed without formal documentation and outside any formal planning process (largely because it did not seek statutory funding); it was a voluntary sector initiative; it was inexpensive and uncontroversial; it was underpinned by considerable local and national research identifying unmet need in this area; and it relied on a general level of informal collaboration rather than more formal and comprehensive collaboration. Yet, the scheme shared one essential feature with the core scheme; it would not, arguably, have been initiated at all without the availability of resources and some kind of local joint commitment amongst key statutory and voluntary workers to respond by providing this kind of a service.

3. <u>Operational success: scheme style and impact</u>

The after care scheme was generated in a context of considerable pressure both to improve discharge arrangements and maintain throughput for elderly people attending A&E. Given this pressure and the inevitable tensions they created for A&E staff, it is perhaps surprising that the scheme fitted into the department so quickly and easily. Several general features of the after care scheme explain why this was the case;

a) the informality and adaptability of the scheme;
b) the avoidance of ad hoc and unpopular existing discharge mechanisms;
c) the almost univeral support for the scheme amongst practitioners;
d) the minimal disruption to existing structures, processes and policies;
e) the minimisation of conflict;
f) the personality and style of the ACO.

a) Scheme informality, flexibility and adaptability

There was throughout the planning and operation of the after care scheme an apparent lack of concern to specify in writing the means by which the scheme should operate. This was regarded by many departmental staff as a virtue and strength of the scheme. As a Principal Hospital Social Worker remarked, 'People are committed to the scheme, its goals and success,,,but not over-anxious about detail so that it can work flexibly'. Thus, it was argued that to run the scheme within a more explicit and detailed framework would have been dysfunctional to the

department and would have provoked considerable inter-professional tension because it would have interfered with departmental assessment and referral processes (see section 1 above).

Prior to the arrival of the ACO, nursing staff had (unwillingly) shared the responsibility for arranging after care especially in the absence of hospital social workers. With the arrival of the ACO, nursing staff effectively handed over this responsibility to the ACO. The ACO's general role in arranging social support created problems for the social worker, but it enabled discharges to be arranged more quickly than through a rigid division of labour where only social workers could make certain domiciliary referrals and enabled nurses, as one stated, 'to do what we're trained for'. The senior A&E Sister remarked, 'Referrals procedures for the ACO and social worker aren't strictly adhered to - we refer all old people to the ACO - its better to do that than leave our nurses wondering whether or not to include people... flexibility and speed are vital to us'. However, as a consequence of this liberal approach, A&E staff failed to hold a single, coherent view of the role of the ACO:

> 'The ACO provides extra support after discharge...the things which statutory services didn't provide but make it easier for old people to settle at home...providing the care of a relative rather than a professional' (Social Worker);
>
> 'The ACO is midway between a social worker and medical staff...but we use her for anyone we're worried about sending home' (Sister);
>
> 'To follow up in the community patients we feel are "at risk". The ACO checks our assessment is correct and that the patient is coping' (Consultant);
>
> 'To provide a service for old people with minor medical problems who ought to go home' (Junior Doctor).

The informal management of the after care scheme - through the support committee - enabled any scheme difficulties to be addressed without reference to formal dispute or management procedures within the hospital. A&E staff and Age Concern officers were keen to amicably resolve any scheme difficulties; a nursing officer associated with the scheme explained that given the financial and managerial independence of the ACO and the necessity to retain the post '(A&E) staff were keen not to rock the boat...to lose the scheme would have been disastrous'. Age Concern, for their part, were conscious that, 'we are based in the hospital by invitation...we could not make too many demands on the department'. This unspoken inter-dependency between A&E staff and Age Concern provided an incentive on both sides to fully co-operate albeit on an informal basis.

b) Avoidance of unpopular discharge mechanisms

The introduction of the after care scheme enabled staff to avoid using other informal discharge mechanisms previously used to overcome the dangers associated with early discharge of elderly people. These *ad hoc* solutions were unpopular with A&E staff, and created numerous tensions within the department and between the department and other services;

(i) ***The overnight bed*** - also known as the 'granny bed' - was introduced by a past A&E Consultant who insisted that each night a bed was made up in A&E to enable old people to stay overnight if they would be at risk if discharged in the early hours of the morning. This arrangement was disliked by many nurses because they felt unable to provide adequate supervision of elderly people using the bed, especially those prone to wandering.

(ii) ***The Ambulance Tuck-in Request.*** Nursing staff reported that a last resort measure to secure immediate discharge cover was to ask ambulance men to make sure that the elderly person was comfortable at home by settling them in - making a drink, lighting a fire, helping people into bed etc.

(iii) ***The District Nurse referral.*** Sisters in A&E would often use the community nursing service to visit old people at risk within 48 hours of discharge, as one Sister explained, 'We use the District Nurse as a type of social worker - to check whether old people are still O.K'. Community nurses were aware of this tactic but generally regarded it as the only reliable means of avoiding the possible relapse of a patient within a short time of discharge.

(iv) ***The Emergency Duty Team (EDT).*** Technically, a sister in A&E could contact the social work EDT if an old person required urgent support at home outside office hours. However, contact with the EDT was widely felt by nurses to be very frustrating. Two A&E Sisters remarked that 'The EDT is useless - they won't give advice, won't leave the office, won't lift a finger to help'; 'The EDT is appalling when it comes to old people - typical of social workers'. But EDT members argued that they could not, and should not, provide the kind of service expected of them by A&E staff; if an old person would be at risk if discharged home then they should be admitted to hospital; yet A&E staff felt it wasn't appropriate to admit an old person for what they viewed as social needs.

(v) ***Hospital Home Care Aides.*** The social worker attached to the A&E Department could request that one of the two hospital home care aides provided immediate home support for elderly people. These staff were able to provide daily support to discharged hospital patients for up to one week free of charge, whilst area social services organised domiciliary support. These staff were scarce resources and were only used very occasionally for elderly people in A&E.

c) **Support for the Scheme**

As stated in section 2 of this Chapter, the after care scheme was initiated in a context of widespread agreement and evidence that there was a need to improve after care for elderly people attending A&E. There was no lack of commitment from operational staff to the scheme.

d) **Minimal Change**

The style of the after care scheme meant that it was able to have a positive impact on the department without greatly changing the existing referral process or challenging professional structures, relationships or status. The scheme did not seek to alter the *status quo* by challenging operational practices and procedures, or the legitimacy of professional judgements and models of care.

e) **Minimisation of conflict**

The scheme was perceived as exceeding the expectations of most A&E practitioners. For example, by arranging most community support the ACO made nurses' job less stressful. Nurses remarked that; 'I'm much happier sending old people home now than before because of the ACO scheme - I know a visit will be made within 48 hours...before we sent them home regardless and hoped they wouldn't come back...now I don't have to palm off people into ambulances and say "Oh, God, I hope they'll be alright"'; 'Now we know the ACO visits, we don't have old people on our conscience'. The ACO was also able to check the initial medical/nursing assessment both in the hospital and in the community, sometimes avoiding either inappropriate discharge in the first place, or readmission following discharge. In this context, one Sister referred to the ACO as 'our eyes in the community'; another viewed the ACO as their 'safety valve' - knowing the ACO was able to visit and check discharged elderly people at risk at home, and avoid the incidence of relapse and thus the poor publicity which followed.

More generally, the ACO directly reduced professional conflict (mainly between doctors and social workers) over discharge decisions; the increased capacity to arrange social support as a result of the ACO's appointment meant that, as one nurse said, 'the ACO takes the heat off the social worker', reducing the need for doctors to insist on a social work presence in the department to arrange home support. More specifically, the ACO was able to lobby more effectively against questionable discharge decisions because of her greater credibility, and neutrality as a voluntary sector worker. The social workers - with the ACO as an ally - had to 'nail their colours to the mast' less frequently to get a discharge decision reconsidered. The esteem and respect shown to the ACO by Consultants was based on what one doctor referred

to as 'her immense common sense and practical insight', and enabled non-medical staff to exert greater leverage to try to reverse dubious discharge decisions.

f) Personality and style

This positive appreciation of the ACO was clearly crucial to the success of the scheme, and reflected confidence in the ACO as a person, rather than in the scheme *per se*. Before the ACO was appointed a number of concerns were raised regarding the establishment of this post; nurses feared that an ACO would interfere with or undertake nursing duties; doctors were anxious about giving the ACO any access to medical records; social workers were sensitive to the way in which the ACO might impinge on their own work and responsibilities. As it transpired, however, the tact, reliability and discretion of the ACO quickly overcame most of these fears generating considerable confidence and trust in the ACO, excepting the relationship between the ACO and the A&E social worker (see sections 4 and 5 below).

4. <u>Operational problems: the weakness of flexibility and informality</u>

The scale of conflict associated with the implementation of the after care scheme was considerably less than in the case of the core scheme reported in Chapter 7. But there were some issues where conflict was manifest, even with this smaller, less complex scheme.

a) Conflict of rationales; discharge decisions

Three rationales in section 1a are identified with the after care scheme. However, interviews indicated that staff identified more with some of these rationales than others in relation to discharge. For example, in reaching a discharge decision clinicians strongly reflected the notion of efficient use of resources and the merits of hospitalisation; discharge was justified by reference to the absence of treatable medical problems and the waste of acute resources which would follow admission. The medical model of "need" was uppermost in deciding whether discharge or admission was appropriate. Yet this would cause conflict. Thus, the overall mental and physical frailty of elderly people often meant that some injuries (such as upper limb fractures) whilst not justifying admission for younger people on medical grounds, could severely debilitate elderly patients and their capacity to cope at home. In such situations an absence of rehabilitation in the immediate post-discharge period could lead to a rapid decline in health. The plight of behaviourally disturbed elderly people also posed a dilemma for clinicians; to send such people home could also deny them the opportunity to stabilise at a time when they were especially vulnerable. The welfare of such groups of elderly people was all the more difficult to secure following discharge at evenings, weekends and bank holidays. The need to maintain throughput placed clinicians under pressure to

discharge elderly people even if the domiciliary support was not as great as desired. Yet a more holistic model of care would suggest that the wider needs of elderly people should justify short-term hospital care if quality after care support was unavailable. Yet, by contrast, nursing staff, in advocating discharge, tended to place greater emphasis on the dangers of hospitalisation rather than its benefits. Thus, reference was made to the fact that unless staff time was available to secure the greater physical mobility and mental stability of elderly patients then dependency would increase, and the possibility of returning home could recede into the background.

The ACO was often caught in a dilemma in this trade off between the quality of after care available and the frailty of elderly people on the one hand, and the pressure to discharge and the medical priority to avoid blocking hospital beds, on the other. The lack of clarity as to the prime purpose of the discharge scheme proved a disadvantage in such circumstances since the role of the ACO as either a handmaiden of clinicians, or as an advocate for elderly people or their carers was unclear. Thus, although there was overall support for the after care scheme, there was no agreement from A&E staff that it should prevent discharge if community support, mental or physical frailty subjected the patient to unacceptable risks.

(b) **Process conflicts; roles and referral responsibilities**

Whilst there was unanimity regarding the need to establish better after care co-ordinated through the A&E department, there was from the outset a lack of clarity as to how precisely this was going to be achieved. Community support was provided by the primary health care team (G.P.s and community nurses), wardens (for elderly people in sheltered housing), the social services department (home helps, occupational therapists, meals-on-wheels, social workers), the voluntary sector (home visiting) and the family. In tieing together a package of support services it was important to know who had responsibility for contacting which service. The referral routes to doctors and nurses were through their hospital colleagues, necessitated by the need to accurately convey appropriate information about patient need. But contacting local social service staff and other informal carers was less obviously a task which could only be undertaken by social workers. Referrals, with the exception of those to other social workers or possibly the occupational therapist, were for general support, not technical intervention requiring the exchange of specialist knowledge. Yet the social worker attached to the A&E department in the first 18 months of the scheme's life treated as his responsibility all referrals to area-based social service staff. This created a number of problems; for the department it meant it was tied to the availability of the social worker if such domiciliary referrals had to be arranged prior to discharge; for the ACO it meant she

had to refuse to make direct referrals for community support, inevitably delaying the receipt of domiciliary care (notably home helps and meals-on-wheels services), "silting up" the department and thus creating considerable difficulties for medical staff. By insisting on such a rigid referral process, the social worker therefore came into conflict not only with the ACO but also with medical staff.

5. **Professional relationships and the after care scheme**

This section examines relationships between staff in the A&E department in so far as they affected the assessment, treatment and referral of elderly people due to be discharged.

a) **The ACO/social work relationship**

This was a difficult relationship, particularly in the formative years of the scheme as section 4b above indicates, although problems eased after the appointment of a new A&E social worker. One reason for the initial difficulties was that the ACO and social worker were treated by other A&E staff as substitutable. In practice, the ACO virtually replaced the social worker because of the difficulty nursing staff experienced in locating the social worker. In one sense, however, the ACO and the social worker were strong allies; i.e. in their desire to avoid inappropriate discharge and ensure appropriate after care. The two workers often agreed about the kinds of old people who should not be discharged, and were in such cases often at variance with medical assessment. Both workers adopted a more holistic approach to meeting the needs of elderly people when considering discharge; the social worker being particularly unsympathetic to arguments about discharging elderly patients purely on arguments related to the absence of medical need. Thus, the social worker regarded it as 'naive' that elderly people with minor fractures should be automatically sent home; some patients, whose frailty and isolation would be compounded by such an injury, would be at great risk if sent home without adequate nursing care and monitoring.

Following the appointment of a new A&E social worker who was willing to work much more closely with the ACO, these earlier problems receded into the background. Infringements of official referral practices were tolerated because the new social worker acknowledged that the ACO could arrange services which he had little time to do, but would involve him if some specialist input was required in the case of more difficult elderly patients - such as handicapped, mentally infirm, alcoholic or behaviourally disturbed patients. This build up of trust was crucial and meant that there was less reason to define role boundaries. Indeed, the ACO was perceived by hospital social workers as enabling the A&E social worker 'to concentrate on what he's trained for'; 'it is good for us to be released from work with the

elderly in casualty with so many other people to see'; 'making up for some of our deficiencies and allowing us to concentrate on more urgent needs'. Yet the outcome of this improved relationship was to virtually eliminate direct social work contact with elderly patients in A&E. But in the very short timescale in which to co-ordiante after care it was often not possible to use the A&E social worker to arrange after care support; the ACO was the only alternative to discharging people without any statutory domiciliary support.

b) **The nursing/ACO relationship**

The most harmonious departmental relationship was between the ACO and nursing staff. This was particularly important because of all A&E staff the ACO had to maintain most contact with nurses. There were several reasons for such a positive relationship. To begin with, there was no role conflict between the ACO and nurses (as had existed with the social worker). Indeed, although nursing staff had been used to arranging social support for discharged elderly people, it was a task they felt neither qualified nor equipped to do. The ACO thus took an inappropriate burden from their shoulders as two Sisters acknowledged; 'The ACO has taken the pressure off nurses and social workers'; 'The ACO has made my job easier - I spend less time on the phone trying to organise help from relatives, district nurses or the police'. More generally, one nurse manager remarked enthusiastically that 'The ACO has done a good PR job for the hospital, saved money, nursing time and re-admissions'.

The roles of the ACO and nursing staff were complementary and their priorities and perceptions of need similar; both spent more time than most in direct contact with elderly people; both had a genuine interest in the overall well-being of elderly patients; both saw their goal as to support the discharge of patients as and when they could cope or be cared for at home. Although nurses did share with social workers some misgivings about the clinically based discharge system, they found it easier to work with the ACO to secure safe discharge than with the social worker. A key reason for this was the confidence placed in the ACO as against the social worker. For example, the senior A&E Sister stated, that 'Social workers are a load of bunkem,,,I won't touch them,,,I use the ACO to contact social services - she gets on and does something'. Another Sister remarked that 'The ACO is committed, reliable, visible and available, what more could we want?' Other nurses described the ACO variously as 'brilliant', 'excellent', 'superb', 'couldn't do without her'. The ACO, unlike the social worker, was not perceived as authoritarian, or imposing expertise. Thus, as the senior A&E Sister commented 'We trust the ACO's judgement - if she said a person couldn't go home I would resist discharge - if a social worker said the same, I wouldn't be so sure'.

c. **The nursing/social work relationship**

As section 5b above makes abundantly clear, social workers were not well respected by the nursing staff despite sharing some common perceptions about the weakness of clinical decision-making in the discharge process. Social workers were regarded as inept and unable to fulfil the kind of role which, in theory, they should with elderly people. Moreover, these two groups had widely differing views of elderly people and their needs, and of the ideal discharge procedures. In terms of the latter, nurses said social workers could not provide social service support in the timescale expected by nurses. Social work support for elderly people was described by various nurses as 'rubbish', 'appalling'; 'social workers don't attach much priority to old people...they should get all the information on old people to be discharged, but they're not interested, so we don't bother them'. The appointment of the ACO in many ways reinforced this perception of professional disengagement by showing what could be done if someone spent more time with elderly people.

One of the causes of this negative relationship, however, was the lack of clarity about the social workers' role. Two nurses confessed that 'I really don't see what a social worker has to offer'; 'I don't know what the social worker is for...they seem quite ineffective, impractical and non-constructive'. Whilst a lack of clarity about the role of the ACO increased social referrals, the lack of clarity about the social work role reduced referrals.

d. **The clinician/ACO relationship**

Junior doctors in A&E changed every six months, making it difficult for them to establish a consistent relationship with the ACO or to understand referral procedures for elderly people. For example, whilst all four junior doctors interviewed knew of the existence of the ACO, only one knew a social worker was specifically attached to the A&E department. Of the remaining three, two realised a social worker could be contacted if necessary, the fourth doctor was surprised to hear that any social work support could be made available. All junior doctors interviewed were surprised at the numbers of elderly people attending A&E, and none felt that their training had equipped them to respond appropriately to the range of needs that elderly people presented.

The ACO earnt the respect of medical staff in the department; and was not perceived as a threat to clinical judgement even if she questioned a medical decision. Indeed, the ACO became skilled in recognising less obvious health needs missed on initial medical assessment (such as feet problems, mild strokes and balance difficulties). If such needs were missed, the ACO, with the support of nursing staff, would seek a medical reassessment and,

invariably, undertaken. Moreover, the A&E Consultants gave the ACO explicit authority to request re-admission to A&E if, as a result of a home visit, the patient was clearly not revovering, perhaps because of post-treatment complications.

It was inferred by some social work staff that the relative powerlessness of the ACO (in terms of her voluntary, unskilled postion), would render her liable to exploitation by medical staff. But other medical and nursing staff argued that the neutrality of the ACO and the high regard in which she was held enabled her to influence decision-making and that doctors would not simply discharge more patients home because the ACO was able to visit them. Thus, most staff argued that the ACO ensured safer discharge rather than more discharge.

e. **The nursing/clinician relationships**

Doctors' overriding concern was perceived as to maintain patient throughput, said one Sister, 'The medics priority is to dispose of the problem'. The doctor's concern was to identify the injury/illness and recommend appropriate clinical action; nurses were concerned not just about treatment but the wider needs of old people - as the senior A&E Sister said, 'We work at cross purposes with doctors. They examine, treat, discharge. We make sure they will be safe at home. That's quite different'. Medical practitioners, like social workers, were regarded by nurses as apportioning low priority to the needs of elderly people, for example one Sister stated; 'In general, doctors aren't interested in elderly people; because their problems are often not medically-related'.

f. **The social work/medical Relationship**

The relationship between these two groups was generally poor and was not helped by the ignorance of the social workers' role especially among junior doctors; for example, one doctor said that 'The social worker provides some general back-up, but he has no particular emphasis or role'. As a result, some doctors often said they relied on nursing staff to make a social work referral.

These two groups held opposing perspectives on the needs of elderly people. The clinicians concentrated on the presenting health needs, the social workers considered wider social, emotional and psychological needs, as well as patients rights and wishes. As a result, different conclusions were often reached about the discharge of elderly people. According to one social worker; 'The Consultants would do anything to remove pressure on hospital beds,,, my priorities aren't the same,,,they think of the effect on the hospital, I think of the effect on the individual and family, so we take each other with a bag of salt'. The

Consultants certainly felt pressured by social workers to make more 'social admissions', but they regarded this as inappropriate, mindful of the long-term problems it could present their colleagues on the wards. A typical example of a "social admission" would be an old person with a broken arm. To the social worker this injury might increase frailty and social isolation by impairing mobility and thus coping capacity at home; preventing the old person getting dressed, going upstairs, making food and other essential daily tasks. Moreover, a social worker argued that this risk resulted from a physical injury, and thus the hospital should take responsibility for the patient. The doctors, however, argued that they would not admit younger people for such a fracture - no acute treatment was required - so on the same basis the elderly person should be discharged. In addition, it was felt that admission could reinforce rather than reduce mobility problems; lack of time to rehabilitate patients on the wards could lead to the long-term dependency of an old person.

6. Summary

Community care banner goals - extent of consensus and support

Underpinning the establishment of the after care scheme - unlike the core project - was considerable evidence of unmet need, evidence which had accumulated over many years. This evidence indicated that after care arrangements for elderly people discharged from the A&E department needed improving - a point on which there was universal agreement during the short planning stage of the scheme. Other justifications for developing the scheme were also mentioned by interviewees; clinicians particularly perceived the scheme as a means to avoid unnecessary admission/readmission, thereby ensuring optimal use of scarce acute resources. Other staff, saw the scheme as a means to achieve better quality support at home. These two sets of considerations were not always in harmony - as in the case of the discharge of frail but non-acutely ill elderly people. As with the core project, the scheme owed its origin largely to chance - in the case of the after care scheme this took the form of an unexpected private donation. Thus, neither the general support for the scheme nor the varying degrees of support for the scheme as a means to effect quicker discharge, ensure better quality care at home, or improve service efficiency were by themselves sufficient to initiate the scheme.

A distinctive feature of the after care scheme was informal manner in which it was planned and managed. The private funding of the scheme facilitated the independence of the scheme from statutory committee and formal planning systems. Moreover, the dynamics of the A&E department made the formal specification of after care policies and procedures undesirable.

Collaboration, Consensus and Community Care; the importance of models of care

The after care scheme operated largely on an informal basis in the absence of an explicit or detailed philosophical framework or operational policy. This feature of the scheme explains much of the way in which it operated successfully - and unsuccessfully. The scheme was based on an agreed general assumption that after care should be improved for elderly people due to be discharged from A&E. The scheme was not based on an agreement as to how after care should be improved (beyond the appointment of an ACO) by whom, for whom and in what circumstances. Hence, there were no explicit statements about relating the rights or wishes of patients to the decision to discharge or a packages of after care support; there were no assumptions about changing the policies or procedure of community care agencies to enable them to more readily respond to the needs of discharged patients; practitioners in the community or in the hospital were not expected to change their attitudes/priorities or provide their support to patients in different ways. This is not so say that there were not a wide range of specific issues related to the community care of elderly people which this scheme was concerned about and which were implicit in the assessment and referral process. For example; in what situations was it reasonable to return elderly people home (did this depend on the elderly person's wishes, home circumstances, mental/physical frailty, in-patient bed availability, demands on the department at the time of assessment)? Other issues centred on how needs were defined, what weight was to be apportioned to them, who should respond to them and how?

The decision to discharge was based on a clinical judgement not inter-professional consensus. This judgement could be influenced by the views of other staff and the wider circumstances of the patient, for those patients obviously at risk if discharged quickly. In these cases the medical model was challenged; how well did it take into account essential health needs in relation to an individual's capacity to recouperate at home rather than in hospital? Ordinarily, the medical model determined whether expensive, limited acute resources should be utilised; it did not give weight to social, housing, environmental and practical considerations. Clinicians discharged elderly people home because it was the logical outcome of treating urgent medical needs. Conflict over the discharge of frail elderly patients illustrated that considerations which should govern discharge home were neither self-evident nor commonly perceived. As it was, the ACO was able to defuse many such disputes by being able to secure more adequate care following discharge home. However, one of the rationales underpinning the after care scheme assumed that discharge home was a positive decision enabling elderly patients to return home to receive adequate care at the time they needed, rather than as a result of a negative decision taken to maintain throughput and avoid hospitalisation.

The ACO did not change the views of staff which produced conflict; she reduced the basis for that conflict - the limited capacity to ensure the proper care of elderly patients at home. As a result of this, and the lack of joint detailed assessments of need or joint priorities and policies, inter-professional collaboration remained relatively superficial and inter-professional consensus relatively unimportant to the improvement of after care. However, had the ACO been more interventionist and proactive and thus put pressure on A&E staff to reach discharge decisions based on different criteria, then the schme would have drawn attention to itself; regardless of unmet need the scheme would have been harder to initiate and potentially much less successful on the ground had it been necessary to reach a consensus about who should be discharged home, how, when and with what support services - as was the case with the core project.

Consensus and Community Care

As noted, if anything, the after care scheme reduced the likelihood of disagreement surrounding the discharge decisions of elderly people, by making safer the option to discharge elderly people home. Many of the operational difficulties associated with the core scheme reported in Chapter Seven were, it was argued, the product of bureaucratic, ideological and power conflicts manifest in demarcation disputes and various role and authority conflicts. Conflict associated with the after care scheme is summarised in Table 16 below.

Inter-professional disagreement and conflict in relation to the scheme was limited to a few areas; the roles of the ACO vis-a-vis the social worker in supporting elderly patients and making referrals; the criteria for referring elderly people to the scheme. These issues reflected professional concerns about the role of skilled professional input and assessment vis-a-vis that of the ACO as a lay person; concern about losing the power of 'gatekeeping'; concern at the status and credibility of social workers. However, in practice, a set of opposing considerations militated against developing the role of key professionals in the referral process such as their attitudes to the treatment and support of elderly people; the time and availability of social workers. As noted above, disagreement also existed in relation to debates about the viability of discharge for elderly patients on the margins of hospital and community care. Practitioners disagreed on the care to be provided because of their definitions of need, the priority they attached to these needs, the capacity to provide resources to meet those needs and their roles in securing those resources.

Table 16: The After Care Scheme - Areas of Conflict/Disagreement.

TYPE OF CONFLICT	AREA OF CONFLICT BY RELATIONSHIP/ISSUE
POWER	ACO/social worker - status of ACO, authority to refer, credibility Social worker/doctor - appropriateness of models of care in deciding discharge "Gatekeeping" of community resources
BUREAUCRATIC	Responsibility for domiciliary referrals Pressure to maintain throughput versus time to secure adequate after care Process difficulties; access to community services out of hours
IDEOLOGICAL	Definitions and relative priority of medical and social needs The theory and practice of social work intervention and role Priority and harmony of rationales associated with after care scheme

Inter-professional consensus or disagreement; impact on collaboration and community care

This scheme indicates that inter-professional conflict centred on attempts to formally resolve disputes on a few specific issues such as; the boundaries of community care vis-a-vis hospital care; referral processes and procedures; the appropriateness or otherwise of clinical models of care when making decisions to discharge some frail elderly people. It was not acceptable to resolve these issues by establishing a set of jointly agreed guidelines or criteria about the desirability of discharging elderly people home in certain circumstances; this was alien to informal and flexible way in which the department worked, the nature of collaborative relationships in the department, and the speed with which discharge decisions had to be made and followed through. To formally collaborate in order to reach agreement on discharge decisions was simply not practical, given the constraints on the department.

Departmental structures and processes assumed a minimum of formal collaboration, and were not reliant on reaching decisions by consensus. This was also true for after care arrangements. By taking specific responsibility for after care, the ACO introduced greater flexibility into the departments discharge processes and in some ways reduced the need for close collaboration or formal discharge criteria. This made it quicker to arrange discharge and easier to ensure patient throughput.

However, collaboration - in the limited sense in which it was required to deliver appropriate after care - was hindered by similar factors to those identified in Chapter Seven in respect of the core project; lack of clarity regarding the responsibilities of practitioners; different models of care; lack of congruent perceptions of need; conflicting professional priorities and constraints; professional attitudes towards elderly people; professional autonomy, credibility and status; their power to control resources.

The next Chapter in this third section examines some aspects of the day-to-day work and relationships of community care practitioners maintaining elderly people at home rather than a specific initiative but still exploring the three questions raised at the start of Chapter Seven.

CHAPTER NINE

Case Study 3: Local Inter-Professional Networks and the Maintenance of Elderly People in their Communities.

Introduction

The fieldwork studies in Chapters Seven and Eight have examined the nature of inter-professional and inter-organisational collaboration as related to specific community care schemes for elderly people. However, this study examines the perceptions, working practices and collaborative relationships of community care practitioners working with elderly people; it does not focus on any particular initiative. In a sense this is a 'control' study; examining local service provision where there were no specific incentives or projects to enhance collaboration or community care. The study was conducted in three localities, and 80 practitioners in these areas were chosen for interview. The areas had different socio-economic and demographic characteristics, and their access to local health and welfare services for elderly people also varied (see Appendix 1). Whilst all three areas were within the boundary of the same District Health Authority and Social Services Department, areas 1 and 2 (an inner city area with an adjacent suburban area) were wholly within one city council Housing Authority and area 3 (a second suburban area) was within a separate borough council Housing Authority. The structure of this Chapter is different from that of Chapters Seven and Eight. It is broken down into a four sections in which the perceptions of different community care practitioners (G.P.s, district nurses, home helps, social workers and wardens) are compared on a selected range of issues to provide another means of addressing the three questions set out at the start of Chapter Seven (p114).

1. Perceptions of Community Care: Theory and Practice

There was general consensus that the range and availability of local community care services was inadequate to meet the needs of elderly people; concerns were registered about the lack of day care, social service support at weekends, evenings and bank holidays, part III places and domiciliary support as well as community nursing services. For example, G.P.s identified four areas of concern mostly related to perceived shortfalls in resources;

- the shortage of long-term beds, both residential and hospital based, which led to chronically sick patients remaining at home with limited support;
- the shortage of domiciliary care which led to the dominance of crisis-based intervention rather than prevention;
- the shortage of specialist community-based resources at weekends and evenings, notably night sitting and night nursing and for terminal care;
- meeting the needs of the mentally frail.

These difficulties were perceived by G,P,s as placing them under extra pressure. One G,P, remarked that in providing support to a terminally ill elderly patient that 'her carers want her to die at home but desperately need a break,,,with no social service support at evenings and weekends, and no specialist support services, the options are limited, I end up trying to provide moral support and visit when I can, but its not my help or support they need'. Indeed, some G,P,s opposed a local sheltered housing development, because as one G,P, explained, it would lead 'to the "dumping" of large numbers of increasingly dependent elderly people on my doorstep for whom we would be expected to take responsibility as a practice'.

Concerns about the quality and quantity of services generated some ambivalence towards community care policies;

'Its good to try and keep elderly people at home where they're happiest,,,but for some of our clients we can't provide the necessary support for this' (Home Help Organiser).

'Community care is a good idea, and something we all support, but the community can't care on its own,,,so often community care is simply leaving people largely to their own devices to cope as best they can. That's not such a good idea' (G,P).

'I'd love to be able to support elderly people here for longer - it is their home - but I can't do it on my own, and no-one else seems much bothered' (Housing Warden).

'Elderly people should be given the right to stay at home for as long as possible,,,but other professionals and relatives don't always see that as desirable or viable,,,where do you draw the line? What is an acceptable quality of life?' (Senior Social Worker).

However, attitudes to community care policies did vary between the three localities studied here. For example, G,P,s in areas 1 and 2, because of poor links with hospital and part III facilities, expressed alarm and incredulity in respect of the continuing policy to maintain elderly people at home for as long as possible. Thus, one G,P, remarked that 'I dread the future with more and more heavily dependent elderly people who should be in full-time care of some kind being left largely unsupported in the community'. In area 3, however, greater G,P, satisfaction with residential facilities tended to foster a more positive attitude to the future of community care.

The perceptions of wardens in all areas were similar in one respect; they criticised the shortage of, and limited access to, part III accommodation. As with G,P,s in areas 1 and 2, the lack of local residential resources were perceived as keeping heavily dependent elderly people in their care. One warden commented; 'I had a confused elderly lady here for 15 months waiting to be transferred to a part III home, during that time she got the occasional visit

from a district nurse for bathing, home helps twice a week, but nothing else,,,I didn't get one uninterrupted night's sleep in that time'. This warden, like others, felt she had to carry the main burden of care for their tenants. Wardens and G.P.s were united in their criticism of social workers who were perceived as not trying sufficiently hard to gain admission to part III establishments for old people. One reaction to this was a tit-for-tat response from G.P.s: 'Why should I spend hours on the phone trying to get a social worker client admitted to hospital when my referrals to part III are virtually ignored?'.

A similar reaction followed the introduction of new part III admissions procedure for areas 1 and 2. Part of the original arrangement had been that a Consultant Geriatrician, in return for admitting elderly people referred by social workers for acute assessment and treatment, had right of access to 2 or 3 part III beds per month for patients under her care. This 'swop' arrangement ensured patient throughput for the Consultant and quick access to hospital for social workers' clients. A part III Admissions Panel wholly comprising social workers replaced this arrangement; introducing individual assessments of each elderly person referred to the Panel. As a result, the Consultant could no longer be sure of access to part III beds, thus slowing throughput; the Panel queried the Consultant's clinical judgement as to whether a patient was fit for admission to part III; the Panel insisted that all old people wishing to go home should be enabled to do so. This last stance was viewed by the Consultant as folly, placing some dependent elderly people and their carers under great strain or risk - notably in the case of the elderly mentally infirm. On this point the senior social worker at the hospital sided with the Consultant; 'Area social workers put high priority on patients rights and wishes,,,but old people do get to the point when they have no right to make decisions which put others at risk" adding that the 'drive to community care' had placed enormous burdens on carers; 'Some relatives are praying for old people to die', because of what was referred to as the local policy of 'community care at all costs'.

The most appropriate balance of local services was a matter on which there were a variety of conflicting views in all three areass; for example, one social worker saw the need for a 'vast expansion' of sheltered housing by diverting resources away from residential care which should only provide short-term, shared or respite care. By contrast one G.P. argued for the 'rapid expansion' of residential and nursing homes for the frail elderly as 'part of the local community' - a view supported by many wardens. By contrast, one social worker regarded the tendency to move elderly people from one form of accommodation to another as their needs changed as 'dangerous and presumptious', representing 'not community care,,,but professionals and carers wishes to get rid of the client'.

Experiences of collaboration also varied across the areas. In areas 1 & 2, the difficulty of gaining access to part III had soured relationships between health and social service professionals, as described above. Yet collaboration between professionals was described in positive terms by most interviewees - being referred to as 'essential' and as 'fundamental to community care' and 'a vital means to deliver effective care'.

2. **Roles, Responsibilities and Relationships**

This section of the Chapter describes the key issues which interviewees perceived as affecting their relationships with other statutory carers in providing community care to elderly people, as well as their perceptions of those carers.

(a) ***The District Nurse.*** There were 24 district nurses interviewed across the three localities. Most district nurses defined their roles in very general terms; for example, to maximise their patient's physical comfort and independence. It was recognised by these nurses that this entailed not only physical health care but also chatting, making fires, cooking, addressing emotional needs (e.g. following bereavement), personal care tasks (strip washes and bathing) fetching prescriptions or food notably at bank holidays or weekends when no other social support was available. Only one nurse interviewed expressed resentment at doing such 'social duties'. In areas 1 and 2 where home helps had been targetted towards the most dependent elderly, district nurses complained that they had to increase their input to fit but isolated elderly people as a result. As one nurse argued, 'what is the point of cutting support to elderly people, when that support is maintaining the quality of their lives,,,to remove help is to remove their independence in the long-term?'.

Despite this all-encompassing role, district nurses were keen to avoid undertaking routine nursing duties such as administering basic medicines (notably tablets and eye drops) and bathing people. One nurse argued 'What is the difference between a nursing duty and a home help duty when it comes to giving eye drops, or administering tablets described on a bottle label?' - these were tasks which any caring relative would perform. Thus, nurses argued that home helps or wardens acting as 'good neighbours' (a term used in their job descriptions) should perform these duties. But, in practice, both home helps and wardens were warned against administering medication, and wardens were specifically debarred from bathing tenants because of the possible risk of back injury from lifting. However, in response to cutbacks in routine bathing by district nurses (a task in any case which they argued should be undertaken by nursing auxiliaries) other domiciliary carers such as wardens claimed they had to "unofficially" fill this gap in nursing care. Thus, wardens in area 3 referred to the local

district nurse practice of only bathing incontinent tenants once or twice a week as imposing the 'dreadful burden' on them of having to bath tenants for the remainder of the week.

Many nurses argued strongly for more extensive social work support to cover weekends and holidays. As one nurse commented, 'a 24 hour social service would solve a lot of problems for me'. Another nurse made much the same point, 'it would mean we didn't end up as dogsbodies at weekends'. However, even during office hours nurses reported great difficulty in contacting social workers; 'social workers are hardly ever available'; 'the duty officers don't relay messages, or if they do, calls are hardly ever returned'. More irritating still were the occasions reported by nurses when they learnt of recent social work contact with some of their long-standing patients resulting in important decisions being taken about their future care (for example, admission to residential care). Such decisions were said to be made without discussing the position with the relevant nurse. One social work team had sought to remedy such communication problems by organising monthly meetings with local clinic staff. This was said to have worked well; allowing people to raise issues in a regular forum.

When district nurses sought social work help for patients needing residential or day care in areas 1 and 2, they reported considerable delays in gaining access to such facilities. Indeed, in the time it took to get old people admitted, their health had often deteriorated to the degree that they were 'unfit' for any form of residential care. Similarly, poor access to day centres meant that the possibility of short term rehabilitation of groups such as stroke patients diminished through time creating longer term chronic disabilities. District nurses attributed such delays to more than the scarcity of available facilities, referring to the lack of priority accorded to their patients and the reluctance of social workers to be involved with their patients except on a crisis basis. Social workers' response to this was; 'G.P.s and district nurses have false expectations of...day and residential facilities'; 'we are expected to respond to such referrals without question, irrespective of what the elderly person thinks'. This non-interventionist approach by social workers, aimed at preserving the independence of elderly people, was interpreted by nurses as reluctance to act.

(b) *The Warden* There were 21 wardens interviewed in this case study; the second largest group of interviewees. They reported widely differing work experiences; indicating that there was no such thing as a typical warden's job. Thus, some wardens spoke of considerable job satisfaction, amidst occasional pressures. Others complained of facing relentless daily pressure, and feeling demoralised and isolated. There were two main reasons for this variation. First, a range of contextual factors affecting the warden's work - the number and

mix of tenants on a site, the design of the flats and their location, the type of alarm and warden relief systems, the support provided by family and statutory services, the allocation policies of the relevant housing authority. In terms of contextual factors, in the three localities studied the wardens contacted serviced between 20 and 120 flats. Warden support was related to the size of the housing complexes, although such arrangements varied by locality. Warden cover ranged from that of a single warden on duty during office hours to two or three wardens rotating to provide a 24 hour a day, seven day a week service. Complexes varied in age from 25 years to five months. Although building design was unique to each site, many of the more modern buildings shared common features such as communal lounges and on-site warden accommodation. The geographical location of flats was at times baffling. Flats were built on steep hills, close to busy main roads (with no local crossing points, and in one case, no footpath at all; one complex being at least a ten minute walk from the local Post Office, shops or chemist a several being poorly served by public transport). These locational features had an enormous impact on the warden; they could mean the difference between the majority of tenants being able to fetch their own pensions, prescriptions, shopping or the warden having to - the tenant's independence (and dependence on the warden) was largely determined by these factors. Thus, one warden stated that 'My ladies would love to go and get their pensions and prescriptions, but they'd need a taxi to do so,,,to walk to the bus stop is enough to give most of them palpitations, so they stay in their flats, hardly get out, sending me instead'. The other factor affecting levels of warden support was whether the warden lived on site or not. Many wardens who lived in on-site accommodation found it difficult to have a private life - one such warden commented that 'the main entrance is next to my door, if anyone goes in or out they knock on my door whether I'm on duty or not'.

The type of warden employed, and the cover provided for complexes at weekends or holiday periods did vary between the two Housing Authority areas. This made an important difference. Area 3 operated a flexible approach to warden appointments, recruiting responsible, caring individuals from any background. Areas 1 and 2, however, did not employ wardens with nursing backgrounds, because it was thought that this would encourage them to undertake duties other than those of a 'good neighbour'. To reinforce this approach wardens in these two areas, when off-duty, could switch alarm calls through to a central control facility to be dealt with. The central control had a significant affect on wardens. Those who benefitted from such a scheme were able, as one warden said, to 'switch off themselves,,,not just the alarm'; other wardens were, as another warden remarked, on '24 hour call, 365 days a year'.

The second factor affecting wardens' experiences was the liberal interpretations of a their role. Whether a warden had much need to call upon the help or advice of other statutory carers largely depended upon the needs and numbers of tenants she oversaw. Comments made by wardens on this issue were made in the context of their general view that too often they were left to look after more dependent tenants because their role was misconstrued. Thus, wardens felt they were viewed by other carers as matrons of residential homes rather than good neighbours. Some wardens felt that their roles were distorted by the level and pattern of support provided by their colleagues. As a warden exclaimed; 'I have to do what the home help and district nurse hasn't time to do, but in the ideal world should do'. Inadequate health and welfare support for tenants placed the onus of care on wardens who felt unable to ignore tenants unmet needs, because

- they lived with tenants, and had to maintain a good daily rapport with them;
- if they ignored needs, tenants could get worse, leading to greater pressure on them in the long run; and
- the warden could not ignore problems - they were literally always a few doors away.

On the other hand, wardens had to live with the pressure that if they spent too much time caring for a few dependent tenants, they were bound to be neglecting the majority of other tenants. Wardens cited, in this context, instances where the constant pressure from one or two dependent tenants had emotionally and physically exhausted them. Thus, when home help visits were cut back, or when what one warden described as 'their growing list of don'ts' grew longer, wardens felt vulnerable. These support problems were heightened at weekends and during holiday periods. Not only was health and welfare support more limited, but wardens reported that at these times tenants were often discharged from hospital without warning.

The job descriptions of wardens in the three localities were similar, although produced by the two separate housing authorities involved. In area 3 the warden's job description stated that; 'The wardens' primary duty is to act as a good neighbour equally to each of the tenants ...In an emergency it is the warden's job to summon relatives or to call a doctor or other professional help that may be necessary...The warden is not expected to undertake any day to day care of any tenant, nor to do shopping or to collect pensions or prescriptions except in an emergency and until relatives, friends or the social services department can provide help that is needed'. The job description also stated that the warden was only expected to pay one visit to tenants each morning (except in emergencies), and arrange social activities. All wardens except one regarded this job description as impractical and unrealistic. Some thought the Housing Authority had deliberately defined the job narrowly in this way to justify low

wages and to attract applicants to vacant posts (because very few people would apply for jobs if they knew what was actually involved). The vast majority of wardens believed that their managers expected them to undertake more responsibilities than referred to in their job descriptions. One warden said, 'We are chosen because we will do more than is written down'. Another said, 'You can't be a proper caring warden if you keep to the job description'.

Given this job description it was difficult to identify when a warden was expected to carry out 'emergency' duties and for how long. Thus, if an old person regularly fell, it would be inhumane to leave that person on the floor each time until medical assistance arrived; wardens would help them to their feet and tend minor injuries. Equally, if an old person was incontinent it would be unkind to wait for a district nurse's twice-weekly visit for a bath. If a tenant was sick and needed dressing, feeding or a prescription, it was often not practical to leave this for the family, nurse or home help. And for elderly people who were depressed, lonely, bedfast, confused or exhibiting disruptive/anti-social behaviour, where special support was frequently rather than occasionally needed, was this support an emergency duty or 'normal'? Clearly, the larger and older the complex, the more likely it was that some tenants would have these kinds of needs, thus skewing the burden of care on some sites. This position was reinforced by the views of several district nurses who referred to sheltered housing accommodation as 'part III'. Some G.P.s had a similar understanding, complaining that sheltered housing didn't provide sufficient support to dependent elderly people; one praised wardens for undertaking 'considerable nursing duties' to keep old people in their flats.

Housing managers were aware of these problems and used different means to try to minimise them; one such means being the tenancy allocation procedure. For example, in area 3 tenancies were allocated on a 'first come, first served basis'; there was no points system reflecting 'need' as such, just a waiting list based on time of application. Yet in areas 1 and 2, there was a policy of positive discrimination against frail elderly people - as flats became vacant, potential tenants were vetted, and their dependency level was considered in the context of the demands they might make on a warden. One housing manager explained this stance; 'We are a housing department, not a social services department, so we must draw the line'. As noted, other practitioners tended to view sheltered housing quite differently - both G.P.s and social workers viewed sheltered housing as a facility specifically for the frail elderly. Thus, allocating flats to fit elderly people was thought by social workers to be irresponsible and a misuse of scale resources, since it left some more dependent people isolated in the community, with little regular support.

Many wardens felt that they had to make too much fuss to get health or welfare support for their tenants, G.P.s were particularly criticised. One warden reported that a local G.P. would not visit some tenants; citing the case where after failing to get a G.P. to make a home visit for a tenant, the doctor deputising service diagnosed a broken limb and the tenant was immediately taken to hospital. Some G.P.s felt that sheltered housing tenants made inordinate demands on their time, and objected to making home calls for 'routine' problems - the earlier illustration of some G.P.s campaigning against the siting of a sheltered housing scheme in their area, arose from precisely such concerns. Wardens cited many individual cases of poor support from G.P.s particularly in terms of gaining access to hospital care, where delays in admission left the wardens having to provide intensive interim support. Moreover, on discharge, communication with hospitals was reported as 'minimal' and 'non-existent'. Indeed, wardens had learnt that to prevent a tenant being discharged too early, or without notice, they had to take the tenant's door key off them before they were admitted.

Wardens were similarly unimpressed with the support from social workers, feeling that the needs of tenants came a poor second to those of elderly people living in their own homes. They felt that social workers and other practitioners who controlled resource allocation assumed that they provided a constant level of personal support to each tenant, given this supposed support tenants were perceived as a low priority vis-a-vis elderly people living alone, relatively unsupported, in their own homes.

(c) ***Home Help and Domiciliary Services*** Almost all interviewees felt that domiciliary services were underprovided, particularly outside office hours. As with district nurses in general, in response to increasing demands on their time, home help time in areas 1 and 2 was focussed on the more dependent elderly people by moving away from 'charring' to 'caring' duties. To many interviewees, the wisdom of this was questionable. For example, one district nurse argued that although a client might need a home help for social support this was important to their long-term welfare because they were so isolated. Similarly, a Home Help Organiser argued that withdrawing home helps from less dependent old people, the entire burden of care would transfer to relatives, precipitating in the future breakdown of such support, thus being 'counter-productive to maintaining elderly people in the community for as long as possible'.

Aside from the impact on client or family, the changing home help role led to confusion amongst other community care practitioners in terms of the division of labour between home helps, district nurses, nursing auxiliaries and, to some extent, social workers. Role overlap with social workers was a cause of particular concern within the local SSD offices; social

workers in areas 1 and 2 had tried to develop a more generic thrust to their work, but they had largely failed. As one social worker admitted - 'Increasing statutory responsibilities under mental health and child care legislation means we can't break away from our traditional workload'. Another social worker stated that 'Any extra resources we get as a team are used to tighten up our administrative and monitoring procedures relating to children at risk'. This created some difficulties in agreeing a workable division of labour between different social services staff working with elderly people. From a social work perspective, there was considerable suspicion about the nature of the work undertaken by domiciliary managers who were perceived as 'empire building' given that social workers felt unable to influence the allocation of an increasing range of domicilary services to elderly people. A social worker commented that 'We don't know what they do,,,they've taken over work with the elderly'. Moreover, some social workers suggested that domiciliary managers were undertaking 'trained social work tasks' because of their role in part III admissions procedures; one domiciliary manager was criticised for completing part III applications because, it was said, 'she is unqualified and assessment is a skilled task'. This domiciliary manager defended her position because she felt she had considerable experience of these procedures, and much closer working relationships with the elderly clients they affected. In practice, this role had developed by default rather than design; for example, one social work team which intended to deal with all part III referrals was clearly unable to do so. As a result, a division of labour was agreed whereby all part III referrals from home help clients were followed up by their domiciliary manager, and all other referrals were dealt with by social workers.

Domiciliary service managers' views of the role of the home help service were greatly influenced by what was perceived to be the poor contribution of social workers to the care of elderly people; notably the slow response to social work referrals for elderly people and the social workers' very limited personal contact with their elderly clients and consequent limited understanding of such clients' needs. As one social worker admitted 'domiciliary services have enabled us to forget about the elderly'. Even team-based social work assistants had little time for elderly case work, concentrating instead on arranging short-term care, day care, or making referrals to other services. Decisions reached by social workers were cited by domiciliary managers as 'based on theory, not on knowledge of the individuals circumstances'; 'taking very little or no account of the views of carers'; 'failing to address the real practical issues'. Poor communication between these two elements of the department led to a polarisation of views and anxiety on both sides. As a result, the development of positive community services such as night sitting and home care aide services, took place against a background of social work suspicion.

(d) ***Social Work Services.*** As the above section illustrates, social workers were viewed as marginal to the bulk of work with elderly people in the community, but as vital 'gatekeepers' to key services such as residential and day care. The limited availability of social workers combined with their crisis-based intervention created tensions amongst other statutory carers. From their perspective, social workers regarded many G.P.s as unwilling to provide support to elderly people in the community or to make referrals to hospital for short-term assessment or treatment. On examination the reasons why social workers made referrals to G.P.s, and the latter failed to respond to them were complex. For example, as one senior social worker remarked 'we see ourselves as skilled in bringing our clients to the point where they are able to make informed judgements and take power over their own lives and be treated like mature adults. But unless they comply with medical judgements they are excluded from health care resources which are not used to bring the client to a place of supported independence, but to enable medics to practice in a certain way'. This strong view was perhaps atypical, but it illustrates the different perceptions of the motives behind professional support, explaining why these professionals might disagree as to who should be admitted to hospital or residential care or remain in the community. Jointly agreeing packages of support for elderly people at home was not regarded viable by one team social worker because it was 'simply not on the agenda and unlikely to be so because of the differences between us in style, approach and perception'.

Links between social workers and district nurses were also tenuous. As noted, nurses felt that it was very difficult to get social workers to respond to their referrals. But social workers thought nurses had unrealistic expectations of them. As a social worker noted, 'community nurses expect too much, too soon, too easily'. This point was made particularly in relation to part III admissions procedures where both sets of workers disagreed as to whether a social worker should 'persuade' an elderly person to enter residential care. District nurses and home helps both complained that very dependent elderly people were left at home for too long, and that referrals to part III homes were ignored by social workers. Social workers argued that it was not their responsibility to coerce elderly people to enter a home. These conflicts of interest were made worse because social workers often only became involved when a crisis had been reached; to then be faced with philosophical arguments about the rights of elderly people often seemed incongruous to other carers. As one G.P. remarked 'social workers seem to take pleasure in justifying the ridiculous - keeping very frail, often confused, elderly people in their homes with minimal support and therefore at great risk due to some misguided notion that it better for their client'.

(e) ***G,P,s*** G,P,s were described by one warden as 'a law unto their own' reflecting what many perceived to be the great variation in approach they adopted towards elderly people. Comments have been presented already as to the tendency of G,P,s to look to residential care as a solution to the long-term needs of their more frail elderly patients - an approach which created some conflict with social workers. In return, G,P,s expressed some criticism of social workers at two levels; first, because direct social work support to elderly people was usually crisis-based, short-term intervention; second, that allocation criteria and procedure for key services were felt to be inappropriate. G,P,s were mystified as to how certain resources were allocated; they were also dissatisfied, like district nurses, with the communication links with social workers such as the duty officer system and Emergency Duty Team. This combination meant that G,P,s felt social workers 'do too little too late' and that when they did take decisive action it was sometimes not the support which G,P,s anticipated. G,P,s also reported that their referrals for home help support were refused. In response, home help organisers referred to similar perceptions as mentioned by social workers; 'G,P,s seem to want us to be at their beck and call, and take it very personally if we don't respond immediately and precisely in the way they expect,,,but sometimes that would be wholly inappropriate'. Certainly, G,P,s regarded their clinical judgements as paramount, overriding other considerations; 'a patients health surely must come first,,,and yet sometimes its as if it comes last if you look at how social services allocate resources'. In response, it was clear that both social workers, home helps and wardens felt that G,P,s used them as a substitute for hospital or primary health care support - preferring, as one social worker remarked, 'to shunt the problem to another agency than provide regular support at home'.

In terms of psychogeriatric care, G,P, communication links varied by area. In area 3 they were regarded as good; domiciliary Consultant visits were readily arranged and were credited with 'taking the heat out' of supporting elderly mentally infirm people in the community. But experience in areas 2 and 3 was less satisfactory; psychiatric and medical needs of the elderly - as met by Consultants from a separate hospital to area 1 - were not dealt with with the same enthusiasm, leading to local conflicts as to how to support such people at home.

3. <u>Perceptions of Client Need.</u>

(a) ***District Nurses*** District nurses emphasised the importance of providing respite care for carers as much as direct support to elderly people. Their conclusions from such split loyalties were summed up by one nurse; 'there comes a point when keeping an old person at home threatens the well-being of carers,,,we then end up with two patients with conflicting interests'. Whilst district nurses defended the right of elderly people to stay in their own

homes as their frailty increased (rather than be placed in residential care) they acknowledged the need to provide respite care for relatives which was said to be 'hard to arrange on the scale required'. Thus, day care, night sitting and more intensive home help support were felt to be in short supply.

The socio-economic features of the three areas did affect the demands made on district nurses. For example, in area 1, an inner city location, there was a large proportion of poor quality rented housing with an increasing proportion of elderly people as the younger population declined. In this context a district nurse remarked that 'there are many elderly people in poor housing with poor social contacts wholly reliant on community care services'. The limited availability of home helps in the area was cited as a cause of an over-stretched district nursing service. Although district nurses seemed willing to interpret their own roles broadly to encompass practical and social tasks they felt this could be exploited; 'its O.K on occasions when other support is not available such as weekends, or when there's a need to help out at times of stress...but we can't substitute for social services in every case'. The perceived shift in home help effort towards more dependent elderly people exacerbated this problem, and as a district nurse remarked 'there is a perverse logic to focussing on the most needy, for by doing so the least needy became more dependent, rather than sustaining relatively good mental and physical health'.

District nurses also felt that they were increasingly becoming victims of earlier hospital discharge policies. They reported that larger numbers of patients with specialist needs - stroke patients, colostomy and ileostomy patients, the incontinent or senile, those with mobility problems or the sensorily impaired - were being sent home still in need of intensive daily support. In the case of such dependent elderly patients, district nurses referred to the 'vital importance of sheltered housing'; implying, as one nurse actually said, 'that warden-aided accommodation should be devoted to those elderly who cannot safely be left alone' - a view not accepted by wardens or housing managers. However, there were few district nurses who advocated the increase of residential care on the same grounds.

(b) **Social Workers** It was only the most dependent elderly that seemed to generate a social work referral. This created extra difficulty for social workers in negotiating solutions to their needs since these people were often marginal to health and social care systems - the mentally infirm, the frail but lucid elderly, the 'awkward' or 'disruptive' elderly person. Moreover, the pattern of existing services was geared to general not specialist support; for example, it was unclear whether day centres should take a mix of the physically and the

manageable mentally frail elderly (disruptive elderly people could not be accommodated because of the effect on other clients and staff). These service policies tended to isolate some of the most dependent groups of elderly people and force long-term institutional solutions to be adopted; something which social workers opposed since, as one stated, they viewed community care policy as 'the means to ensure that elderly people can enjoy a normal life and maximum independence'. The willingness of social workers to leave elderly people in the community relatively unsupported was criticised in other quarters; some interpreted such action as a product of their limited understanding of the client or their situation, or their lack of time to make a thorough needs assessment, others were more cynical and attributed this action to a callous disregard for all but children at risk. Even if life in the community for some elderly people was adjudged by other carers to be of an unacceptably poor quality, social workers resisted pressure to adopt institutional solutions to need; as one social work assistant stated, 'we are entitled to make choices about our lifestyle and about the company we keep,,,so are elderly people,,,the choice to live in delapidated accommodation with few social contacts may not be what we would choose,,,but elderly people are not to be treated as children,,,unable to take risks or with restricted freedom'.

This social work approach gave elderly people power, which social workers acknowledged created some conflicts; notably with other professional carers and families. In terms of the former, social workers noted that elderly people could choose to ignore a doctors' advice presumably given to maximise their health. In terms of the latter a threat to withdraw family support to enforce, say, admission to part III, placed social workers in a dilemma; trying to reconcile the needs of the elderly person and their carers. In most circumstances solutions could be negotiated by providing some kind of shared or respite care, but if the elderly person refused to co-operate then the future was less clear.

(c) ***Wardens and Housing Services*** Wardens reported that they had become increasingly concerned at the type of tenants being allocated new tenancies. In theory, new tenants should be able to wash, dress, cook, walk and shop for themselves. Their level of independence should be high; there was no 'part 2½' sheltered housing specifically designed or resourced to cater for frail elderly people in any of the three areas studied. Yet, in practice, wardens reported that new tenants were becoming more frail and thus increasingly dependent on them from the outset. It was unclear whether this was a deliberate policy, or just a reflection of demand outstripping supply, i.e because many people had deteriorated since being on the waiting list. However, the general outcome was that wardens felt unable to merely act as good neighbours, being more akin to nursing auxhiliaries.

Although wardens were aware that tenants should be able to stay in their flats until they died, the reality of looking after large numbers of frail elderly people under one roof made this impractical. Thus, wardens suggested that certain elderly tenants should not be allowed to remain in their flats unless exceptionally well supported - for example, confused or behaviourally disturbed tenants, the bed-ridden or chronically sick and the regularly incontinent. It was not that wardens wished to question the rights of tenants to stay put given these needs, but that they could not provide the essential daily support to maintain a reasonable quality of life for such tenants. However, in opposition to this stance, many social workers were critical of allocation policies which failed to allocate sheltered housing tenancies to frail elderly people. These opposing perspectives show that what was in dispute was not wheher frail elderly people needed supported housing, but who should provide the support in such housing.

Five of the wardens interviewed cited instances of looking after tenants to the degree that their personal health suffered significantly. Some had threatened to resign unless a tenant was relocated. Yet it was this kind of 'blackmail' which social workers objected to; they saw it as an attempt to override the wishes of elderly people by the wishes of a warden, in a context where social workers felt that sheltered housing should be used for more dependent elderly people. On the other hand, wardens felt exploited by social services and primary health care staff who failed to provide adequate care and support to tenants.

(d) ***General Practitioners*** G.P.s interviewed held a range of views as to the means to care for elderly people. One G.P. argued strongly for the more places in nursing homes for elderly people on the basis that community care was a practical policy only for fit elderly people; 'once elderly people become frail and require more than routine domestic or health care support,,,then it is doubtful whether the community has the resources to cope other than on a short-term basis'. The same G.P. clearly regarded the maintenance of large numbers of frail elderly people in the community as inappropriate; 'I can't spend my day paying regular home visits if they have a fall, get bronchitis, become hypothermic, develop senile dementia,,,but a once a week visit is not enough'. Two other G.P.s suggested that they were able to provide more community care support for elderly people, but on exploring this further it became clear that the sources of this support were the district nurses or geriatric health visitors attached to G.P. surgeries rather than G.P.s themselves. One of these two G.P.s clearly saw "community care" as inevitable rather than desirable; 'we don't have a chance to get most frail elderly patients a bed in hospital or homes,,,and unless they've got some money the private sector is out too,,,staying at home is the only option remaining'.

4. The Elderly Mentally Infirm

All practitioners interviewed mentioned difficulties in caring for elderly mentally infirm people in the community. One district nurse described this aspect of her work as 'very frustrating...I don't know what to do'. One of her colleagues commented in similar vein that 'Relatives are stranded, and so are we'. In general terms, the care of 'confused' elderly people posed severe problems for domiciliary services; providing intensive care and support to carers and the clients alike created heavy demands on local services, and tensions between different practitioners allocating resources. In terms of the latter, for example, there were wide-ranging views as to the most appropriate accommodation for the elderly mentally infirm; hospital, residential homes, nursing homes, special sheltered housing or home. One nurse manager thought that 'the demented elderly are not a sensible group to keep at home...they have no regard for themselves or others'. In such cases, district nurses seemed more willing to entertain the notion that elderly people should be placed in supported accommodation or residential care. Thus, one doctor suggested that such old people should not stay with their families because of the stress which was created in the household, and had strong reservations about the virtue of providing long-term support for such elderly people in their own homes: 'the community can't "care" for such people...only provide help for two or three hours a day at the most, and less than that at weekends and holiday periods'. Another G.P. suggested that part III was the most suitable accommodation for this elderly subgroup since 'they can be observed 24-hours a day and properly cared for'. Placing these people in hospital was generally thought by G.P.s to be inappropriate unless the root cause of their behavioural disturbance was treatable. G.P.s reported that the private sector nursing and residential homes would not admit elderly people who were mentally frail, further constraining the availability of practical support and care.

The principles on which housing or domiciliary services were allocated to this group of elderly people were not agreed. Some health care practitioners suggested that the Monday to Friday, 9.00am to 5.00pm social services support virtually precluded caring for such people at home. But one social worker was quick to point to the rights of elderly mentally infirm people to stay at home despite the availability of services or professional judgements of their needs. One social worker took the view that if an old person was 'happily confused' then even though they were disruptive, or a danger to themselves and others, they should be allowed to remain in the community. This view was heavily criticised by wardens, G.P.s and district nurses alike as subjecting the elderly person to neglect, and carers to strain.

Summary and Conclusions

Consensus and local community care for elderly people

There were relatively few issues upon which the practitioners interviewed in the areas agreed. For example, although there was consensus on the view that resources were insufficient to maintain elderly people in the community, and that resource allocations procedures were inappropriate, there was no consensus as to how allocation procedures should be changed and what the pattern of local community care provision should be. The result appeared to be a feeling of stalemate: social workers, home helps and members of the primary health care team were all perceived to be devoting insufficient time to elderly people, without any clear idea of how a new division of labour might improve the situation. Many practitioners argued that they carried an unfair burden of care as a result of their colleagues. Some gaps in provision were heavily criticised by health care practitioners. For example, poor domiciliary support at weekends and holiday periods meant, according to one district nurse, that community care was a 'Monday to Friday, 9 to 5 policy', and, as a warden remarked, that community care 'left old people to cope by themselves for 9/10ths of the day'. At the other end of the spectrum of care, G.P.s strongly argued for an increase in the range of residential care available to frail elderly people, precisely because of the limited support in the community.

Interviewees generally agreed that community care was based on sound principles, but flawed in practice. But even here there were significant perceptional gaps. Social workers for example, were of the view that the principle of supported independence was central to community care policy. They objected to arguments that revolved around providing increased support without reference to ensuring an old person's independence: 'quality of life isn't just a matter of how many home helps an old person gets, but also reflects how their choice, dignity and independence are preserved. A person may have no statutory support and live in apparent squalor, but be content,,,Because they have chosen this lifestyle it should be accepted'. Other practitioners, notably G.P.s and district nurses, tended to hold the view that community care should be comprehensive, accessible and flexible: securing adequate levels of physical health care and thus providing an alternative to institutional care.

The uncertainty about community care services was compounded by confusion and disagreement over the roles and responsibilities of key practitioners. For example, wardens and district nurses complained of being exploited - treated as jacks of all trades. Social workers and G.P.s were both heavily criticised for their minimal input to elderly people. In particular, there was a particular difference of opinion between social workers and other practitioners

as to the appropriate role of social work in the care of elderly people. Yet, in general terms, social workers admitted that there were few incentives to work with elderly people, even though others saw them having an important role to play. This created friction, especially in crises; the social work response was slow and often viewed as inappropriate!

Some perceptional differences expressed by practitioners in this Chapter related to the roles of particular services. Thus, both sheltered housing and part III accommodation were defined in different terms and therefore viewed as catering for different needs. This led to differences of opinion regarding appropriate resource allocation procedures for those services. Yet perceptions of the role of sheltered housing greatly affected wardens and views of part III accommodation were used as a basis for criticising social workers. The strength of feeling on these issues did vary by locality, reflecting the adequacy of procedures to gain access to these scarce resources.

Inter-professional disagreements; impact on collaboration and community care

Disagreement on service and professional roles undermined collaboration and fuelled disputes as to who should do what, for whom and where. Disagreement on the means of delivering care - assessment processes, degrees of client involvement in decisions, priorities placed on other issues such as the welfare of carers, and the weight placed on professional judgements clearly reduced the basis on which local practitioners felt they could collaborate. The limited capacity of G.P.s and social workers to intervene in the substantive care of elderly people led to serious misunderstandings and communication problems. Collaboration mechanisms between these and other practitioners tended to be informal and not conducive to the crisis-based intervention which often forced them together. The nature of crisis communication was that it was perceived as a means to shed responsibility rather than to engage in genuine dialogue and agree shared responsibilities for patient care. Such circumstances served to hinder rather than encourage co-operation and good will, thereby increasing unilateral decision-making, and fostering intra-professional myopia.

There was particular uncertainty over how to respond, if at all, to the needs of the elderly mentally infirm in the community. Roles and relationships were particularly confused in caring for marginal groups as a whole; groups which presented both health and social care needs, and which required integrated and intensive packages of support. On the basis of largely negative experiences of struggling in isolation to care for groups such as mentally infirm, behaviourally disturbed, or chronically sick elderly people, practitioners were sceptical of the practicality of community care policies for such people. As with Chapters

Seven and Eight, Table 17 below summarises the areas of conflict revealed in this study.

Table 17: Day to day conflicts between community care practitioners

TYPE OF CONFLICT	ISSUES
POWER	Gatekeeping; access to part III homes, sheltered housing, hospitals
	Crisis intervention; generating help and support
	Removing people from the community; principles and processes
BUREAUCRATIC	Allocation criteria for home helps, district nurses, part III
	Communication mechanisms - to services, hospitals, in crises
	Allocation policies/admissions policies to key services
	Services at evenings and weekends
IDEOLOGICAL	The boundary of community care services for frail elderly people
	Rights and wishes of elderly people in decision-making processes
	Caring for the elderly mentally infirm in the community
	Priority of elderly people and supporting elderly people at home

In sum, although community care was percieved as a collaborative venture, it was affected by a wide range of factors; the focus and method of professional work; the congruence of professional decisions with another statutory carer's definitions of need, priority and attitudes; the power and status of professionals determining client outcomes; availability and awareness of local resources and allocation criteria; the frequency and formality of inter-professional contact - at crises or at regular intervals. Lack of coherence and consensus on most of these details - effectively the basis on which community care practitioners collaborated - led to services being organised and managed in virtual isolation. Thus, many supposed benefits of "official" community care policies were lost. Communication between groups was generally poor, even on specific issues relating to the care of the same individuals. Many factors mitigated against improvements in liaison arrangements - the pattern and style of practitioners work with elderly people, the different perceptions of need and priority attached to work with elderly people in general, the procedures used to allocate services and so on. These problems were not insoluble, but there seemed to be few instances where mechanisms were introduced to address them. Thus the tendency was to reinforce negative perceptions of both collaboration and community care policy. The climate of resource cut-backs and service rationing further exacerbated these difficulties.

SECTION IV

CHAPTER TEN

Overall Summary and Conclusions

Recap; Origin of Thesis and Areas of Study

This research originated in a perceived contradiction between the avowal of community care policies for elderly people by community care practitioners, and their apparent inability to collaborate to provide such care. The Thesis has explored three inter-related aspects of community care policy and practice in attempting to understand this contradiction;

- the historical and conceptual diversity of community care policies in England and Wales as revealed by official government publications over the period 1800-1982 and a range of professional and academic literature;
- the extent to which community care policies have been officially regarded as dependent upon inter-professional and inter-agency collaboration, and whether in practice community care practitioners have lent such policies their support and agreed on their meanings and implications;
- the relevance of these two aspects to implementing local community care policies.

The nature of Community Care; complexity and diversity

The findings of Sections I and II are that;

- community care is not a recent policy movement. The term was first used officially in the 1929 Wood Report (see p17) and policies and practices now recognisable as similar in nature to community care can be traced back to the 19th century,
- community care is not merely an anti-institutional movement. It was partly this but also a positive policy to develop community-based support in its own right and a neutral policy which emphasised the complementarity of different forms of care and their co-ordination,
- community care is not a simple or coherent policy. It is best understood as an umbrella term for a wide range of policies, and capable of a multiplicity of interpretations.

Moreover, official documents since the 1950's have continued to describe community care in terms of banner goal statements (1) which tend to espouse the simple conventional wisdom that it is good to care for elderly and other dependent people in or near to their own homes for as long as possible. The promulgation of community care as banner goals has hidden the many rationales which have underpinned community care policies.

Intended Community Care activity and Inter-Professional Collaboration

Community care comprises a range of support to elderly people living in or near their own homes; thus, some links between the providers of that support are essential. The very

structure of community care services therefore creates a need for some form of inter-agency collaboration or co-ordination. It is perhaps unsurprising that Section I found that official government publications, especially since the 1950's, have continued to describe community care policies as crucially dependent upon inter-professional collaboration for their success. Yet the literature analysed in this Thesis fails to describe what is meant by collaboration - as it failed to define in any detail the term 'community care'. Thus, At one extreme, the collaborative activity in question may take the form of formal, systematic and structured co-ordination; at the other, informal, ad-hoc collaboration (1). The complexity and diversity of community care policies suggests that the collaborative activity underpinning these policies will be located anywhere in this range.

This Thesis suggests that only an examination of the number, orientation and combination of the features of each community care policy will indicate which kind of collaborative activity is appropriate to secure the implementation of each policy (see Table 18 below). Section III identifies some of the policy features to be examined in this respect;

- the scale and type of any services change being sought;
- organisational structures/processes/procedures;
- management arrangements for services and staff;
- reliance on informal networks;
- decision-making structures and processes;
- areas where joint working is said to be essential;
- service and professional roles and boundaries;
- number of services/boundaries (and the nature of those services);
- the nature of the philosophical framework.

Table 19 below summarises the various features of the intended community care activity in the three case studies (2). By relating these features back to Table 18, the type of collaboration associated with the community care activity intended in each case study can be shown. Thus, in Study A to achieve the community care activity implied by the core model, formal, explicit, specific, negotiable and open collaborative arrangements should be established. The features of community care activity in Case Study B implied a much less formal type of collaboration, associated with fewer specific areas of joint working and informal structures, processes and procedures. The need here was for informal collaboration rather than more elaborate, closely integrated, collaborative project management arrangements. In study C, collaborative activity akin to those in study B is implied, but on an even less structured basis.

Table 18: Collaboration and Community Care Policies: Determining Features of the relationship

FORMAL/ELABORATE COLLABORATION ********* ********* INFORMAL/SIMPLE COLLABORATION

FEATURE OF COMMUNITY CARE POLICY

CONSIDERABLE/CONTROVERSIAL------SCALE/TYPE OF CHANGE---------MINIMAL/UNCONTENTIOUS

FORMAL/OPEN----------STRUCTURE/PROCESS/PROCEDURE----------INFORMAL/CLOSED

JOINT/MANY----------MANAGEMENT ARRANGEMENTS----------SEPARARTE/SINGLE

REGULAR ACCESS----------INFORMAL NETWORKS----------INFREQUENT ACCESS

JOINT/MANY LEVELS----------DECISION MAKING STRUCTURES--------SEPARATE/FEW LEVELS

MANY/SPECIFIC----------KEY AREAS OF JOINT WORKING----------FEW/GENERAL

FLEXIBLE----------ROLES/BOUNDARIES----------FIXED

MANY----------NUMBER OF SERVICES/BOUNDARIES----------FEW

PROFESSIONAL DISAGREEMENT--------NATURE OF SERVICE----------PROFESSIONAL CONSENSUS

EXPLICIT/FORMAL----------SERVICE PHILOSOPHY----------IMPLICIT/INFORMAL

INTEGRATED----------NEEDS ASSESSMENT/SERVICE ALLOCATION----------SEPARATED

Table 19: Features of Intended Community Care Activity by Case Study

FEATURES	Study A	Study B	Study C
Scale/type of change	Considerable & controversial	Significant uncontentious	Not applicable
Structure/process/procedure	Formal & open	Informal & closed	Informal & closed
Management arrangements	Joint/many	Separate/few	Separate/many
Informal networks	Unimportant	Important/regular	Important/occasional
Decision-making structure	Joint/many levels	Separate/many levels	Separate/many levels
Areas of joint working	Many & specific	Few, but specific	Few and general
Service/staff roles/boundary	All Flexible	Some Flexible	Fixed
Services/boundaries: number	Many	Many	Many
Nature of service	Mostly disagreement	Mostly consensus	Not applicable
Service philosophy	Explicit & formal	Implicit & informal	Not applicable
Needs assessment	Integrated	Separate	Separate
Service allocation	Integrated	Mostly separate	Separate

The development of the Welfare State has led to increasing sophistication in community care provision, reflected in the growing range of community care practitioners. As the number of these practitioners has increased, so the task of inter-professional collaboration has become not only more important but also more difficult. In this context, particularly since the

Seebohm Report in 1968, the historical literature has assumed that community care requires more than ad-hoc, informal co-ordination to be effectively and efficiently provided; community care has been described in terms of partnership models of care necessitating more formal and structured collaboration. This has been reflected in the establishment and growing sophistication of formal joint planning processes since 1974.

Alongside the increasing complexity of collaborative activity associated with community care, the historical literature in Section I refers to the existence of a multiplicity of barriers to collaboration. In Section II also, the professional journals and responses to "A Happier Old Age" make similar references to such barriers. In particular, organisational, structural and financial barriers to the implementation of community care have been highlighted in a succession of government documents since 1980 (3). For example, the Audit Commission stated in 1986 that 'responsibility for introducing and operating community-based services is fragmented between a number of different agencies with different priorities, styles, structures and budgets who must "request" co-operation from each other', adding that 'the more agencies that must be involved and the more differences in various agencies styles, structures and systems, the less likely it must be that agreement will be reached' (4).

This Thesis has focussed specifically on professional barriers, not least because they have been less frequently acknowledged in the community care literature. Thus, Sections II and III clearly show that despite the intention to establish particular community care services and activity by means of specific collaborative arrangements, both the activity and collaboration envisaged may be hindered by a range of professional barriers such as:

- threats to professional independence, status and legitimacy;
- negative attitudes towards elderly people;
- conflict with wider organisational structures, policies and procedures and the need for professionals to be seen to comply with these;
- differences between professional value-systems and models of care;
- disparities between professional perceptions of,,,needs, rights and priorities;
  ,,,service roles and responsibilities;
  ,,,professional roles and responsibilities;
  ,,,incentives/benefits of service;
- dependence on the individual professional commitment or charisma of senior officers (5).

A further aim of this Thesis has been to explore the effects of professional disagreement in areas of community care policy and practice, as one of crucial barrier to collaboration (see Table 18) and policy implementation. The findings are summarised below.

Consensus and Community Care

Sections I to III show that the almost universal consensus on the benefit of community care policy is related to the perception of community care as a set of banner goals. These banner goals are so general as to allow a multiplicity of interpretations which suit different professional and organisational goals. Section I also suggests that the robustness of general support for community care across professional divides has implied that inter-professional collaboration could be achieved with considerable ease. But the evidence in Section II is that there is less consensus surrounding detailed features of community care and, therefore, that any such optimism is probably misplaced.

Indeed, Sections II and III show that there were some features of community care policy and practice which seemed certain to generate inter-professional disagreement;

- the right of elderly people to stay at home (particularly marginal groups such as the mentally infirm or terminally ill);
- the role and boundaries of particular services (notably part III homes and sheltered housing) and the roles and responsibilities of some community care practitioners (particularly social workers, district nurses, home helps and G,P,s);
- the processes and criteria by which services were allocated;
- perceptions of need (of carer and cared for) and the best ways to meet these needs.

Given that these features are common to many community care policies, the impact of professional disagreement upon collaboration and thence upon the delivery of community care services is clearly of considerable concern.

Consensus and Inter-Professional Collaboration

The relationship between consensus and collaboration was assumed in Chapter One (p4) to be such that the more sophisticated the elaborate the collaborative activity, the greater the degree of consensus required to underpin it. This implies, for example, that even informal, ad-hoc inter-professional co-ordination may be difficult to establish if there is no consensus on any features of the community care services being provided. However, as argued above, the recent emphasis on community care policies has implied a dependence on formal, structured collaboration. This type of collaboration would, in turn, imply a considerable degree of consensus across a wide range of community care issues.

Given the evidence of widespread inter-professional disagreement on features of community care across many policies, and the assumed relationship between, first, consensus and collaboration and thence collaboration and community care, it is reasonable to question whether community care policies will be undermined by such disagreement. The findings of Sections II and III are that an understanding of the causes and effects of inter-professional disagreement is needed in order to explain why, when and precisely how collaboration, and community care policies are affected by a lack of inter-professional consensus.

Evidence on the causes of inter-professional disagreement in the field of community care is provided in Sections I, II and III. Section I describes the complexity and diversity of community care policies, suggesting that the potential for disagreement as to the meaning and interpretation of community care is not only considerable but inherent. Section II illustrates this, but also suggests that community care is an umbrella term for some controversial issues on which professionals hold conflicting views. Thus, Sections I and II strongly imply that historically community care as a concept and policy has in itself been a prime cause of disagreement. In addition, Section II suggests that a major cause of inter-professional disagreement is the variety of priorities, perceived responsibilities, models of care and value systems of the professions themselves. These, together with their different attitudes to and perceptions of elderly people, lead them to disagree on community care issues, particularly in view of their complexity, diversity and controversial nature. Lastly, Sections II and III show that many community care issues are based on a number of key rationales (needs-based, resource based, humanitarian or organisational), which in turn increase the likelihood of professional disagreement. For example, if the dominant rationale of a local community care policy is based on an elderly person's rights and choices, this would be appear to be more compatible with the ethos of the social work profession than the medical profession - given the evidence in Sections II and III above.

As to the effects of inter-professional disagreement on local service delivery, Section III identifies at least three areas in which it may cause disruption to community care planning and implementation processes, or the collaboration essential to those processes. These areas are related to the power, ideological and bureaucratic bases of professionals. As the Tables in Section III show disagreements may cause power conflicts in areas such as the professional control, allocation and management of resources (staff, services and buildings); and issues relating to professional influence in decision-making processes. Disagreement may provoke inter-professional conflict on ideological issues relating to perceptions of need, their priority and "solutions", and also on issues to do with the appropriate boundary of services

or roles and responsibilities of professionals. Bureaucratic conflict may result from inter-professional disagreement as to the degree to which organisational structures and processes should control the planning and management of community care services.

The degree of disruption that these areas of conflict produced varied according to the type of collaborative activity being pursued. For example, if the collaborative activity centred on joint assessment processes, then disagreement as to definitions of need or of professional responsibilities may result in sufficient ideological conflict to hinder these processes. Indeed, even if there was no ideological confict, the translation of joint decisions into practical service delivery may be subsequently hindered by power or bureaucratic conflicts. The report of the core project, Case Study A (see Chapter Seven), illustrates how this combination of conflicts could interfere with joint assessment and allocation processes.

A final note of caution needs to be made here in relation to the relative importance of consensus as a pre-requisite for collaboration; it is, as indicated elsewhere in this Thesis, only one of the many possible barriers to collaboration. The relative importance of disagreement as an impediment will depend not only on the nature of the particular policy being pursued, but also the particular local combination and inter-relationships of these other barriers.

Consensus, Collaboration and Community Care: explaining the original contradiction

As regards the apparent contradiction which originally stimulated this Thesis (see p178), it is clear that amongst the many possible explanations, the most likely are:

- that the professionals concerned only agreed on community care banner goals, not on the means to implement them. This disagreement undermined attempts to collaborate effectively;
- that the professionals agreed on the means and ends of community care but other barriers (organisational, structural or financial) prevented effective collaboration;
- that the local community care activity was based on loose, ad-hoc, informal co-ordination which was undertaken behind the scenes, and was not easily observable.

An understanding of this contradiction is thus achieved by examining the features of the community care policy being pursued, the extent and pattern of consensus associated with these features and the collaborative activity being attempted to deliver this policy. Taken in context of a comparable understanding of the other crucial contextual variables, most notably the financial and organisation barriers to inter-agency collaboration, these factors provide an adequate explanation of this contradiction will be gained.

Planning Community Care for Elderly People; Future Prospects

However interpreted, the evidence in this Thesis shows that community care is, in both theory and practice, certainly dependent on inter-professional collaboration. The range of possible collaborative activity reflects the diversity and complexity of community care policies. But the historical assumption in the official literature that inter-professional collaboration can be virtually assumed in the field of community care is misconceived; the differences of perspective, priorities and practices between professionals are considerable.

The development of joint planning and joint finance arrangements from 1974 onwards reflected a certain optimism; that organisations could be encouraged to work together to provide community care through the establishment of formal collaborative planning structures (to bring those organisations together) and some small financial incentives (to reward and stimulate collaborative planning). The history of joint planning and joint finance has been generally disappointing (6) exposing an overall weakness of such an approach to inter-agency collaboration, namely its faith in rational planning and its reliance on organisational and professional altruism (7).

In contrast to this broadly optimistic approach to collaborative planning has been the recognition of the growing organisational complexity of community care, which, as the Audit Commission recognised above (p181), is manifest in the fragmentation of services and disjunction of agencies' objectives, structures and priorities. The case studies in this Thesis suggest that amongst community care practitoners there are likely to be many power, ideological and organisational conflicts. The pattern of disagreements revealed in these studies, highlights the plurality of views about how to manage and deliver community care and shows that providers are not naturally inclined to behave altruistically and that the costs and benefits of changes in the management or structure of community care have a strong influence on community care practitioners. The evidence that conflict is commonplace simply confirms that any faith in a purely rational approach to inter-agency co-ordination and community care planning is fundamentally misplaced.

Community care policy since 1981 has come under considerable scrutiny compared to the previous 170 year history covered by this Thesis. From the 1981 DHSS Study on Community Care, "Growing Older" and the Care in the Community Circular of the same year, to the 1985 Report of the Social Services Committee and the "Caring For People" White Paper in 1989, there has been an increasing specification and explication of the philosophy, objectives and, more particularly, the barriers to community care. Yet as Chapter Four briefly shows (p66), there

has still been a failure to make consistent statements about the meaning and implications of community care policies, although the 1989 White Paper tries to state more clearly how it is to be achieved. This Thesis suggests that the specification by the governement of the means and ends of community care may not assist policy implementation to any great extent. A clearly understood policy may certainly avoid the situation where community care is interpreted so widely and thus prevent confusion. But, even if the policy is understood in the same way, the differences between community care professions will certainly mean that it is perceived by some as less beneficial than for others, and thus, again, may not necessarily generate the necessary inter-professional collaboration to achieve the outcomes intended.

Postscript

Community care in the 1990's (or at least from 1993) will operate within a very different framework of assumptions and processes than the past. The introduction of contractual arrangements, market principles, competition and the devolution of purchasing power to case managers will have a profound effect on the nature and development of community care. It is difficult to assess how these changes might influence the nature and type of collaborative activity undertaken in providing community care to elderly people. But whatever the future structure and management of community care services, the successful delivery of community care will still depend in part upon defining the boundaries of professional and agency reponsibilities (albeit through contracts) and therefore defining the areas where collaboration and joint working are essential. A community care contract may still be vulnerable, however, because of the limited professional consensus on these issues; what should be done, how and by whom. In this sense, the historical, organisational and conceptual diversity of community care may continue to have its impact on the degree of collaboration (and hence the quality of community care services), for some time to come. If so, the analysis of the history, theory and practice of community care undertaken in this Thesis may be of some use to todays policy makers and community care practitioners.

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APPENDICES

Appendix 1: Thesis Methodology

General Introduction: Thesis Methods

In this Thesis three methods are used to generate and analyse data; content analysis of a range of community care and fieldwork-related literature; semi-structured interviews and non-participant observation. A brief summary of where these methods are applied is given below;

Table 20; Research methods used by Section of Thesis

METHOD	SECTION I (Chapters 2-4)	SECTION II (Chapters 5-6)	SECTION III (Chapters 7-9)
CONTENT ANALYSIS	Historical, academic & professional literature related to community care	Professional journals and responses to "A Happier Old Age"	Papers (reports, Minutes correspondence relating to projects plus policy/ procedure documents
INTERVIEWS	None	None	Semi-structured interviews
OBSERVATION	None	None	Non-participant observation in two project case studies

Content Analysis; An Overview

As Table 20 shows, this research involves a considerable amount of content analysis. The type of content analysis undertaken was qualitative in comparison to more formal quantitative types of content analysis which would attach numerical values and relative frequencies to the content of the literature analysed (see footnote).

The content analysis in Section I takes the form of a standard documentary analysis; various literature sources were searched and references to community care policy and practice were recorded and used to illustrate the historical development of community care and the diversity of its meanings, although the latter are not quantified but merely described.

Footnote; A detailed account of methods of applying content analysis is provided in Berelson B (1952) "Content analysis in communication research", Glencoe, Illinois; The Free Press (see Chapter III, pp114-134 for a description of qualitative approaches).

In Section II, the content analysis is more sophisticated in that sources from professional journals and the responses of professions and organisations to "A Happier Old Age" are broadly categorised in two ways. First, they are categorised by subject matter. For example, in the journal analysis all comments made in relation to areas such as sheltered housing, part III homes, the role of the district nurse, the care of the elderly mentally infirm, the rights of elderly people to remain in their own homes etc were clustered together. Second, they were divided up by reference to their professional interest group (by medical, nursing, social work or housing groups in respect of Chapter Five and health service and local authority groups in Chapter Six). Then a direct comparison of these perceptions by subject and source was made to indicate the volume and congruence of views on a particular subject within each professional group and across professional groups.

Berelson establishes that there are three purposes to undertaking content analysis;

- to analyse the characteristics of content - the type/style/range of communication;
- to analyse the causes of content - the motivations for communication;
- to analyse the consequences of content - the impact of communication (ibid., pp26-29).

This Thesis primarily describes the content of various documents, having the first of these purposes in mind. However, because some of the data analysed describes the motives behind the comments made; the second of these purposes is also to some extent addressed.

The three inter-related criticisms of content analysis are that;

- there is no "correct" interpretation of content - rather a range of interpretations based on different assumptions;
- the intent behind a communication is not self-evident - what is communicated cannot always be taken at face value - what is said may not be what is meant;
- making generalisations on the basis of communication analysis is problematic. As Berelson states, 'It is difficult to know under what conditions inferences can be validly drawn about the total population or only about the particular audiences; to what extent they refer to the audience or to the producers themselves as (untypical) members of that audience...whether they are correctly based upon a conception of audience characteristics as a source of the content or as an effect of it or both; whether popular values are somehow identifiable, however roughly, as a direct quantitaive function of content emphases. In short, the whole relationship between the content and audience characteristics allegedly "reflected" in it is far from clear' (ibid., p98, brackets in original).

These weaknesses of content analysis are accepted. But to some extent they are ameliorated by the fact that this Thesis has undertaken content analysis of two different sets of data and yet still reaches similar conclusions (namely that there are broad areas of dissensus associated with similar features of community care policies); findings which are broadly confirmed by the interviews undertaken in the three case studies. Thus, any broad conclusions reached as a result of the content analysis are largely confirmed elsewhere in the Thesis.

In Section III the content analysis was of another kind of data - files relating to the two project studies, and policy documents relating to the general care of elderly people in the three areas studied. This analysis proceeded on a similar basis to that in Section I, and was intended to test the validity of comments made in interviews and provide a further source of data on the community care activity being explored in the case studies.

The content analysis undertaken in this Thesis is reflected in the detailed and lengthy Appenices which follow this Appendix. No apology is made for the length of these Appendices; they reflect the methodology adopted and support the conclusions reached in the text.

1. Methodology To Section I

a. Historical data on the policy of community care

Section I comprises a review of the history, theory and practice of community care policies, seeking to illustrate, from a variety of community care literature, the nature of community care policies, their historical origins and principal meanings. The historical analysis of community care policy was based primarily on an analysis of official government sources, supplemented by other community care literature. This focus on official documents was deliberate; to show how community care policies have been promulgated amongst community care agencies and professions by successive governments.

Historical literature was searched over the period 1800-1982 (although a few other key community care documents in the period 1983-1990 are referred to in Chapter Four). No analysis of literature prior to the 19th Century was undertaken because of its limited availability. 1982 was chosen as the later cut-off point for analysis because this coincided with the beginning of fieldwork.

Data on the history of community care policies was generated wherever possible from primary sources to ensure a more accurate perception of the content and emphasis of governments' community care policy initiatives. These sources included the Annual Reports of the Local

Government Board (1871-72 to 1918-19); the Annual Reports of the Ministry of Health (1919-20 to 1967); Royal Commissions of Enquiry; Acts of Parliament; Parliamentary Debates; Official and Semi-Official Government Reports. To supplement this literature, a range of other sources were drawn on to obtain both a fuller understanding of official community care policies and other 'community care' initiatives. Thus, in addition to an analysis of Poor Law initiatives in the 19th Century, reference was also made to the early work of social entrepreneurs such as Charles and William Booth. By referring to these initiatives, a more balanced view of community-based (and institutionally-based) care, support or treatment provided in England and Wales over this period was obtained.

More generally, major texts in the field of community care, such as Kathleen Jones' "A History of the Mental Health Service" (1972, London; Routledge and Kegan Paul) and more recently, Alan Walkers' text on community care (Ed, 1982, "Community Care, The Family, the State and Social Policy", Oxford; Basil Blackwell and Martin Robertson) were used as reference books for historical sources. For identifying the main Parliamentary debates, Royal Commissions etc, the published summaries of government publications were consulted, and references were sought under main headings related to elderly people and community care (or, in the case of the 19th Century, the Poor Law). Lastly, in respect of the two lengthy sets of Annual Reports listed, each annual volume was consulted, and analysed by 'key word' index searches. Thus, for example, references to the aged poor, the boarding out movement (notably the reports of the Inspector of boarding out schemes) and documents reporting on services to the aged poor, were noted and analysed. Reference to such a broad range of sources makes the text in Chapters Two and Four rich in notes and references; this, in itself, further illustrates the complexity and diversity of 'community care' policies - in theory and in practice - over the periods studied.

An important assumption made in Section I of this Thesis relates to the method used to trace community care policies. In Chapter One it is argued in relation to this point that although the explicit, officially-defined 'community care' probably has its origin in the Wood Report of 1929, and has only been popularised as such from the 1950's onwards, it is possible to identify features of health and welfare initiatives earlier in history which we would now accept as reflecting some key elements of community care ideology. Thus, in the 19th Century community care policy themes are identified, although 'community care' as a phrase for a government policy movement, had not yet been coined.

b. **Data on the meanings of Community Care**

Chapter Three of the Thesis particularly seeks to show how 'community care' policy, primarily as related to the needs of elderly people, can be interpreted and understood. The literature search drew on historical sources from Chapters Two and Four, supplemented by other professional/academic sources identified through citation indexes and other major reference books. As such, it drew upon a much broader range of literature - not just government literature sources, but also documents of the major political parties; academic and social policy texts and professional articles and texts. This breadth of literature was consulted to ensure that community care meanings identified were, so far as was possible, not reflecting a biased sample of views.

c. **Overview of methods adopted in Section I**

A combination of literature was searched and subject to content analysis to secure an official view of the historical development of community care policies and a general view of the meanings attributed to them. The perceptions and emphases in this range of community care literature are juxtaposed rather than made the subject of any quantitative content analysis.

2. <u>Methodology to Section II</u>

This Section reports the findings of a content analysis of two data sources; selected professional journals and responses to the 1978 discussion document 'A Happier Old Age'. The purpose of this analysis was to examine the perceptions of key community care professions and professionals on the general and specific meanings attached to community care.

a. **Professional Journals**

The perceptions of four professional groups (medical, nursing, social work and housing) on community care were compared through an analysis of professional journals. These journals were searched within three time periods; 1961-63, 1971-74 and 1976-1982. These time periods were chosen to reflect different stages in the development and conceptualisation of community care (see Chapter One). Two journals were chosen to reflect each of the viewpoints of the four professional groups, except in the period 1961-63 where other journals were reviewed to record a 'social work' perspective;

<u>MEDICAL</u>	<u>NURSING</u>
British Medical Journal	Nursing Mirror
The Lancet	Nursing Times

SOCIAL WORK

The Almoner*

Social Work*

Social Service Quarterly*

Social Work Today

Community Care

HOUSING

Housing/Housing Monthly

Housing Review

The four professional groups were chosen because of their positions as key providers of care and support to elderly people. The journals were chosen on the grounds of their considerable popularity amongst their respective professional audiences; both the readership of, and the contributors to, these journals might then be expected to reflect a wide range of views from within each professional group. It is not possible to demonstrate that the readers and contributors were representative of their colleagues, except by arguing that the relative popularity of the journals implies involvement from all elements of each professional group.

All the journals were searched using relevant citation indexes, together with word searches of the journal indexes themselves. Key words such as 'care in the community', 'elderly or old people', 'psychogeriatrics', 'elderly mentally ill', 'collaboration', together with titles of key policy documents such as the 1963 Health and Welfare Plan and the 1981 White Paper 'Growing Older' were used to locate articles, editorials, letters and other journal correspondence of interest. The views expressed in these sources (mostly in articles) were then analysed under three general headings; community care policies in general and as applied to elderly people; the general care of the elderly and collaboration between carers of elderly people. These three headings alone yielded over 1200 articles for analysis (excluding letters and editorials). Chapter Five reports some of the findings from this database under a few illustrative headings such as general perceptions of community care policy, collaboration, professional roles and the rights of elderly people and the care of the elderly mentally infirm. These issues were selected because they recurred in the historical literature and represented some important practical considerations in the planning and provision of local community care.

The comments made at the outside of this Appendix regarding the weaknesses of content analysis clearly relate to this analysis of professional journals. One point of particular importance is the ability to generalise from a summary of views made in journals to the views of an entire profession. It is argued that the representative nature of the readership of, and contributors to, these journals, plus the large numbers of articles analysed was some

guarantee of ensuring a broad range of perspectives were registered on any issue from within each profession. A critic might suggest, however, that the type of people who contributed to these journals could be said to be the most outspoken or forward thinking of their profession and thus not a representative sample of their profession.

b. **Responses to 'A Happier Old Age'**

The document 'A Happier Old Age' was selected for a number of reasons as the basis for a further stage of content analysis;

- it represented a commitment to consensus based decision-making;
- it was a formal consultative document to which the major community care professions would be obliged to make a response;
- many of the issues and questions raised by the document concerned specific issues related to the theory and practice of community care;
- amongst the issues raised were several relating to inter-professional and inter-agency collaboration in particular, but also many of the issues analysed in the journals.

Access to the responses to the document was gained through the Central Records Office of the Department of Health and Social Security. All files recording responses to the discussion document were requested and the majority were accessed. A few files were not found and hence a minority of responses could not be analysed. There was no particular preponderance of public sector groups amongst the files not accessed. Over 1400 responses to the document were received by the Department (including individual letters from members of the public and practitioners). Of this total, the Department listed 156 responses from 'major national bodies'. These bodies included a large number of pension societies, major voluntary bodies and other independent sector organisations (including housing associations). Approximately 130 responses were contained in the lost files of which 11 were amongst the listed responses from major national bodies. All the responses made from public sector organisations and professions which were on file (23 in total) were analysed, and it is the analysis of these responses which is reported given in Chapter Six.

These 23 responses varied in that some addressed all aspects of the discussion document whilst others addressed relatively few. It was also the case that whilst some of these respondents represented very large national professions or organisations, others represented much smaller groups. The important common characteristic of these responses is that they were all the outcome of formal consultation processes, and as such they contained the "official"

views of their respective groups; carefully considered replies reflecting a distillation of the most essential views of each group.

The responses of each of the 23 groups listed in Chapter Six (p99) were analysed in depth across 16 sets of issues and questions relating to community care (pp100). Even though only 23 groups were consulted, this broad categorisation of perceptions yielded a very large volume of data. Thus, as with Chapter Five, the data reported in this Thesis also covers a few specific aspects of community care policy and practice - similar aspects to those reported in Chapter Five, to enable comparisons between the two databases on similar subjects to be made. The 23 respondents themselves were divided into two groups; health service and local authority interest groups. The former group included medical nursing and other health service groups; the latter housing, social work and various welfare/social care groups within the public sector. Ideally, the same professional groupings would have been adopted as with Chapter Five; within the medical, nursing, social work and housing professions. But unfortunately, because the responses from housing and nursing interest groups were small in number and limited in content, this was not felt to be practical.

The responses to "A Happier Old Age" were also chosen to provide a contrasting set of data to that gathered and analysed in the professional journals since they;

- represented formally planned, and "official" responses to the same selected issues and questions raised externally by the government;
- were made at one point in time (the summer of 1978);
- provided a corporate perspective of the professions as a whole, rather than the view of a single professional or group of professionals;
- reflected national, consensus viewpoints.

These features suggest that these responses may be more representative of the views of professional groups than the content of the professional journals. However, alternatively, it may be that the document responses reflect an overly theoretical perspective and so perhaps, fail to provide a good gauge of how professionals might repond in practice to the same issues. The latter argument could also be applied to the content of professional journals.

c. Overview of methods in Section II

One method is used in Section II to examine the perceptions of various community care professions; content analysis. However, although the two databases selected for analysis were the product of very different stimuli, the fact that that there were very few differences in the pattern of perceptions across the two databases (see p113) suggests that both journals

and document responses were reflecting the same balance of professional views and offers some protection against the criticism that either database was generating an extreme view of any particular profession or interest group. Moreover, professional perceptions as revealed by the general thrust of these content analyses were largely confirmed by the evidence from the interviews undertaken in Section III. Overall, this suggests that confidence can be placed in the perceptions of the various groups recorded, and their general applicability to professional theory and practices in the field of community care for elderly people.

3. Methodology to Section III

This section describes in detail the methodology adopted in the three case studies reported in Section III of this Thesis; the reasons for choosing the three case studies and the method chosen in each of the sites.

a. Selection of Case Study Sites

The selection of case study site was based on the criteria that;

- it should provide an insight into the planning, management and/or delivery of community care;
- it should involve a range of community care professionals or agencies;
- the case studies as a whole should concern a mix of community care activity;
- there was freedom of access to key staff and documentation, the location of the site and the time taken to negotiate access to site.

Three case studies were undertaken on this basis; two studies of specific projects, and one general study of day-to-day collaboration between professionals working with elderly people in the community. Negotiations to gain access to the two project sites (Case Studies A & B) began in 1983. Fieldwork commenced in both sites early in 1984; in January for Study B (the After Care Scheme) and March 1984 for Study A (the 'core' scheme). However, interviews in Site A did not begin until March; following a detailed analysis of files on the core project and some piloting of the interview schedule (see below, p203).

The original rationale for undertaking the three area studies reported as Study C was related to the research undertaken on the After Care Scheme, and so began as that research was ending in July 1984. Study C was intended to be a follow-up study of elderly people discharged from A&E into the local community. Unfortunately, this longitudinal study of community care arrangements for discharged elderly people did not prove possible (see p198 below). However, the development of fieldwork in Study C proved extremely useful because it provided data on

inter-professional relationships and the structure of local community care services in the absence of any particular project or plan to improve the management or delivery of community care. A summary of the broad features of the three sites is given in Table 21 below and is also shown by Table 19 (p180);

Table 21: **Summary of Main Features of Case Studies**

	STUDY A	STUDY B	STUDY C
People Interviewed;	72 people	44 people	80 people
Research Period;	March-Sept 1984	Jan-August 1984	July-Dec 1984
Agencies involved;	DHA/SSD/HSG/GP	DHA/SSD/VOL	DHA/SSD/HSG/GP
Triangulation;	Files/Observation	Files/Observation	Files

Study A; *The Core Project*

There were many features of the core project which qualified it for study. Of the three case studies, the core project was the most sophisticated in several respects; the range of services provided and professionals involved; the type of collaborative activity associated with the services; the planning processes which established the initiative.

The core project was a deliberate attempt to move away from a classic dependence on institutional services and separated community-based care to a locally integrated and flexible set of community-based services. Moreover, these services were reorganised on the basis of many of the rationales associated with community care policy and referred to in Chapter Three - the need to reflect the wishes of elderly people; provide a choice of services; a coordinated, jointly allocated, flexible pool of services; a more efficient means of providing community support. The core project practitioners were responsible for the joint delivery of all residential and community-based care in a given locality. This project was therefore concerned with primary health care, domiciliary services, sheltered housing and part III accommodation. Another feature of this project was its recent development; it had been open less than a year before the fieldwork began. Thus, interviewees were able to readily reflect on local service provision both before and after the project began, and recall the planning and origins of the scheme. The core project also had an explicit collaborative philosophy. It had to draw upon domiciliary, social work, occupational therapist and administrative staff; wardens and residential staff, housing and primary health care team members (G.P.s, district nurses, health visitors). This range of practitioners and services provided a good opportunity to explore further the consensus surrounding community care issues reported in Section II.

Study B; *The After Care Scheme.*

There were several reasons for choosing the after care scheme for study. First, the rationale of the after care scheme was consistent with a number of community care policy themes; de-hospitalisation; to provide good quality community care; to improve the efficiency of services (hospital and community based) seeking to keep elderly people at home. These themes were in potential conflict. As the ACO noted, 'The priority of the Department is to treat and discharge as many people as quickly as possible - this is often quite inappropriate to the needs of the elderly'.

Second, the A&E department had the responsibility to arrange and co-ordinate community based services for elderly people. In fact between 9,000 and 10,000 elderly people were attending A&E each year at the time of the fieldwork, of these the majority (61%) returned home following treatment (on average, over 100 people each week)*. The creation of an after-care scheme was a formal recognition that elderly people could, following an acute trauma, be discharged home in greater numbers and more safely as a result of better organised after-care. As a result, the scheme safeguarded against, on the one hand, unnecessary institutionalisation and, on the other, the relapse of elderly people 'at risk' when discharged home within hours of admission.

Third, the ACO co-ordinated after-care services, liaising with a wide range of professionals and highlighting differences in professional perceptions of the needs of elderly people and the 'solutions' to those needs. Militating against establishing adequate and responsive after care support was the very short timescale for reaching decisions. Partly as a result of this timescale problem, the scheme operated in an arena of inter-professional conflict; decisions to discharge had to be made quickly and often with a degree of risk attached to them.

Fourth, the scheme provided a stark contrast to the core scheme in several respects;

- it operated on an informal or semi-formal basis rather than a formal basis. The scheme was not formally planned, or set formal terms of reference. Neither did it operate in the context of an explicit service philosophy;
- the project involved the provision of a very specific service, rather than a range of general services. It had a clear focus and objectives, as well as affecting hundreds of elderly people each year.

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*This figure was derived from a secondary analysis of data collected within the A&E department by one of the Consultants.

Fifth, the scheme had certain features which in the case of the 'core' scheme had proved a stumbling block to inter-professional, inter-agency collaboration;

- the discharge scheme operated at an organisational boundary - the hospital/community interface - and thus at the boundary of some professionals' responsibilities;
- the service provided to elderly people in the A&E department indicated that their needs could come second to the overriding objective - rapid patient throughput. As one A&E Consultants stated, 'the function of A&E is to resolve short-term crises not long-term problems'. Elderly people, particularly those with multiple, long-term needs, were not likely to be sensitively dealt with by the department,
- discharge decisions were made at a time of crisis as presenting a challenge to collaborative mechanisms and community care practice.

Study C: <u>Day-To-Day Collaboration in three localities</u>

As mentioned, this fieldwork study did not begin as a discrete study in its own right but rather as a product of the research undertaken on the After Care Scheme. Lack of access to files made this impractical. Yet, having conducted some introductory interviews in the community, it became apparent that there was virtue in surveying community professionals on a wide range of issues related to local community care provision for elderly people. These initial interviews, in effect, were used to pilot a broader set of interview questions listed below which were then adopted to suit each of the case studies (see p207 below). There were 80 practitioners interviewed across the three localities (see Table 22 below).

These three localities were chosen because of their different demographic features and service networks. Thus, areas 1 and 2 were covered by two different social work teams (one of which was a 'patch' based team) within the same social services' area office; both were within the boundaries of the same housing authority and hospital catchment area. Area 3, however, was in a different housing authority, covered by a separate social services area office and hospital catchment area (the same hospital as hosted the After Care Scheme). Interviews with community health staff centred on staff working from four health clinics within these three localities. Social workers, domiciliary staff and wardens were interviewed on the basis that they worked within, or were attached to, one of three social work teams - one covering each of the three geographical areas chosen and operating in the same catchment area as the health centre staff interviewed.

In addition, the three localities had other distinguishing features. Area 1 basically covered two separate communities with quite distinct identities. Half of the area was situated near

to a city centre, with a high density of semi-detached Victorian housing, of which a large proportion was sub-standard and privately rented. The area had a growing Asian community. The other part of area 1 was more suburban, and comprised a high density of large detached middle class relatively modern (1930's onwards) owner-occupied housing. Being on the outskirts of town, and only ten minutes from the motorway, it was much in demand by professional workers. Area 2 was also a city centre site. Like part of area 1, it too had a large proportion of large Victorian property which was slowly being redeveloped. It too had an increasing ethnic population. Neither areas 1 or 2 had access to key local welfare facilities such as residential accommodation, day centres and, in comparison to area 3, had very limited access to sheltered housing. Area 3, by comparison, had a much greater proportion of sheltered housing and other welfare facilities. This was also an entirely suburban area, suffering from little of the deprivation associated with areas 1 and 2.

Table 22: Case Study C: Interviewees by type of practitioner and area.

PRACTITIONER	AREA 1	AREA 2	AREAS 1&2	AREA 3	TOTAL
Domiciliary Staff (SSD)	3	1	1	2	7
G.Ps	-	-	3	3	6
Social Workers*	4	5	0	5	14
Wardens	-	-	6	15	21
Housing Managers	-	-	1	2	3
District Nurses	5	10	4	5	24
Hospital Consultant	-	-	2	-	2
Hosp Social Worker	-	-	1	-	1
Hospital Health Visitors for Elderly	-	-	2	-	2
TOTAL	12	16	20	32	80

* i.e social workers of all grades including social work assistants, generic and specialist social workers and social work managers.

Overview: selection of case study sites

The three studies chosen fitted the overall criteria identified at the outset of this section both individually and as a whole. Tables 19 and 20 summarise the difference between the three studies; they confirm that, taken together, the range of community care activities covered was was considerable. The text refers to Case Study C as a "control" study. This term is used in

the sense that this study provides a perspective of inter-professional relationships and consensus in the absence of any particular initiative to improve those relationships or focus those perceptions. This provided some security against the argument that the two project studies were atypical or unrepresentative of normal inter-professional and inter-agency activity in the field of community care for elderly people.

b. **Methodology: Structure of Work adopted in Fieldwork Sites**

This section is considered under several headings:

i) Examination of files
ii) Interview Structure and Content
iii) Interviewees
iv) Non-participant observation
v) Other data.

i) Examination of Files

Before interviews were conducted in the fieldwork sites, time was spent examining files relevant to the area of activity being studied in the fieldwork sites. In Case Study C, where there was no specific service focus, general policy documents relating to local community care services and material such as standard job descriptions for wardens and home helps were studied. The files were used to provide background knowledge of local services, to influence the structure and content of interviews and to enable interviewees comments to be verified, or otherwise. The most comprehensive analysis of files took place in the case study of the 'core' scheme. The basic documentary sources examined for this study were:

- files held by the social service department on both the core scheme and services for elderly people from 1977 to 1984;
- files held by the local housing authority on the core project 1977-1984;
- minutes and papers of Joint Management Group meetings 1982-1984;
- minutes and papers of the Core Team meetings 1983-1984;
- case notes of selected clients transferred to/using core services.

The files examined in Case Study A were more comprehensive because of the formality and sophistication of the project and its planning processes. Nevertheless, for Case Study B access was gained to the files on the after-care scheme held by Age Concern and the Hospital and Support Committee Minutes. Although, as noted, it did not prove possible to examine individual patient records because of conditions imposed by the medical ethics committee.

ii) **Interviews**

Interview Schedules

All interviews undertaken in the fieldwork sites were semi-structured. Under headings relating to different aspects or stages of the local service being studied, various questions were asked. The questions were open-ended, and opportunity was taken during interviews to probe the responses to these questions either to clarify or explore further any issues raised. The questions were designed not to test an interviewees knowledge of community care policy or good professional practice in the field of collaboration, but rather to build up as comprehensive a picture of the particular services being studied, how that service fitted in which local community care provision and the philosophy of local care, as well as the effects the service had on inter-professional and inter-agency collaboration. The interviews were therefore used as a means to explore the nature of local community care policy and practice.

The main structure of the interview schedules used was divided into a number of general headings, and sub-headings which are listed below;

1. *The origins and planning of the scheme/service and the structure of local care*
   - when the scheme began, who was involved? (by agencies/professionals & seniority)
   - what considerations stimulated the scheme? (financial, moral, political, need etc)
   - what were the costs/benefits/changes envisaged in beginning the scheme (as above)?
   - did different agencies' involvement reflect these perceived cost/benefits? If not, in what sense was the scheme supported, and how?
   - how did the scheme represent a move towards 'community care'? Did this in itself generate support for the scheme? If so from whom?
   - how did the scheme differ from the pre-existing local pattern of care?
   - in what detail was the project planned and by whom?
   - were project goals defined? or a scheme philosophy? or operational staffing plans etc? were there different options of these? Who defined them and why?
   - where any aspects of philosophy/operational policy difficult/easy to agree?

2. *Scheme/service implementation and delivery, and collaboration*
   - were the same actors involved as in the planning stage? Did this make any difference?
   - did priorities/constraints/support of any professionals/agencies influence the scheme?
   - was it important to agree on the operational aspects of the local service? Why?
   - what were the main strengths/weaknesses of the way in which services were managed?
   - what mechanisms were etsablished to encourage/enable collaboration to take place; how did they differ from the past?; how did they help/hinder joint working and why?

3, *Interviewees' role and perceptions*

- what role did you play in the project?
- what impact did the scheme have on your job content/approach to community care?
- did the scheme impact on your relationships with other practitioners? If so, why?
- do you view the project as successful/unsuccessful? If so why?
- were/are you committed to the project philosophy/objectives? If so, has your attitude changed? Why/why not?

The precise structure of interviews undertaken in the two project studies varied. By and large, interview structure was tailored to the interviewees, to avoid wasting interviewees' time and to focus on those areas where each interviewee was most knowledgeable. For example, if someone was only marginally involved in the planning of the scheme then the questions under section two above were covered by a general question; Can you recall any of the background to this scheme? A positive response was then explored in more detail. If an interviewee was involved at every stage of the scheme from its inception to its operational management then the interview clearly took longer to conduct. Thus, the time taken to complete interviews varied enormously; from ½ an hour to nearly four hours in the case of one 'core' scheme interview. One notable feature of all interviews undertaken in Case Study A was that, as a condition of access to the site, there was an obligation to return interview transcripts to all interviewees for comment. This proved to be valuable in a number of respects; providing a mechanism to check information and clarify comments, as well as to follow up any outstanding issues. Only one interviewee (a G.P.) questioned the substantive content of an interview, and after discussion, the issues in question were resolved; all other interviews were returned approved subject to only minor amendments.

The interview structure in Case Study C was much more general. Questions came under five broad headings;

A. Community care service provision for local elderly people, and the interviewees perception of those services in terms of their allocation, availability, present and future roles.

B. Interviewees objectives/priorities in keeping elderly people at home, their justification of those objectives/priorities. Their perceptions of other colleagues' objectives, priorities in this field, and perceptions of their appropriateness.

C. The importance of joint planning, co-operation, collaboration. The effectiveness of collaborative mechanisms. Barriers/incentives to collaboration which exist and the reasons for them.

D. Interviewees perceptions of the key issues on which practitioners agreed or disagreed in

respect of community care for elderly people,

E. Interviewees perceptions of the meaning and implications of community care policy. Views as to when community care was no longer a viable option; who should determine the kind of care provided and on what basis.

Piloting and non-response rate

The general structure of the interviews - which covered broadly the same issues in each case study was piloted, as referred to above, at the outset o' the fieldwork, on a number of local practitioners providing care and support to elderly people living in the close proximity of the hospital where the after care scheme was based. Three G.Ps, two social workers, two domiciliary service officers, four district nurses and two wardens were interviewed at this early stage. As a result of these interviews, some modifications were made to the wording of the schedule, but its structure remained basically unaltered.

The non-response rate from individuals contacted during the course of the fieldwork was very low. Only in Case Study C was there a refusal to be interviewed; by a Senior Social Worker; although it also proved difficult to obtain a broad range of G.Ps for interview. The refusal of the Senior Social Worker to be interviewed was related to a negative experience of some previous research with which she was involved (see p214). The limited access to G.Ps was related to the difficulty in contacting G.Ps (many receptionists refused interviews on behalf on G.Ps without asking them) and the lack of interest shown by them in the research. In the local study five G.Ps across the three areas refused interviews on this basis. It may be argued, particularly given a lack of interest in the research by some G.Ps who refused, that the sample of G.Ps interviewed may have been biased. This situation was avoided where possible by trying to speak to as many G.Ps working in the health centres chosen for study as possible. This small non-response rate contrasts with the overwhelming co-operation received in conducting the research with all 196 interviewees.

Example of Interview Schedules

The interview schedule used in the case of the core scheme is set out below;

Section 1. I would like to begin by asking some questions about the origins and planning of this scheme, and your involvement, if any, in the scheme's inception;

Q; Can you recall when it was that you first became involved in this project and why?

Q; Can you explain why the project began, and what the concerns were which surrounded the project; what need did the scheme address? In what ways, if any, was it envisaged that the project would affect the quality, quantity or structure of local services?

Q: What was your initial impression of the project: its significance and priority to you/your colleagues; the appropriateness of its philosophy and goals.

Q: To what extent were the project's goals/philosophy explicit and detailed? Was this philosophy broadly acceptable or not?

Q: Who was opposed or committed to the project in these initial stages and why?

Q: In what sense, if at all, did this initiative represent a commitment from your agency, or individuals within it, to developing local community care services for elderly people? Was this commitment explicit or implicit, formal or informal? Please explain.

Q: Did the project aim to challenge/change existing structures, models of care, procedures, professional power, status or convenience of working? Was this perceived as a problem, if so why? Please illustrate.

Section 2. Can you explain your perception of some operational aspects of this project:

Q: Were any constraints (practical, professional or organisational) imposed on the project - how it should operate, what issues it should address, what policies it could change/challenge.

Q: On what issues, if any, was the project strongly supported/challenged, why and by whom? Please give examples.

Q: For whom/which needs was the project catering? Was this realistic? Please explain. Were there any alternative means of addressing the same need? What benefits/drawbacks did those alternatives have in comparison to 'core'?

Q: How has this project been managed jointly? Has this been satisfactory? Please explain.

Q: Have the project philosophy and goals been fully accepted and implemented? Has this varied by group/agency, or varied through time? Please illustrate.

Q: Has commitment to the project been consistent across agencies/professions? If so, why?

Section 3. These next questions particularly explore how inter-professional collaboration has been affected, if at all, by the project:

Q: Can you recall how far practitioners now involved in 'core' collaborated before the project began? What were the main stimuli/barriers to collaboration prior to establishing the core project? Have those stimuli/barriers disappeared or changed? Why?

Q: What were the previous means of liaising in respect of the needs of elderly people, and on which issues was contact between yourself and other groups maintained? How, if at all, have these mechanisms changed?

Q: What were the sources of referrals to your service in the stage before the core project? Have the pattern of referrals changed? Please explain.

Q: To what extent was there multi-disciplinary assessment of need in the pre-core days? How have these procedures changed, if at all? Why?

Q: How, if at all, has the project improved your understanding of other practitioners roles/responsibilities? Please explain.

Section 4, Lastly, can I now come on to examine your particular role in respect of the project and how that might have changed:

Q: In your work with elderly people, what impact has the scheme had on your role/ responsibilities, or the way in which you do your job?

Q: How, if at all, has the project worsened/improved the service to elderly people? Why?

Q: How, if at all, has the project worsened/improved collaboration? Or the efficiency/ effectiveness of local services? Please illustrate.

Q: Would you view the scheme as generally successful or unsuccessful? If so, why?

Q: How, if at all, would you change the scheme, its planning or implementation, either in the way it has been developed or the services which it provides? Why?

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The same interview structure of questions was used in interviews concerning the after care scheme, except that there were a few additional questions relation to perceptions of the role of the ACO, and referral, procedures to the ACO and various community-based agencies.

The Three Locality Studies

The interview schedule for the local area studies was quite different, as explained above:

Section 1, I would like to ask a series of general questions about the service you/your colleagues provide locally for elderly people:

Q: Do you regard the service provided by your department/profession in this area as adequate - in terms of the range, level and availability of services offered?

Q: Are there any obvious gaps in provision which you should, but cannot meet - either because of the extent of service you offer (evenings, weekends, holiday periods); in terms of the targetting of your service to particular groups (terminally ill, elderly mentally ill etc), or the process by which you allocate and monitor services?

Q: Do any groups of elderly people particularly fall between stools? Please explain.

Q: To what extent, if at all, are you having to ration your services? On what basis do you do this? What effect is this having?

Q: What are the main objectives of your department/authority in keeping elderly people at home? What are your priorities, and how do these relate to the needs of the elderly?

Q: Given extra resources would you/your colleagues be willing and able to improve the service you provide to elderly people? Are there any other factors, other than resources, which hinder the development of services to elderly people?

Q: Are there any services which you provide for elderly people which you regard as outside, or marginal to, your responsibilities? Please explain?

Q: Are there any particular incentives/barriers to you/your colleagues working with elderly people? Please illustrate.

Q: What factors most critically impinge on the service you provide for elderly people?

Section 2: I would now like to ask questions about your perceptions/experience of other services provided locally for elderly people:

Q: Have you any comments about the availability, adequacy and appropriateness of the following services or professional input, in terms of keeping elderly people at home for as long as possible? (SHOW CARD):

- social work support
- social service domiciliary support
- community based occupational therapy
- sheltered housing and warden services
- day centres/day hospitals
- part III accommodation
- short stay/respite care
- terminal care, night sitting,
- General Practitioner support
- District nurse support
- health visitor support
- access to diagnosis/treatment in hospital
- specialist support for the mentally infirm (community psychiatric nursing, domiciliary assessment visits etc)
- out-of-hours services
- other (please specify)

Q: What do you regard as the areas in which services should be most urgently improved? Why?

Q: Do you regard the approach taken by other agencies/professional in working with elderly people as appropriate? Are their objectives congruent/complementary with yours? Are their allocation procedures/referral practices such as to encourage joint working?

Q: To what extent (in what areas, on what issues) would you say collaboration with other professions proceeds smoothly? Why is that? Are there any issues on which there is very

limited/non-existent collaboration? Why?

Q: How often do you meet face-to-face with other community care practitioners? Do you regard this level of contact as adequate? Do you think there are other ways in which links with other professionals/agencies could be improved? If links are under-developed, why is this?

Section 3, I would like to ask some general questions now about 'community care' policy, and what that means to you and elderly people:

Q: Can you tell me what you understand by community care?

Q: Is community care always the ideal solution for meeting needs of elderly people?

Q: What do you see as the advantages/disadvantages of keeping old people in their own homes/returning them to their own homes for as long as possible?

Q: Is there agreement within your profession/agency as to the level and mix of services to be provided for elderly people living in the community? Is there such agreement between your profession/agency and other professions? Why is this? Is this just true for the locality in which you work?

Q: Do you think community care is a viable policy for elderly people? Why/why not? Can the situation be changed? If so by what?

x-x-x

To some extent the questions asked in all the case studies were specifically not designed to be mutually exclusive; the same issue being explored through different questions. In general, interviews conducted with staff in the three locality studies were shorter than those in the project studies; only one person was interviewed for more than 1½ hours in the locality studies (out of 80 interviewees). In the project studies 41 people out of 116 were interviewed for more than 1½ hours.

The method for recording interviews was by taking verbatim notes. These were typed up, and comments on similar issues were then compared across groups. As noted, the interviews conducted with staff involved with the core project were approved by the relevant interviewees. The data yielded as a result of the interviews undertaken was considerable. As indicated in Section III of this Thesis, that data has been reported selectively, by focussing on a small range of issues in each case study.

iii) Selection of Interviewees

In the two project studies, the criteria on which people were selected for interview were very broad; to interview anyone who was involved in the origin, planning, development,

management or running of the service concerned. This was to try to ensure that perceptions on similar issues from the widest range of practitioners could be compared through time, as well as by agency/profession. For Case Study 3, where for example, interviews were centred on a health centre or clinic, or the work of a social work team/area office, all staff were contacted and asked if they could be interviewed. There was therefore no attempt to sample interviewees having identified a site or a locality for study; the selection criteria was comptence to speak about the particular issues being explored. This was an ambitious approach and proved unworkable in Case Studies B and C where some selection of interviewees had to take place (see below). The interviewees contacted in each study are listed by their title;

Case Study A; The 'Core' Scheme (72 people interviewed)

a) *Social Service Department Personnel* (52)

i) *Residential and Day Care Division* (14)

1 Principal Assistant Director
1 Principal Assistant
1 Residential Homes Supervisor (JMG member)
1 Warden (CT member)
2 Assistant Wardens (CT members)
1 Driver/Care Assistant
5 Care Assistants
2 Catering Staff

ii) *Community Services Division* (22)

1 Principal Assistant Director
1 Principal Assistant
1 Area Social Service Officer (JMG member)
2 Senior Social Workers
1 Patch Co-ordinator (CT member)
3 Social Workers (all CT members)
1 Principal Domiciliary Services Organiser
1 Advisor, Sensory Handicaps
1 Occupational Therapist
1 Domiciliary Services Organiser (CT member)
2 Home Help Organisers
1 Senior Home Help Organiser
6 Home Care Aides

iii) *General Management/Administrative/Planning staff* (16)

1 Director of Social Services

3 Deputy Directors (2 past, 1 present)

1 Assistant Director, Service Development

1 Principal Assistant, Capital Programming (retired)

1 Consultant, Elderly & Physically Handicapped (former staff)

1 Chief Projects Officer

1 Area Administrative Officer

1 Regional Social Work Service Officer

2 Principal Development Officers, Elderly (past and present)

1 Principal Planning and Development Officer

1 Senior Clerk (Secretary to JMG)

2 Clerks (CT members)

b) *Housing Officers*, (5)

1 Director of Housing

2 Assistant Directors of Housing (including 1 JMG member)

1 Chief Housing Assistant (CT member)

1 Warden Services Co-ordinator (CT member)

c) *Medical Staff* (8)

1 Consultant Geriatrician (local catchment hospital)

1 District Community Physician

6 General Practitioners (in 3 local practices)

d) *Nursing and Allied Staff* (7)

1 Nursing Officer (JMG member)

5 District Nurses (including 1 CT member)

1 Health Visitor

The large number of social service department staff interviewed reflected what proved to be their dominant role in the planning and day-to-day running of the project, All the local G.Ps were interviewed, and many of the district nurses attached to their surgeries (a separate meeting was held with district nurses in the area to discuss the project at their request), No-one contacted to be interviewed refused to participate in the study; one G.P refused to

accept the substance of his transcribed interview, but after assurances regarding confidentiality were given, he withdrew his objections.

***Case Study B; The After Care Scheme* (44 people interviewed)**

a) *Hospital Social Work Staff* (7)

1 Group Principal Social Worker (Support Committee member)

1 Deputy Group Principal Social Worker (Support Committee member)

1 Senior Social Worker

1 Social Worker attached to Fracture Clinic

2 Social Workers attached to A&E (past and present; Support Committee members)

1 Social Worker (attached to Geriatric Wards)

b) *Emergency Duty Team* (3)

1 Assistant Director of Social Services (EDT Manager)

2 Senior Social Worker (one formerly worked in A&E)

c) *Medical Staff* (7)

3 Consultants (one past, two present, all on Support Commitee)

1 Senior Registrar

3 Senior House Officers attached to A&E

d) *Nursing Staff* (18)

1 Director of Nursing (Support Committee Member)

2 Divisional Nurse Managers (responsible for A&E)

2 Senior Nursing Officers (attached to A&E; Support Committee members)

1 Sister-in-Charge of A&E (Support Committee member)

3 Sisters (permanent days)

3 Sisters (permanent nights)

2 Sister (Fracture Clinic)

4 Staff Nurses

e) *Age Concern Personnel* (5)

1 Chairwoman of Age Concern (Support Committee Member)

1 Age Concern England Field Officer (Support Committee Member)

1 Executive Committee Member (also on Support Committee)

2 After Care Officers

f) *Other* (4)

1 Divisional Ambulance Officer

1 Physiotherapist (Fracture Clinic)

2 Hospital Home Care Aides

There were large numbers of medical and nursing staff, in particular, working in the A&E department. Thus, junior staff (staff nurses, junior doctors) were selectively interviewed; at least three of each were interviewed in each case. The individuals were chosen simply on the basis of their availability at the time of the research. The majority of these staff worked or had worked in the A&E department (or Fracture Clinic); others were responsible for the running of the A&E department, or the after care scheme itself through the Support Committee. Introductions to these staff were made through various members of the Support Committee. The social workers interviewed included those who covered for the A&E social worker when sick/on leave; those who managed this social worker; and those on the Support Commitee. EDT social workers were interviewed because of their role in providing emergency support to elderly people discharged home outside office hours. A representative of the ambulance service was interviewed on a similar basis; as were three A&E night sisters.

Case Study C; Professional Relationships in Three Localities **(90 people interviewed).**

Area 1 only (12) ;

a) *Social Services staff* (7)

3 Social Work Assistants

1 Social Worker for the Elderly

3 Domiciliary Service Assistants

b) *Primary Health Care Staff* (5)

5 District Nurses

Area 2 only (16)

a) *Social Services staff* (6)

1 Senior Social Worker

2 Social Workers

1 Social Worker for the Elderly

1 Social Work Assistant

1 Domiciliary Services Assistant

b) *Primary Health Care Staff* (10)

1 Assistant Divisional Manager

9 District Nurses

Areas 1&2 (20)

a) *Social Services Staff* (1)

1 Domiciliary Services Manager

b) *Primary Health Care staff* (7)

3 General Practitioners

1 Director of Nursing

3 District Nurses

c) *Housing Staff* (7)

1 Manager, Warden Aided Accommodation

6 Wardens

d) *Hospital Based Staff* (5)

1 Consultant Psychogeriatrician

1 Consultant Geriatrician

1 Hospital Social Worker

2 Health Visitors for the Elderly

Area 3 (32)

a) *Social Services Staff* (7)

2 Senior Social Workers

1 Social Worker for the Elderly.

2 Social Work Assistants

1 Domiciliary Services Manager

1 Domiciliary Services Assistant

b) *Primary Health Care Staff* (8)

3 General Practitioners

5 District Nurses

c) *Housing Staff* (17)

2 Housing Managers

15 Wardens

The basis for selecting staff in these three localities was more difficult, Having negotiated access to the staff informally, the only way to arrange interviews was by prior arrangement with senior managers, or by telephone invitation, There were weaknesses in this approach, First, I found G,Ps not only very difficult to speak to on the phone, but also reluctant to participate in the study (see above), As a result, although I contacted all G,Ps practices (five) who worked in the 4 health centres, at least one G,P in each of three of those practices (five in total) refused me access, The reluctance of one partner to participate in the study sometimes blocking access to the other partners, Hence there are fewer G,Ps in the sample than intended, The ground for refusing access was generally given as lack of time or interest in the research, even though the time commitment sought from them was ½-1 hour, Only one other professionals refused an interview; 1 Senior Social Worker in area 3, on the basis that she had been the subject of a critical research report on their work with elderly people a few months previously, I was referred to this research as a source of data, Unfortunately, it was undertaken as a cross-cultural study by a researcher of French origin, who went to live in Australia, and was not contactable, The social services department would not give me access to the report itself because of its sensitive nature,

The rationale for interviewing the small number of hospital staff covering areas 1 and 2 was that the poor access to this hospital facility for elderly people was mentioned in several interviews, It was argued that elderly people were kept in their own homes with inadequate support for too long because admission to hospital could not be arranged, The reverse was also argued; that elderly people were discharged home too rapidly and thus inapropriately,

A notable feature of Case Study C was the large number of wardens interviewed, This reflected the large number of sheltered housing flats in the area, In fact, prior to commencing interviews, the relevant authorities were asked for a list of all sheltered housing sites in the areas chosen for study, One, and sometimes two wardens were interviewed in each site, as well as the relevant housing managers responsible for warden services in those areas,

iv) <u>Non-Participant Observation</u>

As a means of both acquainting myself with the routine working of each of the two projects, and to verify interview and documentary data, some periods of non-participant observation

were undertaken as part of Case Studies 1 and 2. Observation undertaken in Case Study 1 was the most comprehensive; from the beginning of the research through to its completion, a habit was made of sitting within the development (the day centre, general office, and core team office) at various times of the day during office hours. Then on two seperate occasions, I stayed overnight in the development to observe activities undertaken in the evenings and at weekends. In addition to this, I followed some of the core staff (an Occupational Therapist, social worker, and domiciliary manager) around during follow-up work on clients.

This work was not important just because of the the quantity of data it yielded, but also because it served to confirm or otherwise the differences in work style and approach adopted by individual staff working in the core project. It also highlighted some differences in perceptions between groups, as staff frequently felt it necessary to justify their actions when being observed. These comments were recorded.

In respect of the after care scheme, two forms of observation were used; first, sitting in the A&E department to observe how elderly patients were 'processed' by staff (this was undertaken at various times of the day and night and at weekends); second, following the after care officer during her rounds of elderly patients in the department. Such observation was routinely undertaken during most of the 45-50 visits paid to the hospital during the research. Thus observation enabled a comparison to be made between actual assessment procedures and referral practices, and those described on interview, and also helped to gauge how these practices varied according to the workload of the department, and the particular staff on duty. Lastly, observation helped to indicate the range of duties undertaken by staff working with elderly patients in the department, and how the roles of staff varied.

v) Other Data

Most of the data collected in all three studies was qualitative in nature. However, it was possible to cross-check some of that data with more quantitative material. For example, in the 'core' project, information was recorded on individual clients received core services. This information, for example, recorded the extent to which assessment was multi-disciplinary and the basis on which decisions were made. It was also agreed that as part of the general evaluation of the core scheme, that other (social services) officers would collect data on the use of various services offered by the project, supplemented by interviews with the clients in receipt of those services. This data was also useful in indicating how core services were being allocated - whether according to the stated philosophy or not.

Although access to patient files was not possible in the after care scheme, There had been, as already mentioned, a number of studies of elderly patients attending A&E over a number of years, This data was examined to indicate the pattern of attendance by elderly patients. Of particular note, was the fact that one of the A&E consultants had for some time conducted research on all elderly people admitted to the department indicating age/sex of patient, home address, prognosis, discharge outcome. Again, this information revealed the range of needs being met by the department, and how they were handled in terms of discharge. Some needs - such as those resulting from hip fractures were followed up in a study of an orthopaedic ward are not reported here. In terms of the third case study, use would have been made of the research undertaken in area 3 by another researcher. However, as mentioned, this proved to be inaccessible.

c. Conclusion: overview of case study methodology

The research methodology in the case studies proceeded on the basis of providing as much information as to the roles, relationships and responsibilities of different professionals seeking in some way to provide community care services for elderly people. Interviews were not therefore focussed on those roles, relationships and responsibilities, but rather on broad areas of activity - either project based activity as in Case Studies A & B or areas of routine activity as in Case Study C. The combination of research methods in the fieldwork provided a rich and varied source of data on each service/locaility studied. The data sources also provided a means to cross-check the validity of data from one particular source.

Thesis Methodology: Confidence in the data

This Appendix has described in some detail the range of methods used to explore the three different aspects of community care policy and practice set out at the start of this Thesis (p1). In each Section of the Thesis different methods were used (see Table 20) to generate or analyse data. In the first two sections content analysis was the only method used; but in each of these Sections more than one source of data was analysed to avoid reliance on potentially biased documentary sources. In Section III, a range of data was generated by different research methods to explore further the complex relationship between inter-professional consensus, inter-professional collaboration and community care for elderly people. The overall weaknesses of the data sources analysed and methods used in this Thesis are mentioned in this Appendix (such as the selectiveness of the document analysis in Section I, and the representativeness of the summarised perceptions in Section II). However, the consistency of findings from all these data sources suggest that any bias in these methods and data sources are not significant.

Appendix 2: Notes and References to Chapter Two

1. Personal Social Services Council/Central Health Services Council (1978), "Collaboration in Community Care - a Discussion Document", London; HMSO, see p6.
2. Westmoreland J.E (1965), "Community Care for the mentally disordered" Chapter 45, pp386-395, in Farndale W A J, Ed, "Trends in Social Welfare", Oxford; Pergamon Press, see p386. For a similar argument, see also Hawks,D (1975) "Community Care; An Analysis of Assumptions", in *British Journal of Psychiatry*, Vol 127, September 1975, pp276-285 (see p276).
3. Notably, 9 Geo, I c7 (passed in 1772).
4. 22 Geo, III c83.
5. Exceptions to this being, for example, non-able bodied paupers requiring medical attention, and child apprentices.
6. Quoted in Dunkley,P (1982), "The Crisis of the Old Poor Law in England, 1795-1834: an interpretative essay", New York; Garland Publishing, p146.
7. See Rose M,E, Ed, (1971), "The English Poor Law 1780-1930", Newton Abbot; David Charles, see pp222-233.
8. ibid,, pp224-225.
9. Booth C (1902), "Life and Labour of the people in London. Final Volume: Notes on Social Influences and Conclusions", London; Macmillan, see pp207-209.
10. Thus, Booth advocated more State action in the fields of public health, housing and factory conditions, whilst castigating the wealthy for their apathy regarding the plight of the poor, ibid,, pp209-210.
11. Booth W (1890), "In Darkest England and the Way Out", London; Salvation Army, see pp72-73.
12. Thomson D (1983), "Workhouse to Nursing Home; Residential Care of Elderly People in England since 1840", in *Ageing and Society*, Vol 3, Part 1, pp43-69, see p46.
13. See, for example, Drage G (1914), "The State and the Poor", London; Collins, pp84-89. Drage refers to changes in the balance of provision, both through time, and by locality. In terms of time, after 1870 the workhouse test was applied, generally speaking, more rigorously, and up to about 1890 disqualified many old people from relief. Thereafter, this 'less elligibility' rule was relaxed (see p84). In terms of local variations in services, more old people were relieved in workhouses in London than in the provinces, where rural elderly were more likely to receive a variety of outdoor relief, some in 'cottage homes' (see p87,89). The argument that the old and infirm should be exempt from the most harsh features of the workhouse was put in "Report of the Royal Commission on the Poor Laws and the Relief of Distress", (1909),

Cd 4499, Vol 1, London; HMSO which stated that 'the attempt has generally been made,,,to render their life in the workhouse preferably to that of the able-bodied' (para 308, p215); see also para 326, p219 and Chapter 7 on 'The Aged' (pp214-232). Bryant comments on the thinking of the time; 'To men and women nursed in a kindlier tradition, it seemed an outrage that old folk who had laboured all their lives and become destitute through no fault of their own should be torn from each-other's company, and herded into sexes into prison-like institutions' (Bryant A (1967), "Protestant Island", London; Collins, quoted in Gibson,R (1981) "Little Grains of Sand", in *'British Medical Journal'*, Vol 283, 19th-26th December, p1647).

14. See "Report of the Royal Commission on the Aged Poor", (1895), C 7684, Vol 1, London; HMSO. On page lxxxiv of this Report, the Commission suggested that aged inmates had access to 'light and interesting occupation', literature supplies, amusements, some small luxuries, greater variety and better quality of food, leaves of absence, freedom to visit friends, separation form 'unfit' inmates, opportunity for privacy, and the right for married couples to live together rather than be separated. See also Local Government Board (1896), "Twenty-Fifth Annual Report of the Local Government Board 1895-96", C 8212, London; HMSO, (Circular 54 of the Local Government Board), pp156-161.

15. Local Government Board (1901), "Thirtieth Annual Report of the Local Government Board 1900-1901", Cd 746, London; HMSO, Circular No 11, pp17-20 (see pp18-19). See also Drage G (1914), op,cit,, (reference 13), p86.

16. For example, the Royal Commission on the Poor Laws, (1909), op,cit,, (reference 13) referred to compulsorily admitted old people to institutions on a 'small number of cases where old people were 'too infirm to look after themselves' (para 338, p225). For a brief history of the slow change in workhouse provision for the aged, see Gibson R in British Medical Journal (1981), op,cit,, (reference 13), pp1647-1650.

17. Quoted in Longmate N (1974), "The Workhouse", London; Temple Smith p137, brackets mine. On the other hand, similar reasons were given for promoting 'small houses' to accommodate the elderly. See reference 35 below.

18. See Heywood J,S (1978), "Children in Care", London; Routledge and Kegan Paul, Third Edition (First Edition 1959), Chapter 2; Pinchbeck,I and Hewitt,M (1973), "Children in English Society", Volume 2, London; Routledge and Kegan Paul, Chapters XII to XIV inclusive.

19. Rousseau J,J (1948), "Emile", 1st published 1911, London; J,M Dent and Sons, see p6.

20. See Kessen W (1965), "The Child", New York; John Wiley, see p80.

21. Longmate referred to 'the decision made in 1834 that children should normally be taught within the workhouse walls' - Longmate N (1974), op,cit,, (reference 17), see p167.

22. See Longmate N (1974), op,cit,, (reference 17) Chapter 14, "Outcast Infants", pp165-181. For example, a Poor Law Guardians wife, Mrs Archer, published a pamphlet in 1861 on the plight of pauper orphaned girls. In it she stated that 'under the workhouse system of bringing them up, their minds are contracted and their affections shifted to such a degree that they are unfitted for being placed out in those situations of life where they would most likely to make a favourable impression,,,To remedy this evil, I would propose that we should use our influence with Guardians to get all such children placed with trustworthy cottagers under whose care they may have the same advantages as other children and the opportunity of gaining a proper knowledge of life' (Archer H (1861), "A Scheme for Befriending Orphan Pauper Girls").

23. For a brief summary of scattered homes, cottage homes and boarding out see the Royal Commission on the Poor Laws (1909) op,cit,, (reference 13), paras 373-394. In terms of the economy of these non-workhouse care options, the Royal Commission on the Poor Law (1909, op,cit,, (reference 13), p238) stated that boarding out compared favourably with the workhouse because 'the expense is relatively small and involves no capital outlay'. For a general exposition of the virtues of non-workhouse education see the Local Government Board (1874) "The Report on the Education of Girls in Pauper Schools" by Mrs Nassau (Local Government Circular No 22) in Local Government Board (1874) "Third Annual Report of the Local Government Board 1873-74" C 1071, London; HMSO, pp311-394. This Report was based on the education of orphan children in pauper schools, and was 'unfavourably impressed with the effect of,,,massing children together in large numbers" for education purposes. The Report claimed that such conditions led to the moral condition of such children being 'disappointing' and in terms of physical health, Mrs Nassau noted that 'I did not see a single case of ringworm or opthalmia, and the children, almost without exception, looked strong and thriving and happy' (see p341).
The ideology for providing a range of non-workhouse education, from boarding out to 'scattered' and 'cottage' homes, is given in Pinchbeck,I and Hewitt,M (1973), op,cit,, (reference 18) Chapter XVII. They comment that the Nassau Report 'sounded the death knell of the large, institutional tradition' (in terms of the education of children) - see Vol 2, p517. The Royal Commission on the Poor Law (op,cit,, (reference 13), para 273, p237) commented that 'Schools of various types, but all separate from the workhouse have increased in number'. For more information, see; Rose E,M (1971), op,cit,, (reference 7), pp178-191, 256-258; Heywood J,S (1978), op,cit,, (reference 18) Chapter 5; Gorst J,E Sir (1906), "The Children of the Nation: how their health and vigour should be promoted by the state", London; Methuen, Chapter XIV; Percival T (1911), "Poor Law Children", London; Shaw and Sons, Chapters II to V inclusive and

Chapter XIV; Drage G (1914), op,cit,, (reference 13), pp169-181,

24. Boarding out was officially encouraged, for the first time, in a Poor Law Order on 25th November, 1870; by the 1890's there were sufficient schemes operating to warrant the appointment of an Inspector of Boarding Out Schemes, That Inspector, Miss Mason, referred frequently to the supposed advantages of family life and its importance in the socialisation of children, and its general therapeutic advantages, For example, Miss Mason wrote that 'When boarded-out, children learn the common things of everyday life; they mix with the general population, and grow up in the habits of the class to which they belong, They learn to take care of themselves, become acquainted with the value of money, the need of economy with regard to food, clothing etc,, and with the arrangements of a cottage, and so forth; and above all they form friendships, or at least make acquaintances, with people upon whom they can more or less fall back in later life, and especially in the intervals between situations' (Local Government Board (1896), op,cit,, (reference 14), Circular No 70, see p232), See also Local Government Board (1887), "Sixteenth Annual Report of the Local Government Board 1886-1887", C 5131, London; HMSO, see p128; Local Government Board (1890), "Nineteenth Annual Report of the Local Government Board 1889-1890", C 6141, London; HMSO, Circular No 60, pp197-210, see p198; Local Government Board (1901), op,cit,, (reference 15), Circular No 55, pp185-191, see p186; Local Government Board (1903), "Thirty-Second Annual Report of the Local Government Board 1902-1903", Cd 1700, London; HMSO, Circular No 42, pp166-203, see pp183-184, These views are similar to those expressed by the much later Curtis Committee - see reference 74 below,

25. See Local Government Board (1896), op,cit,, (reference 14) pp231-232; see also Local Government Board (1874), op,cit,, (reference 23), Circular No 22,

26. See reference 23,

27. Local Government Board (1910) "Thirty-Ninth Annual Report of the Local Government Board 1909-1910", Cd 5260, London; HMSO, p102 (pp97-105 comprise the 25th - and last - Annual Report by Miss Mason, the first Inspector of borading out schemes, In this Report, a brief history of the origins of boarding out is given); see also Local Government Board (1903) op,cit,, (reference 24), pp183-184 and Drage G, (1914), op,cit,, (reference 13), pp185-186, Thus the privacy of the family as an institution had its disadvantages, To overcome such variations in family care, boarding out had to be carefully monitored and controlled through vetting procedures and the work of the Boarding Out Inspectorate, As Packwood was to comment, "The quality of home life can, then, be just as impaired as that of life within an institution, as evidenced by the increasing number of children taken into care, The individual home, is, moreover, potentially far more of a 'closed'

institution than any hospital or residential home' Packwood T (1980) "Community Care; The Universal Panacea" Chapter 4, pp63-83, in Anderson D C, Ed, (1980) "The ignorance of social intervention", London; Croom Helm, see p72,

28. Royal Commission on the Poor Laws (1909), op.cit., (reference 13) p262,

29. See Heywood J.S (1978), op.cit., (reference 18), Chapters 1 to 3 inclusive; Pinchbeck I and Hewitt M (1973), op.cit., (reference 18), Chapter XVI,

30. Local Government Board (1896), op.cit., (reference 14), p233, Thus, boarding out was not seen as an option for feeble minded or unruly children (Local Government Board (1893), "Twenty-Second Annual Report of the Local Government Board 1892-93", C 7180, London; HMSO, Circular No 46 - The Report of Miss Mason - pp115-128, see p116, Compare reference 44 below,

31. Jones K (1972), "A history of the mental health services", London; Routledge and Kegan Paul, p182, Scull argues that in the mid 18th Century 'The overwhelming majority of the insane were still to be found at large in the community' (Scull A.T (1979), "Museums of Madness", London; Allen Lane, pp13-14,

32. Scull A.T (1983) "The asylum as community or the community as asylum; paradoxes and contradictions of mental health care" in Bean.P, Ed, "Mental Illness: Changes and Trends" Chichester; John Wiley and Sons, p329,

33. See Jones K (1972), op.cit., (reference 31), Chapter 8; also Drage G (1914), op.cit., (reference 13), p68,

34. For example, MacIntyre S (1973) , "Old Age as a Social Problem", pp41-63 in Dingwall R, Health C, Reid M and Stacey M, Eds, "Health Care and Health Knowledge", London; Croom Helm, pp48-49, See also the Royal Commission on the Poor Laws (Minority Report, 1909, op.cit., (reference 13), pp278-279 which called for the retention of some institutional care so that a 'helpless old people may escape from, or protect himself against, the tyranny and repeated cruelties to which the aged are some times occasionally subjected, even by their own children, There should be for all such cases,,,asylums or retreats'. A strong influence on perceptions of old age, and their care outside of the workhouse resulted from the movement to establish old age pensions; see "Report of the Royal Commission on the Aged Poor", op.cit., (reference 14); "Report of the Committee on Old Age Pensions" (1898), C 8911, (The Rothschild Committee), London; HMSO; "The Report of the Select Committee on the Aged Deserving Poor" (1899), Parliamentary Paper 296 (The Chaplin Committee), London; HMSO; "The Report of the Departmental Committee on Financial Aspects of House of Commons Committee of 1899 as Regards the Aged Deserving Poor" (1900), Cd 67, London; HMSO, Charles Booth, referred to above (references 9 & 10), published widely on this subject; (1892) "Pauperism and the endowment of old age",

London; Macmillan; (1894) "The Aged Poor in England and Wales", London; Macmillan; (1899) "Old Age Pensions and the Aged Poor", London; Macmillan.

35. See Royal Commission on the Poor Law, (1909), op.cit., (reference 23), para 359, p232.

36. See Means R and Smith R (1983) "From Public Assistance Institutions to 'Sunshine Hotels': Changing State perceptions about institutional care for elderly people, 1939-48" in *Ageing and Society* Vol 3, Part 2, pp157-181, see pp159-162.

37. See Thomson D (1983), op.cit., (reference 12) p50; the percentage of over 85's in institutions doubled between 1871 and 1901 (see p52).

38. Thomson D (1983), op.cit., (reference 12), p47, brackets mine.

39. See Drage G (1914), op.cit., (reference 13), pp94-95.

40. On 1st January 1920, of 46,846 people over 70 years old receiving relief, 9,345 were old age pensioners (Ministry of Health (1920a) "First Annual Report of the Ministry of Health 1919-1920", Part III, Cmd 932, London; HMSO, p49.

41. See Ministry of Health (1937) "Eighteenth Annual Report of the Ministry of Health 1936-37", Cmd 5516, London; HMSO, p99. Another Report added that arrangements for old people in Old People's Homes should be such that they were in 'more quiet and comfortable surroundings' (Ministry of Health (1935), "Sixteenth Annual Report of the Ministry of Health 1934-35", Cmd 4978, London; HMSO, p224). These views reflected the earlier conclusions of the Royal Commission of the Poor Law (see reference 14 above).

42. See Ministry of Health (1936) "Seventeenth Annual Report of the Ministry of Health 1935-36)", Cmd 5287, London; HMSO, p127.

43. For example in 1913, a Poor Law Institutions Order made the removal of children from the workhouse, over the age of three obligatory. Later, the Public Assistance Order of 1930 prohibited the retention of any child, aged between three and sixteen years, in the institution for more than six weeks, except in sickness wards, or on medical grounds (see "The Report of the Care of Children Committee", (1946), Cmd 6922, (The Curtis Committee), London; HMSO, p10). References to the difficulty in keeping children out of the workhouse were frequently mentioned in Annual Reports; Ministry of Health (1926), "Seventh Annual Report of the Ministry of Health 1925-1926", Cmd 2724, London; HMSO, p121 which stated that 'There is still insufficient compliance with the provisions...which requires the removal of children over the age of three years of age from the workhouse'. See also Ministry of Health (1928), "Ninth Annual Report of the Ministry of Health 1927-1928", Cmd 3185, London; HMSO, p167, and Ministry of Health (1936), op.cit., (reference 41), p128 which 'regretted' that a few authorities still kept children in General Institutions; finally, see Ministry of Health (1937), op.cit., (reference 40), p101.

44. See Ministry of Health (1920a), op.cit., Part III (reference 40), p39 - the shift from workhouse to boarding out was clearly promoted in this Annual Report (see pp42-43). But in practice, the numbers of children boarded out peaked in January 1915 (ibid, see Appendix II to this Annual Report, the Report of the SuperIntendent Woman Inspector of Boarding Out (pp128-139). This Appendix also stated that 'some children are temperamentally and physically unsuited to boarding out. To this class belong the mentally backward or deficient' (compare reference 30 above). The implication of this view was that handicapped children tended to be kept in workhouse accommodation.

45. See, for example, Ministry of Health (1921), "Second Annual Report of the Ministry of Health 1920-1921", Cmd 1446, London; HMSO, p134 which stated that 'a limitation of capital expenditure, the general shortage of housing accommodation and the high cost of building have prevented a solution of the difficulty (of accommodating children more appropriately) by the provision of new children's homes' (brackets mine); a later Report reported that it 'regretted that owing to the financial stringency a number of children still remain in general Institutions in contravention of the regulations' (Ministry of Health (1933), "Fourteenth Annual Report of the Ministry of Health 1932-33", Cmd 4372, London; HMSO, p200). Another Report stated that 'The tendency continues to be towards smaller units rather than large single homes,,,the larger homes are generally considered less desirable on account of the institutional atmosphere' (Ministry of Health (1935), op.cit., (reference 40), pp226-227).

46. Ministry of Health (1938), "Nineteenth Annual Report of the Ministry of Health 1937-38", Cmd 5801, London; HMSO, p90, brackets mine.

47. Evans E.J, Ed, (1978), "Social Policy 1830-1914. Individualism, collectivism and the origins of the Welfare State", London; Routledge and Kegan Paul, see p223.

48. See Evans E.J ibid., Chapter 18; Gilbert B.B (1966), "The evolution of national insurance in Great Britain: the origins of the welfare state", London; Joseph, Chapter 2; Searle G.R (1971), "The Quest for National Efficiency: a study in politics and political thought 1899-1914", Oxford; Blackwell.

49. Compare, for example, Health Visitor duties described throughout the 1920's in different ways; in the early part of this period it was stated that 'the duties of the Health Visitor are not yet stereotyped,,,up to the present time she has generally been charged with the duty of looking after expectant mothers, and especially of visiting their homes and of bringing them to the Maternity Centre' (Ministry of Health (1920b) "1st Annual Report of the Ministry of Health 1919-1920", Part I, Cmd 923, London; HMSO, p46); elsewhere they were described as 'mainly concerned with the care of the under-fives not living in institutions'; and home nurses were primarily to work with

maternity cases and children with infectious diseases (Ministry of Health (1921), op.cit., (reference 45), pp22-23 & p25). See also Ministry of Health (1924), "Fifth Annual Report of the Ministry of Health 1923-1924", Cmd 2218, London; HMSO, p15 which stated health visitor duties included 'the giving of advice to the mothers as to the care and management of their infants'; Ministry of Health (1925), "Sixth Annual Report of the Ministry of Health 1924-1925", Cmd 2450, London; HMSO, pp15-16 - for example, the home help was to 'undertake domestic work during the confinement of a mother, either at home or in an institution' (ibid., p18). Throughout this period the requirement for Health Visitor training grew as indicated by the commentary in Annual Reports on Health Visitor.

50. For example, Ministry of Health (1922), "Third Annual Report of the Ministry of Health 1921-1922", Cmd 1713, London; HMSO, p14.

51. 110 Day Nurseries are referred to, set up to allow mothers to work in munition factories (Ministry of Health (1924) op.cit., (reference 49) p19). The 1920 Dawson Report (Consultative Council on Medical and Allied Services (1920), "Future Provision of Medical and Allied Services. Interim Report of the Consultative Council on Medical and Allied Services", Cmd 693, London; HMSO) advocated a broader range of domiciliary health services which it defined as 'services, preventative and curative, which revolve around (the home)' (para 9, brackets mine). These services included those provided by doctors, nurses, pharmacists, midwives and health visitors. However, the emphasis placed by this Report on these 'domiciliary' services was secondary, such services would 'constitute the periphery of the scheme, the remainder of which is mainly instiututional in character' (ibid., para 9). This is explained by the fact that the Report defined 'institutional' services to include primary and secondary health centres, hospitals and recouperation centres to prevent disease and restore health after illness. The co-ordination of these domiciliary and institutional services was regarded as vital.

52. For a brief history of the mental health services, see Ayer S and Alaszewski A (1984), "Community Care and the Mentally Handicapped", London; Croom Helm, Chapter 1.

53. Jones K (1972), op.cit., (reference 31), see p191.

54. Jones K (1972), op.cit., (reference 31), p209.

55. The Board of Control commented in 1914 that 'It is difficult to convince members of the Councils that the expense of maintaining the feeble-minded who cannot maintain themselves must eventually be borne by the community' (Annual Report of the Board of Control, 1914) - quoted in Jones K (1972), op.cit., (reference 31), p213. Watkins comments that 'The change of emphasis from institutional to community care reflected

both the difficulty of getting local authorities to spend large sums of the ratepayers' money on providing and maintaining residential institutions, and a growing belief that many mental defectives were better cared for in the community' (Watkins B (1975), "Documents on Health and Social Services 1834 to the Present Day" London; Methuen, p372).

56. Jones K (1972) op.cit, (reference 31), p214. Thus, at the start of the war, many mentally infirm people were forced out into the community due to wartime contingency planning. It took many years for institutions to function again in a positive role - to treat and care for people - and a similar time for community care to be seen as a positive option rather than an inescapable outcome of underproviding residential care.

57. See reference 56.

58. "The Royal Commission on Lunacy and Mental Disorder" (1926), Cmd 2700, London; HMSO, commented that 'It has become increasingly evident to us that there is no clear line of demarcation between mental illness and physical illness' (para 38) and that the approach should thus be 'to get in touch with the patient at the earliest possible stage of his attack and by care and treatment to ward it off or at least mitigate its effects' (para 45). The growth in, and change of, medical treatment meant that 'insanity is coming to be regarded from an entirely different standpoint' (para 40) continuing to say that 'The problem of insanity and essentially a public health problem to be dealt with on modern public health lines' (para 50). The Commission commented that 'The keynote of the past has been detention; the keynote of the future should be prevention and treatment' (para 42).

59. Jones K (1972) op.cit., (reference 31), p217. Thus, 'Certification should be the last resort in treatment, not the pre-requisite of treatment' (Royal Commission on Lunacy and Mental Disorder (1926), op.cit., (reference 58), para 45, p19).

60. This movement away from hospital care was facilitated by the newly acquired technique of electro-convulsive therapy, leucotomy and insulin treatment. After care was deemed appropriate if the discharged patient 'could receive a certain amount of attention in suitable surroundings at home, or obtain appropriate employment ' (Royal Commission on Lunacy and Mental Disorder, (1926), op.cit., (reference 58) para 157, p81). Although after care facilities had existed, albeit on a limited scale, since 1877, largely due to the efforts of the Mental After Care Association, the Royal Commission was the first major body to acknowledge a statutory responsibility for after-care (see para 53).

61. Board of Education and Board of Control (1929) "Report of the Mental Deficiency Committee" (The Wood Report), part III, London; HMSO, pp75-76 (para 88) .

62. ibid., p53, (para 56).

63. Jones K (1972) op,cit,, (reference 31), p222 (see pp217-223 in general). Thus, Institutions were to be a 'flowing lake of the greatest fluidity' not 'stagnant pools' (The Wood Report, part III, op,cit (reference 61), para 99, p91.

64. Co-ordination was all the more necessary because of the role of institutions suggested in relation to community-based services. See the Wood Report (1929) op,cit (reference 61), part III, para 88, pp75-77.

65. The Wood Report, op,cit (reference 61) part III, paras 56-57, pp53-54. Thus, the Report recommended that the local Mental Deficiency Authorities should 'make far more use than at present of the existing forms of community care' (part III, p101).

66. The Wood Report, op,cit,, (reference 61), part III, p54 (para 57).

67. The Wood Report, op,cit,, (reference 61), part IV, p164, emphasis mine. See also part III, para 99, p90.

68. As argued above, see references to the Wood Report (references 61 to 67 inclusive).

69. See Means R (1981) "'Community Care' and Meals on Wheels. A study in the politics of service development at the national and local level" University of Bristol; School for Advanced Urban Studies, Working Paper 21, p7 and Means R and Smith R (1983), op,cit,, (reference 42), pp163-164.

70. However, there was a shortage of domestic help to facilitate home births whilst family networks were disrupted by the war (Ministry of Health (1944), "Summary Report of the Ministry of Health for the year ended 31st March, 1944", Cmd 6562, London; HMSO, p17). Following the war there were shoratges of health visitors and trained social workers, which meant that the role of the health visitors had not developed as broadly as hoped. Amongst other things, this meant that social care for the mental defective in many areas was 'at a standstill' (Ministry of Health (1950), "Report of the Ministry of Health for the year ended 31st March, 1949", Cmd 7910, London; HMSO, p121,275). Also see the Ministry of Health Circular 110/46, which drew attention to shortages of home helps in particular, drawing attention to the virtue of appointing home help organisors. Later, Circular 179/44 asked welfare authorities to establish domestic help under the special defence regulations. The help was mainly for housewives, elderly people were included in so far as their infirmity might affect the running of the household (see Ministry of Health (1945), "Summary Report of the Ministry of Health for the year ended 31st March, 1945", Cmnd 6710, London; HMSO, p60).

71. See Ministry of Health (1942a), "Summary Report of the Ministry of Health for the period from 1st April, 1939 to 31st March, 1941", Cmd 6340, London; HMSO, this records 'disappointment' that 'too many of the evacuated children were verminous when they arrived in the country,,,and far too many had uncleanly habits' (ibid,, p9). See also

references 72-73 below,

72. One Report said that 'More time and effort must be devoted to instructing mothers in,., matters such as the necessity for cleanliness and for training infants and toddlers in good habits' (Ministry of Health (1942a), op,cit,, (reference 71), p10); another Report spoke of 'concern,.,to safeguard the well-being of the country in the future stating that the past year had furnished plentiful evidence of a widening conception of social services' adding that 'A fact revealed by evacuation perhaps, more than by any other of the emergencies of war was that far too many women failed to accept or to understand their responsibilities, either as mother or housewives, Much of the protective and welfare work now being carried on throughout the country takes the first principles of health and hygiene - and indeed of domesticity - directly in the home, Parents are thus being encouraged to recognise that they have a personal and civic responsibility for instilling these principles into their children' (Ministry of Health (1942b), "Summary Report of the Ministry of Health for the period from 1st April 1941 to 31st March 1942" Cmd 6394, London; HMSO, p21),

73. Reference was made to 'healthy mothers and children' being a 'vital asset to the nation's future', in the light of which expectant and nursing mothers and children under five 'must at all costs be safeguarded,.,no matter how drastically' the curtailment of the distribution of essential commodities was (Ministry of Health (1942b), op,cit,, (reference 72) p15,17), There was a strong feeling that the Government should encourage the birth and maintenance of healthy children, In 1943 Beveridge said, 'We haven't now anything like enough children being born to keep our race in being,.,If the British race is to continue there must be many families of four or five children', Beveridge justified the family allowance 'not merely for the abolition of want but in order to improve both the quality and quantity of the population' (Beveridge W (1943), "The Pillars of Security", London; George Allen & Unwin, p83, 125 & 172); elsewhere he stated that 'the low reproduction rate of the British community today,.,makes it imperative to give first place in social expenditure to the care of childhood and the safe-guarding of maternity' (Beveridge W (1942) "Social Insurance and Allied Services", Cmd 6404, (The Beveridge Report), London; HMSO, para 15, p8),

74. For example, ante-natal and post-natal hostels, children's hostels, mother and children hostels, short-stay nurseries, social centres, as well as work done by local welfare committees, and their officers, in the community (see Ministry of Health (1942a), op,cit,, (reference 71), pp20-21), The government encouraged welfare authorities to provide domestic assistance under Government Circular 2729 of 1942, General service

developments took place under a range of Acts; the 1944 Education Act, the 1945 Family Allowance Act, the 1948 National Assistance, National Health Service, Local Government and Children's Acts.

The emphasis on supporting mothers and children at home was encouraged by Reports such as the Curtis Committee in 1946 which identified, like the boarding out movement 60 years earlier, the benefits of family life; 'The result (of care in residential homes) ...was a lack of personal interest in and affection for the children, which we found shocking. The child...was merely one of a large crowd, eating, playing, sleeping with the rest, without any place or possession of his own or any quiet room to which he could retreat...Where individual love and care had been given, the behaviour of the children was quite different...On the whole our judgement is that there is probably greater risk of acute unhappiness in a foster home, but that a happy foster home is happier than life as generally lived in a large community...The evidence is very strong that in the free conditions of ordinary family life with its opportunities for varied human contacts and experiences, the child's nature develops and his confidence in life and care in society are established, in a way that can hardly be achieved in a larger establishment' (The Curtis Committee (1946) op.cit., (reference 43), paras 418, 422 & 461). Thus, care by adoption and fostering were the best compensations for the loss of 'normal' home life. To ameliorate the negative effects of institutional care, small group homes of 10 to 12 children or the use of scattered and cottage homes were encouraged (ibid., paras 461-462, 477-488).

75. See Beveridge W (1942) op.cit., (reference 73), para 238, p92. The comment was also made that 'It is dangerous to be in any way lavish to old age, until adequate provisions has been assured for all other vital needs, such as the...adequate nutrition of the young' (para 236, p92). Similar views were expressed in the "Royal Commission on Population Report" (1949), Cmd 7695, London; HMSO, paras 296, 299 & 305.

76. Nuffield Foundation (1947) "Old People. Report of a Survey Committee on the problems of ageing and the care of old people" (The Rowntree Committee), London; Oxford University Press, para 180, p63.

77. ibid., p70. Thus, Bevan told the House of Commons that 'The workhouse is to go. Although many people have tried to humanise it, it was in many respects a very evil institution'. Bevan saw the need to provide welfare authority homes for 'a type of people who are still able to look after themselves...but who are unable to do housework, the laundry, cook meals and things of that sort'. Not large homes since, as Bevan put it, 'Bigness is the enemy of humanity' the optimum size of homes was 25-30 persons (Hansard (1948) "Parliamentary Debates. House of Commons 1947-1948" Vol 444,

Cols 1608-1609). Compare with a similar but later movement within the field of mental handicap: 'one of the earliest meanings associated with community services and community care was the development of small residential units in the community as opposed to the provision of residential facilities in large isolated institutions' (Ayer S and Alaszewski A (1984) op.cit., (reference 52), p38, emphasis in original).

78. Ministry of Health (1950) op.cit., (reference 70), p311. Discussion regarding the most appropriate environment in which to care for old people takes place elsewhere in this Report (pp119-120). Indeed, this Report states that the home help service 'has played a most important part in enabling the elderly chronic sick, who require care rather than active treatment, to remain at home and lead fuller lives in their family circle than they can in a hospital ward' (p122). Another Annual Report made the point over 15 years later that in respect of the elderly and long-stay patient 'it is important to secure that people are kept on their feet and able to live happy and useful lives for as long as possible'; this later Report continued to place considerable importance on the need to develop more forms of suitable accommodation and the need to undertake rehabilitation (Ministry of Health (1947) "Report of the Ministry of Health for the year ended 31st March, 1946", Cmd 7119, London; HMSO, pp81-83). See also Means R and Smith R (1983) op.cit., (reference 42), pp162-173; see also reference 77 above.

79. See Means R and Smith R (1983) op.cit., (reference 42), pp172-174. The position in terms of residential provision for elderly people at this time was complicated. The old workhouses ceased to exist as 'about 100 of the 400 former public assistance institutions became chronic sick hospitals (administered by health authorities), about 200 became joint-user establishments (administered by health and welfare authorities) ...and the remaining 100 became welfare homes (administered by welfare authorities)... The tricky part of this operation was to decide which of the inmates of the old institutions were "sick" and needed nursing and medical attention, and should therefore be regarded as hospital patients, and which were merely infirm and in need of "care and attention" only. A frail old person may not only be on the borderline between the two categories, he may change from the one category to the other by week, or even by day. Thus there arose a situation in which hospitals complained that their beds were "blocked" by patients who should have been in welfare accommodation, while the staff of old people's homes complained that they had to care for patients in need of a degree of nursing care for which they had neither the equipment nor the staff' (Watkins,B (1975) op.cit., (reference 55), see p96, brackets mine).

80. See Central Association for Mental Welfare (1939) "The Voluntary Mental Health Services" (The Feversham Committee) London; The Feversham Committee, para 10. This

Committee advanced three ways of organising 'community care' in the mental health field; first, where the statutory authorities were wholly responsible for service provision; second, where statutory authorities provided limited provision, leaving wider responsibilities to voluntary bodies; third, where voluntary bodies undertook to provide the vast majority of service provision. The last approach of the three was recommended by the Committee.

81. The Rowntree Committee stated that 'it should be pointed out that the provision of domiciliary services,,,when added to the total cost of old-age and supplementary pensions may often raise the total cost of preserving the independence of old people above the cost of care in Institutions or Homes' (Nuffield Foundation (1947) op.cit., (reference 76), para 130, pp48-49).

82. Central Association for Mental Welfare (1939) op.cit., (reference 80), para 305, see also para 365.

83. See National Health Service Act (1946) sections 25, 28, 29 and para 2(1)c, also reference 88 below.

84. The Act conferred on the local health authority a wide range of duties to provide, amongst other things:

a) A health visiting service 'for persons suffering from illness and expectant and nursing mothers, and,,,to prevent the spread of infection' (Section 24);

b) A home nursing service 'for persons who require nursing in their own homes' (Section 25);

c) 'Arrangements for the purpose of prevention of illness, the care of persons suffering from illness of mental defectiveness, or the after care of such persons' (Section 28);

d) 'Domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother, mentally defective, aged, or a child not over compulsory school age' (Section 29);

e) 'The service of specialists,,,if necessary on medical grounds, at the home of the patient' (Section 2(1)c).

The Act superceded the powers to provide domestic help under the wartime defence regulations referred to above. The Minister of Health regarded the effectiveness of health visiting, home nursing and care/after-care services to be dependent on the adequacy and efficiency of the home help service (see Ministry of Health Circular 118/47, para 52). In terms of this provision, the Act allowed health authorities to provide health visiting, home nursing and services for care and after-care either directly or through the auspices of an appropriate voluntary organisation.

Similarly, under the National Assistance Act, local authorities were required to provide directly, or through voluntary associations, residential accommodation for aged people (See National Health Service Act Section 24(2), 25 and 28(3), and National Assistance Act Section 21 and 26). Bell argued that the National Assistance Act 'did not confer powers upon local authorities to provide a comprehensive welfare service. The assumption appeared to be that voluntary organisations should be encouraged to fill the gaps' (Bell K M (1965) "The Development of Community Care" in *Public Administration* Winter 1965, pp419-435, see p421).

85. For example, in terms of housing, Section 136 of the Local Government Act (1948) permitted a County Council, with the consent of the Minister of Housing and Local Government, to make a payment towards the cost incurred by District Councils for erecting bungalows or grouped dwellings for the elderly. Section 41 of the Act also allowed the housing authority to make improvement grants to housing associations, whilst Section 40 enabled the local authority and housing associations to build hostels and receive an Exchequer contribution to costs thereby incurred.

86. Ministry of Health (1959) "Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services", The Younghusband Report, London: HMSO, paras 248-249.

87. For example, health visiting shortages were noted; see Ministry of Health (1951) "Report of the Ministry of Health for the year ended 31st March, 1950", Part I, Cmd 8342, London: HMSO, p47; Ministry of Health (1954a) "Report of the Ministry of Health for the year ended 31st December 1953", Part I, Cmd 9321, London: HMSO, pp130-131. This Report also admitted that 'in spite of the ever-growing demand for the (home help) service many authorities are finding it necessary to restrict any expansion because of financial limitations' (ibid., p129). Even by 1961 'small' numbers of psychiatric social workers existed; Ministry of Health (1962) "Annual Report of the Ministry of Health for the year 1961", Part II, Cmnd 1856, London: HMSO, p154. Chronic Sick Hospital beds were lacking; Ministry of Health (1952) "Report of the Ministry of Health covering the period 1st April, 1950 to 31st December, 1951", Part I, Cmd 8655, London: HMSO, p15. Hospital-based after care schemes were rare; Ministry of Health (1951), Part 1, op.cit., (this reference) p49. Part III accomodation; Ministry of Health (1951), Part 1, op.cit., (this reference) p150. In general, see Hansard (1953) "Parliamentary Debates, House of Commons", Vol 512, Debate on Accommodation for chronic sick and aged, 6th March 1953; Boucher C.A (1957) "Survey of Services available to the Chronic Sick and Elderly 1954-1955", Report on public health and medical subjects No 98, (The Boucher Report), London: HMSO, pp51-55. Other forms of health and welfare provision

were only in their formative stages of development and so despite agreement the recognition that old people wished to remain at home, the limited provision of community services, and day shelters, day hospital, short term admission, special housing, out-patient facilities and clinics might preclude this (Ministry of Health (1954b) "Report of the Ministry of Health for the year ended 31st December, 1953", Part II, Cmd 9307, London; HMSO, pp193-197.

88. See reference 75 (The Report of the Royal Commission on the Population).

89. Ministry of Health (1952), Part 1, op.cit., (reference 87), p16. The rising cost of institutional care clearly affected thinking about community care. The Sixth Report of the Select Committee on Estimates, 1951-1952 examined child care services, and as Bell writes the committee was 'forceful in its insistence that boarding out was much more economical than other forms of care and that the tax payers' interests must be safeguarded' (Bell K M (1965), op.cit., (reference 84), see p422.

90. Ministry of Health (1956) "Report of the Ministry of Health for the year ended 31st December, 1955", Part I, Cmd 9857, London; HMSO, p26. See also Ministry of Health (1958a) "Report of the Ministry of Health for the year ended 31st December, 1957", Part 1, Cmnd 495, London; HMSO, p33 - here the Ministry of Health encouraged the establishment of geriatric departments to provide active treatment and encourage rehabilitation home (see reference 91). In general terms, the Report added a statement on community care philosophy: 'When adequate treatment can be provided at home, admission to hospital should be regarded as a last resort, and everything possible should be done to enable old people to stay at home unless they clearly need treatment of a kind that can only be given in hospital, or the domestic circumstances are such that they cannot be treated adequately at home' (ibid., p32). The emphasis here was thus on preventing or delaying admission to hospital.

91. "Royal Commission on the law relating to mental illness and mental deficiency 1954-1957" (1957), Cmnd 169, London; HMSO, paras 601 & 603, p207. See also paras 46-48. There was a strong emphasis at this time placed on the need to avoid long-stay in-patient hospital care; Memorandum RHB(50)39 encouraged the development of convalescent annexes to acute hospitals to allow nursing care after actual treatment but prior to discharge. Short-stay psychiatric units were to be attached to geriatric departments to enable more effective and rapid treatment and discharge (see also Ministry of Health (1951), Part 1, op.cit., (reference 87), p72). Hospital patients were more precisely classified to ensure appropriate use of acute geriatric, long-stay and convalescent wards (see Ministry of Health (1954a), Part I, op.cit.,(reference 87), p29). Half-way house accommodation between hospital and home and between hospital and part III

accommodation was encouraged (Ministry of Health (1954a), Part I, op.cit., (reference 87), p29, this Report also stated that 'increased emphasis is now being placed on the development of services for old people in their own homes', rehabilitation of hospitalised elderly people was 'to make them fit for discharge to live in the community again' (p28); see also Ministry of Health (1954b) op.cit., (reference 87), pp195-196; Ministry of Health (1957a), "Report of the Ministry of Health for the year ended 31st December, 1956", Part II, Cmnd 325, London; HMSO, p209; Ministry of Health (1958a), Part I, op.cit., (reference 90), p32; Ministry of Health (1952), Part I, op.cit., (reference 87), p15; Memorandum HM(57)96, Circular 14/57,

92. See Ministry of Health (1954b), Part II, op.cit., (reference 87), pp196-197, Thus, the development of short-term facilities, out-patient services and clinics, new therapeutic treatment and rehabilitation not only changed the pattern of hospital admissions, but were 'designed to help relieve relatives as much as the patient and to give help before the strain of caring for the old person has reached such a point as to cause rejection of the patient by the relative' (Ministry of Health (1958b) "Report of the Ministry of Health for the year 1957", Part II, Cmnd 559, London; HMSO, p225),

93. Ministry of Health (1954b), Part II, op.cit., (reference 87), p193, See also Ministry of Health (1957a), part II, op.cit., (reference 91), p206, See also reference 93 below,

94. Unfortunately, only five small units were operating by the end of 1953 (see Ministry of Health (1954a), Part I, op.cit., (reference 87), p16); only three short-stay psychiatric units were noted as operating in the country (also p16), This shortfall is noted elsewhere Ministry of Health (1954b), Part II, op.cit., (reference 87), p196 ; see also Ministry of Health (1951), Part I, op.cit., (reference 87), pp72-73 and Ministry of Health (1957a), Part II, op.cit., (reference 91), p209,

95. "The Report of the Committee on the Economic and Financial Problems of the Provision for Old Age" (1954), Cmd 9333, (The Phillips Committee), London; HMSO, see paras 6, 105-106, 119-120, 123, 147-148,

96. ibid., para 270,

97. ibid., para 264, Thus, adequate domiciliary services were a means to 'prevent greater cost' (ibid., para 323),

98. ibid., para 322, Paras 258-259 referred to the need to integrate old people into the community drawing on family and neighbourhood support which no welfare service could replace. In general terms it was stated that 'Old people should as far as possible continue to live as members of the community' (para 275, p75), Another document referred to 'the importance of enabling them (elderly people) to continue to live independently in their own homes, where most of them wish to be, and of delaying

admission to residential care for as long as possible, is generally recognised' (Ministry of Health (1957a) op,cit,, (reference 91), p206).

99. See Ministry of Health (1957a), part II, op,cit,, (reference 91), pp206-207, and also Circular 14/57. Elsewhere it was argued that short-stay hospital provision, if it facilitated active treatment, speedier discharge and return to the community, was cost-effective and desired by the consumer - see The Phillips Committee (1954), op,cit,, (reference 95), para 271, p74.

100. "The Report of the Committee of Enquiry into the Cost of the National Health Service", (1956), Cmd 9663, (The Guillebaud Committee), London; HMSO, para 647, p217, (brackets mine). MacIntyre argued that the Phillips Report made much the same point; 'By taking it as axiomatic that old people would prefer to be active, productive and independent, the Phillips Committee was able to present the concept of community care as being deeply humanitarian as well as organisationally efficient' (MacIntyre S (1973) in Dingwall R, Health C, Reid M and Stacey M, Eds, op,cit,, (reference 34), p54).

101. See The Boucher Report (1957), op,cit,, (reference 87), p54.

102. See Hansard (1953) op,cit,, (reference 87), see col 734 (first quote); cols 780 & 782 (second quote).

103. Hansard (1950) "Parliamentary Debates, House of Commons", 29th June, 1950, Vol 476, Col 2631. Circular 18/57 and 55/57 urged local authorities to provide more housing for the elderly by using powers to make grants to District Council housing authorities to cover costs of employing wardens. These powers were extended in 1958 through the Local Government Act.

104. This period saw the growth in domestic and nursing help available to the elderly, and a broadening range of statutory and voluntary services such as night sitting, boarding out schemes, luncheon clubs, neighbourhood schemes, grouped dwellings, holiday schemes and day centres. See Ministry of Health (1957b) "Report of the Ministry of Health for the year ended 31st December, 1956", Part I, Cmnd 293, London; HMSO, pp131-132 and Ministry of Health (1957a), part II, op,cit,, (reference 91), pp207-208; Ministry of Health (1959), "Report of the Ministry of Health for the year ended 31st December, 1959", Part I, Cmnd 1086, London; HMSO, pp192-193; The Boucher Report (1957), op,cit,, (reference 87), p55. Adequate domiciliary services were deemed 'essential' (The Phillips Committee (1954), op,cit,, (reference 95), para 323; voluntary services had a 'valuable contribution' to make and General Practitioners were 'vitally important' (The Boucher Report (1957), op,cit,, (reference 87), pp54-55).

105. Means R (1981), op,cit,, (reference 69), p9.

106. The Phillips Committee (1954), op,cit,, (reference 95) stated that the co-ordinating of

central and local authorities and voluntary organisations concerned with old people 'requires urgent consideration' (para 276, p75). Para 260 stated that 'considerable difficulties arose because so many different authorities were involved in making provisions for old people, and their respective duties were not always clearly defined; the Report thus emphasised the fact that 'closer co-operation' was 'urgently needed' (para 327).

107. The Guillebaud Committee (1956), op.cit., (reference 100), paras 644-645, pp216-217. This general problem was also discussed in Parliament; Hansard (1953) op.cit., (reference 87), cols 709-711, 723. In attempt to avoid such co-ordination problems, definitions of service responsibilities were put forward in a number of places; Community Health Services Council (1952) "Report on co-operation between Hospital, Local Authority and General Practitioner Services" see paras 16(a)i, ii and paras 25(a) and (b). See also Phillips Committee (1954), op.cit., (reference 95), paras 324-326; Guillebaud Committee (1956), op.cit., (reference 100), paras 640-652 (pp214-219); Hansard (1953), 6th March 1953, op.cit., (reference 87), cols 722-725. However, there were many references in the literature of the time to co-ordination problems being exacerbated by shortages of certain facilities; it was thus claimed that 'at least 25% of people placed on waiting lists do not need admission to hospital but require,.. patients occupying hospital beds,.,could be discharged if there was suitable welfare accommodation elsewhere' (Ministry of Health (1954b), Part II, op.cit., (reference 87), p196; see also Ministry of Health (1954a) Part I, op.cit., (reference 87), p181). The reverse to this was also claimed, namely that shortages of hospital accommodation led to people remaining in welfare homes when they were 'sick' - see Ministry of Health (1952), Part I, op.cit., (reference 87), p17 and Ministry of Health (1955), "Report of the Ministry of Health for the year ended 31st December 1955", Cmd 9857, Part I, London; HMSO, p25. Liaison difficulties in the mental health field were also 'acute' and the 'greatest barriers' to service development (see Jones,K (1972), op.cit., (reference 31), pp283-284).

108. See Watkins B (1975), op.cit., (reference 55), p96.

109. Ministry of Health (1952), Part I, op.cit., (reference 87), p17.

110. The Boucher Report (1957), op.cit., (reference 87), p55. This was also emphasised by the Younghusband Report (1959), op.cit., (reference 86), Chapter 12.

111. The Royal Commission continued; 'It is not always in his best interests to remove hims from a not entirely satisfactory home to even the best-run foster-home or public institution' - see the Royal Commission on Mental Illness and Mental Deficiency (1957), op.cit., (reference 91), para 361. Similarly, out-patient treatment was endorsed

because the patient 'does not lose touch with his family' (Ministry of Health (1957), Part I, op,cit,, (reference 91), p110). The emphasis was similar for the elderly, see reference 102 above.

112. See Ministry of Health (1960), "Report of the Ministry of Health for the year ended 31st December, 1959", Cmnd 1086, Part I, London; HMSO, p8,11.

113. Royal Commission on Mental Illness and Mental Deficiency (1957), op,cit,, (reference 91), paras 95-96, pp29-30.

114. Jones K (1972), op,cit,, (reference 31), p283, brackets in original.

115. See DHSS (1962) "A Hospital Plan for England and Wales" Cmnd 1604, London; HMSO; DHSS (1963) "Health and Welfare. The Development of Community Care", Cmnd 1973, London; HMSO; DHSS (1966) "Health and Welfare. The Development of Community Care", Cmnd 3022, London; HMSO. The relationship between hospital and community services was recognised; see Community Health Services Council (1969) "Functions of the District General Hospital", London; DHSS/Welsh Office.

116. DHSS (1962), op,cit,, (reference 115), para 31, p9. The Plan goes on to say that local authority services would affect the number of hospital beds required for all types of illness and infirmity, having 'a special bearing on hospital provision for the elderly' (para 38, p11). It was added that special housing schemes 'has also made it possible for more to be cared for outside hospital' (para 39, p11). On a more general level, the Plan acknowldeged that 'Plans for the expansion of community care cannot dispense with the contribution that can be made by voluntary effort' (para 44, p12).

117. DHSS (1963), op,cit,, (reference 115), see Appendix A. The inadequacies of services, and the variations in those services documented in the Health and Welfare Plans was referred to in the later Seebohm Report - "Report of the Committee on Local Authority and Allied Personal Social Services", (1968), Seebohm,F, Chairman, Cmnd 3703, (The Seebohm Report), London; HMSO, see paras 74-78, 293, 309. The Report acknowledged that 'community care' had had a limited impact, and in respect of the mentally disordered 'The widespread belief that we have "community care",,,is, for many parts of the country still a sad delusion and judging by published reports will remain so for years ahead' (para 339). Reference was also made to the 'grave shortage of suitable accommodation for the mentally ill aged' (para 308). Variations in service were also recorded in Appendix G to the Sebohm Report (ibid,, pp310-317).

118. DHSS (1963), op,cit,, (reference 115), p15.

119. DHSS (1963), op,cit,, (reference 115), p15.

120. As expressed in the 1948 National Assistance Act.

121. Ministry of Health (1961) "Report of the Ministry of Health for the year ended 31st

December, 1960", Part I, Cmnd 1418, London: HMSO, p122. The idea that old people had the right to accept/refuse services offered to them was expressed elsewhere: 'The essence of community care and after care is that it is a permissive service which an individual is free to accept or refuse' (Ministry of Health (1962) op.cit., reference 87, see p154.

122. Ministry of Housing and Local Government Circular 10/61, "Services for Old People", p1. The Circular helped make old people independent by enabling Housing Authorities to provide 'a full range of small bungalows, flats and flatlets designed for old people'. Special housing was further encouraged by a subsequent Circular (Circular 82/69), which endorsed the development of Category 1 and Category 2 sheltered housing.

123. Ministry of Health (1962), Part II, op.cit., (reference 87), p158.

124. Ministry of Health (1962), Part II, op.cit., (reference 87), p152.

125. The Seebohm Report, (1968), op.cit., (reference 117), para 476; the personal social services were to be 'encouraging and assisting the development of...mutual aid' (para 477). The Report defined the role of the community worker as 'a source of information and expertise, a stimulater, a catalyst and an encourager...we...consider that such work should be undertaken by the local authority social services department as well as by voluntary organisations' (paras 480-481). The social services department was to 'preserve and strengthen common identity and activity' in the community, promoting community activity where it did not exist - 'A clear responsibility then should be placed upon the social services department for developing conditions favourable to community identity and activity' (paras 482-483).

126. See the Seebohm Report, op.cit., (reference 117), paras 491-494.

127. Prior to the Seebohm Report, increasing emphasis had been placed on the powers available to local authorities to use volutary organisations to prrovide certain kinds of community-based services. The Seebohm Report brought to the fore the notion that statutory and voluntary sector provision should be co-ordinated to provide the most appropriate level of service provision.

128. See the Seebohm Report, (1968), op.cit., (reference 117), para 310. The Seebohm Report thus took on board the need to care for carers: 'If old people are to remain in the community, support and assistance must often be directed to the whole family of which they are members' (para 311).

129. The Circular stated that 'Although the health and welfare services are not under one authority, their purpose is to provide what is essentially a single service for each individual who needs it...If they are to formulate effective development plans, they will need to assemble and consider jointly the basic information about elderly people

in each area and their present and prospective needs for services, and to reach agreement on the desirable priorities and long-term plans for the area'. See "Memorandum for local authorities and hospital authorities: care of the elderly in hospital and residential homes", Circular 18/65, para 9.

130. The Seebohm Report (1968), op.cit., (reference 117), para 478.

131. The Seebohm Report (1968), op.cit., (reference 117), para 294.

132. Bayley M (1973) "Mental handicap and community care", London: Routledge & Kegan Paul, p342.

133. The Seebohm Report (1968), op.cit., (reference 117), para 478.

134. The Seebohm Report (1968), op.cit., (reference 117), para 478.

135. The Seebohm Report (1968), op.cit., (reference 117), paras 498-499. Para 497 speaks of the need to encourage informal 'good neighbourliness' and the 'crucial role of volunteers'.

136. Derricourt N.J (1983) "Strategies of Community Care" pp270-285 in Loney M, Boswell D and Clarke J, Eds, "Social Policy and Social Welfare", Milton Keynes: Open University Press, see p275. Italics in original.

137. The Seebohm Report (1968), op.cit., (reference 117), para 338.

138. The Seebohm Report (1968), op.cit., (reference 117), para 337. This is a remarkably similar sentiment to that expressed to that expressed by the 1957 Royal Commission on Mental Illness and Mental Deficiency, op.cit., (reference 91).

139. The Seebohm Report (1968), op.cit., (reference 117), para 474 (see also para 2). For community development and participation - see paras 480-494, and reference 125 above.

140. Means R (1981), op.cit., (reference 105), p19. For example, as the Seebohm Report noted (op.cit., (reference 117), Appendix F, p293), the Health Service and Public Health bill contained a clause which made it a duty of the local authority to provide a home help service.

141. Walker A, Ed, (1982) "Community Care. The Family, the State and Social Policy" Oxford: Basil Blackwell and Martin Robertson, p6 & pp32-34.

Appendix 3: Notes and References to Chapter Three

1. Thus, authors have described community care as a loose term; 'it has all too often been treated as a vaguely worthy objective, not requiring to be spelled out with any precision' (Freeman,H (1969) "Community Care" in *New Society*, 10th April 1969, pp560-561); 'it is a woolly concept,,,a linguistic sleight of hand' (Lappin,A (1970) "Community Careless" in *New Society* 9th April 1970, pp589-591, see p589). In general, see Elkan,S (1967) "The different meanings of community" in *Case Conference* Vol 14 No 8, December 1967, pp282-284. As Allsop states 'Community care eludes precise definition as it means different things to different professionals and agencies and has changed over time' (Allsop,J (1984) "Health Policy and the National Health Service" London; Longman, p108); similarly, 'it is used to cover a wide range of care and an equally wide variety of understandings of community' (Bayley,M (1973a) "Mental handicap and community care", London; Routledge and Kegan Paul, p1); 'far from being a coherent policy, community care is best seen as a set of different, competing, and often conflicting policies which tend to be well institutionalised and therefore to exist independent of one another' (Webb,A and Wistow,G (1983a) "Public Expenditure and Policy Implementation; the case of Community Care" in *Public Administration* Spring 1983, Vol 61(1)); 'community care itself remains a vague concept, not uniformly accepted' (Age Concern (1977) "Profiles of the Elderly: No 4 - Their health and health services" Mitcham; Age Concern Publications, p7); 'community care has proved,,,most difficult to define precisely, and,,,(is) open to the widest range of interpretations,,,"community" and "care",,,are so overladen with ambiguity, idealistic values and connotations has been elevated to almost mystical status and, in this process, has lost touch with reality' (Walker,A (1986) "Community Care; Fact and Fiction" pp4-15 in Willmot,P, Ed, "The debate about community: papers from a seminar on 'community in social policy'", Discussion Paper No 13, London; Policy Studies Institute, p4). 'The phrase "community care" means little in itself,,,It has come to have such general reference so as to be virtually meaningless, It has become a slogan with all the weakness that that implies' (House of Commons (1985a) "Second Report from the Social Services Committee", Session 1984-85, Community care with special reference to adult mentally ill and mentally handicapped people, Volume I, Report together with the Proceedings of the Committee, House of Commons Paper 13-I, para 8, p x) and elsewhere the same Committee stated that 'The term community care is imprecisely defined, it can mean everything and nothing' (House of Commons (1985b) "Second Report from the Social Services Committee", Session 1984-85, Community care with special reference to adult mentally ill and mentally handicapped people, Volume III, Minutes of Evidence (4 July-21 November 1984), House of

Commons Paper 13-III, para 4,10, p632); Packwood criticised community care policy, describing it as a 'comprehensive dogma'; a 'form of ignorance'; a 'vague and ambiguous slogan'; a policy which 'rarely,,,spell out precisely what is intended', 'an ill-assorted collection of hopes, plans, objectives and ideologies which do not necessarily sit easily together'; 'rhetoric,,,used too widely without clarification' (Packwood,T "Community Care,,,The Universal Panacea" Chapter 4, pp63-83 in Anderson,D,C, Ed, (1980) The Ignorance of Social Intervention London; Croom Helm, see pp63-65); 'We suggest,,,the operational meaning of concepts of community care,,,should be spelt out in more detail and precision, wherever and whenever they are discussed' (Rehin,G,F and Martin F,M (1968) "Patterns of Performance in Community Care" London; Oxford University Press for Nuffield Provincial Hospitals Trust, p214), Thus, 'the reality proved to be very difficult from the intention. In the event "community care" has proved to be a more elusive concept than was originally expected' (Spencer J C (1970) Chapter 2, "Introduction to community care" in World Health Organisation, European Social Development Programme (1970) "Study Group on the meaning and implications of Community Care" (Report of a Conference held in Bristol, 9th-18th September 1969, Paper SOA/ESDP/1969/6), New York; United Nations, p19), Lastly, Walker said that the policy of community care 'remains a precarious one' referring to 'the confused relationship between the meaning of community care in public policy statements, its meaning in the actual policy carried out, and the sense in which politicians and administrators use it' (Walker A (1981) "Community care and the elderly in Great Britain; Theory and Practice" in *International Journal of Health Services*, Vol 11 (4), pp541-557, see p547; 'There seems to be a lack of satisfactory of community care and some confusion as to its meaning' (Tinker A (1984a) The elderly in modern society, (1st Edition 1981), London; Longmans, p37), Moroney speaks of 'ambivalence' as to the purposes of community care (Moroney R M (1971) "The Family and the State", London; Longmans, p1),

2. For a similar argument, see Ayer,S and Alaszewski,A (1984) "Community Care and the Mentally Handicapped", London; Croom Helm, Chapter 2, They examine some of the 'ambiguities' of community care by isolating three separate meanings it has; as an alternative to institutional or hospital care; as an alternative to segregated or specialist services; and as care by the community,

3. See, for example, Personal Social Services Council (1975) "Living and Working in Residential Homes", London; PSSC, This lists reasons why the movement against residential care developed (p8ff); it can be seen that these factors operated in parallel and were related to each other, Ayer,S and Alaszewski,A, (1984, op,cit,, (reference 2)) admit that their conceptions of community care to some extent co-existed

leading to considerable confusion as to the meaning of community care (see pages 53-4, 63-4). In general, social provision for elderly people has always varied, both in range, emphasis and primary rationales, representing different respones through time to different needs, and reflected in different local patterns of service. This point is made by several writers; Bell K M (1965) "The Development of Community Care" in *Public Administration* Winter 1965, pp419-435 (see pp425-426); DHSS (1978) "The DHSS Perspective", pp1-17 in Barnes,J and Connelly,N Eds, (1978) "Social Care Research" London; Bedford Square Press, pp5-6; Townsend,P (1979) "The Care of the Elderly in Britain and Japan: The relative Effectiveness of Community Care and Residential Services for the Elderly" (Revised Text of Tokyo Lecture, April, 1978), unpublished, p11; Packwood, T in Anderson D C, Ed, (1980) op.cit., (reference 1), p65; Allsop,J, (1984) op.cit., (reference 1), pp108, 114.

4. See, for example, Lukes S (1974), "Power: a radical view", London; Macmillan; Bachrach P and Baratz M S (1962), "The two faces of power" in *American Political Science Review* Vol 56, pp947-953; Bachrach P and Baratz M S (1963) "Decisions and non-decisions; an analytical framework" in *American Science Political Review* Vol 57, pp641-651; Bachrach P and Baratz M S (1970), "Power and Poverty: theory and practice", New York; Oxford University Press.

5. Spencer J C in World Health Organisation (1970) op.cit., (reference 1), p15. Such a stance is widely supported elsewhere, for example, see Packwood, T in Anderson D C, Ed, (1980) op.cit., (reference 1); Rollin,H,R (1966) "Mental Health, Community Care in Britian?" in *Transactions and Studies of the College of Physicians of Philadelphia* Vol 33, pp186-192; Scull,A (1984) "Decarceration, Community Treatment and the deviant - a radical view" Second Edition, (1st Edition 1977), Cambridge; Polity Press and Basil Blackwell, p65; Plank suggests that community care 'should more accurately be called the reaction against residential care' (Plank,D (1977) "Caring for the Elderly: Report of a Study of various means of caring for dependent elderly people in eight London boroughs" London; Greater London Council, p4). For example, 'What is perhaps unique about the present impetus toward community care is the almost total rejection of long-term institutional care of any kind' (Hawks,D (1975) "Community Care; An Analysis of Assumptions" in *British Journal of Psychiatry* Vol 127, September 1975, pp276-285, see p276); community care,,,'is conceived of in uniformly positive terms both because of its seperateness from institutions (now designated as 'bad') and because of the presumed benign influence of the people who form the neighbourhoods and localities and where needful people live. Community is good,' (Johnson M,L (1982) "The realities and potential of community care" Revised text of a paper presented at DHSS Seminar,

September 28th-30th, University of East Anglia, p1, brackets in original (published under the same title as Chapter 6, pp93-117, by Johnson M,L and Challis D in DHSS, Ed, (1983) "Elderly people in the community: their service needs. Research contributions to development of policy and practice" London; HMSO)). Thus, for example, Tinker sees community care as developing as a result of a number of influences, the majority of which related to the role and changes in institutional care (see Tinker,A (1984a) op,cit,, (reference 1), pp37-38); similarly, of the five rationales identified by Johnson and Challis as underpinning community care policy, only one actually referred to any positive conception of community as such (see Johnson M,L and Challis D (1983) op,cit,, (this reference), pp96-97). Payne writes; 'Probably the most clear element in the origins of community care is the movement for de-institutionalisation of the social services' (Payne M (1986) "Social care in the community", Basingstoke; Macmillan, p11).

6. See Allsop,J (1984) op,cit,, (reference 1), p110 and also Lappin,A (1970) op,cit, (reference 1). These views have to be set alongside the fact that residential care has changed in function through time. See for example, Harris,D (1977) "Seven models of Residential Care" in *Social Work Today* Vol 9, No 1, 30th August, 1977, pp19-20. Thus, Means argues that in the 1960's 'Community Care,,,came to mean keeping people out of hospital' (See Means,R (1981) "Community Care and Meals on Wheels. A study in the politics of service developments at the national and local level" University of Bristol, School for Advanced Urban Studies, Working Paper 21, p9).

7. Bell writes 'it is better, wherever possible, to provide help and support for people living in their own homes, with their own families, in their own neighbourhoods, rather than in institutions' (Bell K M (1965) op,cit,, (reference 3), p419, emphasis mine). See also reference 13. Hobman writes; 'In recent years it has been generally held that community care is to be preferred to institutional care' (Hobman,D "A Protaganists view" in Kinnaird,J, Brotherston,J and Williamson,J, Eds, (1981) "The Provision of Care for the Elderly" Edinburgh; Churchill Livingstone, p29). Yet this perception suggests more complex implications; 'Given the choice, it is believed, the majority of old people would like to retain their independence as long as possible,,,But is must not be forgotten that preferences vary widely. Some people do prefer the safeguards of a residential home' (ibid,, p34 - a statement made in the Chapter "Housing Policies", pp31-40 by Thom W T); 'Community care does not have an absolute value regardless of other circumstances,,,It is preferred to institutional care if,,,in practice,,,the benefits,,,outweigh the costs' (Martin,F,M and Rehin,G,F (1969) "Towards Community Care" London; PEP, p258); '"common knowldege" and research have combined to produce the view that old people prefer to be cared for in their own homes by their own friends and

kin' (Johnson M L (1982) op.cit., (reference 5), p4). By contrast; 'Care or treatment at home is not necessarily preferable to care in hospital. Every environment must be judged on its own merits in terms of the effect it has on the patient's behaviour and clinical condition, as well as the effect of the patient's behaviour on those with whom he lives and works' (Bennett D, Chapter 7, "Community care services", pp87-102 in World Health Organisation (1970) op.cit., (reference 1), p92); 'While it might be correct that the majority of the elderly would prefer to live independently in their own homes if they were physically fit and financially secure, if these conditions are not met then many might prefer to be looked after in hospital or home' (MacIntyre,S (1973) "Old Age as a Social Problem" pp41-63 in Dingwall R, Health C, Reid M and Stacey M, Eds, "Health Care and Health Knowledge", London; Croom Helm, see pp58-59).

8. For example, the progression to boarding out, the post-1960's emphasis on residential care, the advocacy of community hospitals in the 1970's - see Chapter Two. For the elderly mentally infirm, for example, 'community care is intended,,,to eliminate the traditional large psychiatric hospitals,,,by a gradual transfer of long-stay provision to smaller discrete units in local or community hospitals' (Personal Social Services Council (1978) "Policy Issues in Residential Care: A Discussion Document" London; PSSC, p35). Similarly, a Conservative Party pamphlet argued that the elderly mentally infirm should be kept out of hospitals and at home 'wherever this is practicable - using institutions only as a last resort' (Conservative Political Centre (1981) "The right approach to mental health" London; CPC, p23). Hawks argued that 'Central to the advocacy of community care is the assumption that the numbers of patients requiring long-term stay in hospital will decline' (Hawks,D (1975) op.cit., (reference 5), p278). Payne describes the community care as to 'reduce the size of institutions providing personal care, and decentralise them, to encourage people in them into making independent decisions about everyday life and to bring them into more regular contact with other people outside institutions' (Payne M (1986) op.cit., (reference 5), p11).

9. This could be termed community care by default, i.e 'community care' - keeping people out of residential institutions - is the by-product of other policy changes. It is not the provision of actual services in the community but rather the under-provision of non-community services which forces people to return to/remain in the community. For example, very recently it was said that psychogeriatric patients had to be left in the community due to lack of staff and residential places; 'These factors will combine to ensure that most of the elderly with mental disorders will,,,live outside institutions, even when institutional care is judged by all concerned to be desirable or appropriate' (Hemsi,L (1980) "Psychogeriatric Care in the Community" in *Health Trends* Vol 12, pp25-

29); 'the number of elderly people requiring hospital care has multiplied faster than the number of available beds, with the inevitable result that elderly people with physical and mental disability have spilled over into old people's homes and the community' (Muir Gray,J,A (1977) "The treatment of the elderly sick - where and by whom?" in *Modern Geriatrics* August 1977, pp19-22). In the early 1960's Townsend argued that the development of health and welfare services was a case of unplanned 'community care' through underprovision of various kinds (see Townsend,P (1963) "The timid and the bold" in *New Society* 23rd May 1963, pp16-18). Also Glennerster,H (1985) "The wilting flowers of community care" in *Community Care* 12th September 1985, pp19-20.

10. DHSS (1962) "A Hospital Plan for England and Wales" Cmnd 1604, London; HMSO; DHSS (1963) "Health and Welfare. The Development of Community Care" Cmnd 1973, London; HMSO; DHSS (1966) "Health and Welfare. The Development of Community Care" Cmnd 3022, London; HMSO; DHSS (1976) "Priorities for the Health and Personal Social Services in England. A Consultative Document" London; HMSO; DHSS (1977) "Priorities in the Health and Social Services. The Way Forward" London; HMSO; DHSS (1981a) "Care in Action: a handbook of policies and priorities for the Health and Personal Social Services" London; HMSO.

11. Thus, community care has been promoted to ensure more swift and effective treatment, or as part of a broader preventative approach to need, Webb,A and Wistow,G point this out in Loney,M, Boswell,D and Clarke,J, Eds, (1983b) "Social Policy and Social Welfare" Milton Keynes; Open University Press, p215. 'Community care then should not be thought of only as a new approach to problems of treatment and care, but as a combination of economic, social and cultural measures which have as their objective both to take care of those already suffering from some handicap or defect but also to take care that as few people as possible become liable in the future to these same defects or handicaps. Prevention may be not only better than cure, but also better than care; we may be able to go so far as to say that if care is community care it can at the same time be an effective form of prevention' (Kuenstler P, Chapter 1, "Introductory Comments", pp7-13 in World Health Organisation (1970) op.cit., (reference 1), p13). The implications of adopting this approach are to justify a shift to primary health care services, thus the Audit Commission referred to community care as involving 'The movement of health services out of hospital settings into more local, domestic settings' (Audit Commission to Local Authorities In England and Wales (1986) "Making a reality of Community Care" London; HMSO, p10). In terms of financial cost, up to the 1970's community care was usually assumed to be cheaper. Thereafter, views on the cheapness of community care began to change, to that expressed by Brotherston - 'Community care is cheaper of course, but it is cheaper only because the services of the family are free and the

accommodation is free; it is not necessarily cheaper in terms of social cost' (Brotherston,J,B "Policies for the care for the care of the elderly", pp14-23 in Kinnaird,J, Brotherston J B and Williams J, Eds (1981) op,cit,, (reference 7), p21).

12. Bayley argued that community care as a positive principle - "an explicit and recognisable policy with that name" - dates from the 1961 Annual Conference of the National Association Of Mental Health (See Bayley,M (1973a) op,cit,, (reference 1), p5). A Conservative Party pamphlet referred to 'the new emphasis on community care' in 1973 (Conservative Research Department (1973) "Cash and Care", 12th February 1973, Notes on Current Policies, No 3, London: Conservative Central Office, p45).

13. Walker says: 'With the concept of community care so enlarged as to include all types of formal care and treatment,,,Planning for community care thus became primarily directed to co-ordination between services, not major shifts of resources from one to another' (Walker,A (1983) "A Caring Community", Chapter 11, pp157-172 in Glennerster,H, Ed, "The Future of the Welfare State" London: Heinemann, p160); 'Community care has also been taken to include certain types of residential (communal) and hospital care, which are seen to be part of the supportive network within the community,,,community care is a philosophy in which the starting point of the service is the patient/client and his needs rather than administrative boundaries and the needs of organisations' (Personal Social Services Council/Central Health Services Council (1978) "Collaboration in Community Care - A Discussion Document" London: DHSS p7, 48); 'It is no good in a complex urban society,,,thinking of community care as simply care at home; we have to see care as a total package, as a continuum. It is quite artificial to think of community care just as keeping people at home, that simply will not do,,,It is essential to see a whole range of provision; it is also important to provide a choice' (Bayley,M (1982) "Community Care and the Elderly" in Glendenning,F, Ed, "Care in the Community: Recent Research and Current Projects" Stoke-on-Trent: Beth Johnson Foundation, Department of Adult Education (University of Keele) and Age Concern England, p35); 'we should stop using community care as if it were an alternative to residential care, and work towards an integrated and flexible range of services, both domiciliary and residential, which will,,,offer,,,the appropriate form of help at the right time' (Bell,K M (1965) op,cit,, (reference 3), p433); '"Community Care" does not only mean extra-mural services provided outside hospitals, or methods of avoiding sending people to hospital ,,,The patient must be offered a spectrum of integrated services, from full-time permanent care in an institution to occasional support for himself or his family at home' (Freeman,H, (1969) op,cit,, (reference 1), p560); 'Institutional and community care are not mutually exclusive alternatives' (Packwood,T

in Anderson D C, Ed, (1970) op,cit,, (reference 1), p75); 'The prevention of hospital admission is not an adequate aim for community care, The value of hospital is being rediscovered and it is now recognised that local hospitals at least are themselves part of the community and its services,,,Care or treatment at home is not necessarily preferable to care in hospital' (Bennet D in World Health Organisation (1970) op,cit,, (reference 7), pp91-92), From another perspective it was argued that 'It should not be assumed that old people are better off, or happier in their own homes; for some a residential home may be therapeutic or at least more satisfactory than a lonely, isolated existence in a cold, deteriorated house' (Brearley,C,P (1975) "Social Work, Ageing and Society" London: Routledge and Kegan Paul, p101), See also reference 35,

14. For example, Packwood argues that 'Institutionalism is acceptable where it is seen as temporary and as necessary for the resumption of normal life' (Packwood,T, in Anderson D C et al, Eds, (1980) op,cit,, (reference 1), p68), Walker refers to a 1927 Royal Commission which referred to community care to include all forms of care 'which it is appropriate for the local health or welfare authorities to provide' (Walker,A, (1983) op,cit,, (reference 13), p158), In terms of a network of services, community care is defined as including hospital and institutional care (Spencer J, "The caring community; a summary of main themes", pp164-169 in World Health Organisation, (1970) op,cit,, (reference 1), p164); see also Personal Social Services Council/Central Health Services Council (1978) op,cit,, (reference 13), p7), Likewise, see the comments by Bell at reference 13 above, More recently, the Audit Commission referred to community care as involving 'the bringing of services to people, rather than people to services; and the adjustment of services to meet the needs of people, rather than the adjustment of people to meet the needs of services' (Audit Commission, (1986) op,cit,, (reference 11), p10), By comparing the philosophy and objectives outlined in the PSSC, document "Living and Working in Residential Homes" (1975) with the general philosophy of community care, it can be seen that both 'community'-based and residential services have common service principles,

15. See Bayley,M, (1973a) op,cit,, (reference 1), especially Chapter 1 (pp1-23) and Chapter 19 (pp312-344), Allsop,J (1984) op,cit,, (reference 1), makes other distinctions between care 'in and care 'by' the community (pp108-109),

16. See Bayley,M in Glendenning F, Ed (1982) op,cit,, (reference 13), p35,

17. See, for example, the paper by Morrison R,M (1965) "The Price of Mental Health" in Proceedings of the National Association for Mental Health Annual Conference, February 25th and 26th, 1965, London: National Association for Mental Health, Morning Session Friday 26th February, pp54-60,

18. Bayley,M (1982) op,cit,, (reference 13), p35 (italics in original), See reference 16,

19. Bayley,M (1982) op,cit,, (reference 13), p35 (italics in original),

20. Walker,A, Ed,, (1982) "Community Care, The Family, the State and Social Policy" Oxford; Basil Blackwell and Martin Robertson, p4, italics in original,

21. Derricourt,N,J (1983) "Strategies of Community Care" pp 270-285 in Loney,M, Boswell D & Clarke J, Eds (1983) op,cit,, (reference 11), see p270,

22. Walker,A, Ed,, (1982) op,cit,, (reference 20), p5, italics in original,

23. Walker,A, Ed,, (1982) op,cit,, (reference 20), p4,

24. Walker,A, Ed,, (1982) op,cit,, (reference 20), p5,

25. Walker,A, Ed,, (1982) op,cit,, (reference 20), p5,

26. Walker,A, Ed,, (1982) op,cit,, (reference 20), p6,

27. Abrams,P (1978) "Community Care: Some Research Problems and Priorities" pp78-99 in Barnes,J and Connelly,N, Eds (1978) op,cit,, (reference 3), p78,

28. By and large, the assumptions of Abrams, Walker and Derricourt, are that community care happens outside closed institutional settings, Thus, May writes that community care is 'the provision of adequate care and treatment,,,without admission to hospital or institution in the best interest of the patient and his associates' (May,A,R (1964) "Principles Underlying Community Care" in Freeman,H, Ed, "Psychiatric Hospital Care", Chapter 13, pp112-122, London; Balliere, Tinndall and Cassell, see p112), See also reference 8 above and 32 below and Elkan,S (1967) op,cit,, (reference 1); Allsop,J (1984) op,cit,, (reference 1); Gladstone,D (1981) "Community, co-ordination and collaboration; some themes in policy for the mentally handicapped", Chapter 10, pp172-190 in Jones,C "The year book in Social policy In Britain 1980-1981" London; Routledge and Kegan Paul,

29. For example, see Wheeler,R (1982) "Staying Put; A New Development in Policy?" in "*Ageing and Society*" Vol 2, Part 3, pp299-330,

30. For example, see Johnson,M and Challis,D in DHSS, Ed (1983) op,cit,, (reference 5) who describe community care as activities performed 'by professionals working **outside** formal residential settings', p93, emphasis is mine,

31. Thus, Isaacs et al write that 'The expression "community care" is applied to the services available **outside** hospital to people who need help, other than financial, to enable them to live a satisfying life' (Isaacs,B, Livingstone,M and Neville,Y (1972) "Survival of the Unfittest" London; Routledge and Kegan Paul, p84, emphasis is mine),

32. Johnson writes that 'The term community care is in its principal historical meaning a suitably emotive label which indicates the provision of services outside institutions' (Johnson M L (1982) op,cit,, (reference 5), p1, See references 8 and 28,

33. Thus, if the prime goals of community care were to pursue care and treatment which was client-centred, involved choice and freedom etc, progressive institutional care could be part of a 'community care' service offered.

34. Hawks wrote that community care took the form of 'almost total rejection of long-term institutional care of any kind' (Hawks,D (1975) op,cit,, (reference 5), see p276). Packwood emphasised that 'Institutionalism is acceptable where it is seen as **temporary** and necessary for the resumption of a normal life' (Packwood, T in Anderson D C, Ed, (1980) op,cit,, (reference 1), p68, emphasis is mine). See reference 5.

35. Community care as a policy of comprehensive local service could include residentiual care. Olsen sees residential care as 'a significant cog in,,,total provision,,,part of the total community resource' in Wing,J,K and Olsen,R, Eds, (1979) "Community Care for the Mentally Disabled", Oxford; Oxford University Press, p165. Much earlier Aves writes of residential homes as 'a vital and most important part of community service. They are not something apart' in Slack,K,M, Ed (1964) "Some aspects of Residential Care for the Elderly", London; National Council of Social Service, p12; community care 'does not set out to exclude the hospital and institution from the framework of services, but rather to consider how the institutions can be organised as part of a much wider network of systems of care including both neighbourhood and family' (Spencer J C in World Health Organisation, (1970) op,cit,, (reference 14), p164, emphasis in original); 'Rather than reflecting a policy of de-institutionalisation, therefore the concept of community care has been broadened to encompass residential institutions,,,(community care),,,includes institutional treatment, institutional care and community treatment' (Walker,A (1981) op,cit,, (reference 1), p547, brackets mine). See also reference 13 above. Hobman writes that 'Residential care should, however, be reagrded as an aspect of care within the community' (Hobman D in Kinnaird J et al, Eds (1981), op,cit,, (reference 7), p29).

36. Hospitals which provide short-term care, rotational care or shared care maintain the possibility of a client's long-term future in the community. Titmuss said community care 'if it is to be a reality for many people it must must start in the hospital' (Titmuss,R,M (1961) "Community Care - Fact or Fiction?", Morning Session, Second Day of Proceedings of 1961 National Association of Mental Health Annual Conference entitled "Emerging Patterns for the Mental Health Services and the Public", London; National Association for Mental Health, p67). Hoggett writes that 'Hospitals are of course part of the community' (Hoggett,B (1976) "Mental Health", London; Sweet and Maxwell, p161); 'The value of hospital is being rediscovered and it is now recognised that local hospitals at least are themselves part of the community and its services' (Bennett D in World Health Organisation (1970) op,cit,, (reference 13), p91).

37. Community care was defined as total care 'provided by the service most appropriate to the patient's needs, regardless of administrative boundaries and definitions' (Personal Social Services Council/Central Health Services Council, (1978) op.cit., (reference 13), p7, also p48); community care for the mentally ill was 'a variety of services, both clinical and social, which provides a range of care from the in-patient bed...to the visit of the mental welfare officer', because they took as vital the provision of a 'flexible responses' to mental health needs and the availability of a 'muliplicity of tactical choices' (Rehin,G,F and Martin F,M (1968), op.cit., (reference 1), p211); a DHSS publication states that in terms of community care, 'the primary aim is a service in settings more appropriate to the needs of the individual being cared for' (DHSS (1981b) "Care in the Community - A Consultative Document on Moving Resources for care in England" London: HMSO, para 7,1); '"Community Care" is about changing the balance of services and finding the most suitable placement for people from a wide range of options. It is not about imposing a community solution as the only option, in the way that institutional care has been the only option for many people in the past (Audit Commission (1986) op.cit., (reference 11), pp1-2). Abrams argued that 'Community care must be understood as a complement not as an alternative to other forms of social care. It may be seen as the base on which the more specialised forms of provision build or as the ideal which the more specialised forms underpin and sustain. But from either point of view the meshing together of community care and other forms of provision seems bound to become a major issue for policy...' (Abrams,P (1978) in Barnes J and Connelly,N, Eds, op.cit., (reference 3), p79); '"Community Care" does not mean merely extra-mural services provided outside hospital, or methods of avoiding sending people to hospital ...The patient must be offered a spectrum of integrated services, from full-time permanent care in an institution to occasional support for himself or his family at home' (Freeman,H (1969) op.cit., (reference 1)). Jones K et al argue similarly that 'The hospital, no less than the local authority home or hostel, is part of the community care spectrum rather than being set over against it...The emphasis is much more on seeing what kind of care for what kind of patient/residents/client in what kind of circumstances is most appropriate' (Jones K, Brown J and Bradshaw J (1983) "Issues in Social Policy", Revised Edition (1st Edition, 1978), London: Routledge and Kegan Paul, Chapter 6 "Community Care", pp102-115, see p113).

38. DHSS (1981c) "Report of A Study on Community Care" London: HMSO, paras 2,1-2,4, pp7-9.

39. Individualistic and community stances can conflict. It was pointed out by one author, for example, that 'In debating the virtues of routine visiting there are many who fear that individual freedom and privacy may be restricted by the over-zealous organisation

of welfare' (Townsend,P (1975) "Sociology and Social Policy" London; Allen Lane, p74),

40. Stevenson stated that 'Caring for the carers thus becomes a central plank in community care' (26th Eleanor Rathbone Memorial Lecture, 4th November, 1980 - "The Realities of a caring community", Liverpool; University of Liverpool, p11), The government's White Paper stated that 'The government sees the primary role of public services as an enabling one, helping people to care for themselves and their families by providing a framework of support' (DHSS (1981d) "Growing Older" Cmnd 8173 London; HMSO para 6,10); 'Government puts increasing emphasis on the supportive, supplementary and specialist functions of state provided care. They are to be seen as an adjunct to care which exists in the community in great measure, both in its informal and more organised forms' (Johnson,M L and Challis,D in DHSS (1983) op,cit,, (reference 5), p109), As the Secretary of State for Social Services put it, 'Central government, local government, health authorities, voluntary bodies, and, not least, employers and the general public must all recognise the full burdens being borne by caring relatives. They should be ready to offer practical help and support. Services provided for elderly people,,,must take account of the needs of carers' (Fowler,N (1982) Speech to Age Concern, 11th May, 1982), The point has been made that 'more fundamentally, the helping professionals need to see their task as being to support the informal and generally local help being given, rather than the other way round. The community can care. It is up to the professional helpers and helping services to help it to do so' (Bayley, M (1973b) "The community can care" in *"New Society"*, 25th October 1973, pp207-209, see p209), A Conservative Party pamphlet recorded that, in terms of the elderly mentally infirm, 'The main objective of community care must therefore be to support,,,families as well as sustaining those without families' (Conservative Political Centre, (1981) op,cit,, (reference 8), p23); an earlier Conservative pamphlet made a similar point in a section entitled the new emphasis on community care; 'In the past, much of the burden of care fell upon the family alone. Now, the Social Services can relieve or support a family in need' (Conservative Research Department, (1973) op,cit,, (reference 12), p45),

41. See Walker,A, Ed, (1982) op,cit,, (reference 20), pp32-34,

42. Ten years later, the collaboration of the environmental health, employment training services, police and supplementary benefit authorities were called a 'prerequisite for community care' (Personal Social Services Council/Central Health Services Council, (1978) op,cit,, (reference 13), p48),

43. Boyson R (1975) in Butterworth,E and Holman,R, Eds, "Social Welfare in Modern Britain" Glasgow; Fontana/Collins, p384,

44. Townsend,C (1981) "Helping Others to Help Themselves" London; Conservative Political

Centre, p23.

45. Williams,I (1979) "The Care of the Elderly in the Community" London; Croom Helm, p94. Self help/self care is a prominent feature of community care philosophy. Much of this emphasis is expressed in the notion of independence; 'The major objective in planning services for the elderly must be to promote and to prolong their maximum independence. The best way to have people looked after is to keep them capable of looking after themselves' (Brotherston J B (1981) in Kinnaird J, Brotherston J B and Williams J, Eds op.cit., (reference 11), p14); 'there has also been a recent revival of the concept of community care, under a new guise - that of self-care as a way of reducing the social costs of the health services' (MacIntyre (1973) in Dingwall R, Health C, Reid M and Stacey M, Eds, op.cit., (reference 7), p57). The Audit Commission stated that 'The change to a community-based service,,,involves a change of approach, with emphasis and priority placed on encouraging patients and clients to do as much for themselves as possible (an 'enabling' service), with 'care' provided only where it is really needed' (Audit Commission (1986) op.cit., (reference 11), p11, brackets in original). Entwined with the notion of self-help is the idea of independence; to help oneself is to maintain one's autonomy. Thus, 'A central aim of most policies - central and local - is to preserve or restore the independence of elderly people' (Tinker,A (1983) in DHSS, Ed, op.cit., (reference 5), p53). The notion of independence, however, is difficult to define, and can be problematic in terms of its application, see reference 88 below.

46. See Bayley,M (1973b) op.cit, (reference 40); Henwood,M and Wicks,M (1984) "The forgotten army: family care and elderly people", London; Family Policy Studies Centre; Moroney,R,M (1976) "The Family and the State: Considerations for Social Policy" London; Longmans; Isaacs,B, Livingstone M and Neville Y (1972) op.cit., (reference 30). This principle has been espoused over many years, for example, 25 years ago it was stated that 'One thing is certain - the care of old people will always remain largely a family matter. The role of the community, local and national, is to assist the family to fulfill its wished-for roles and responsibilities however they may develop in future years' (Richardson, I,M (1964) "Age and Need" Edinburgh; Livingstone, p120).

47. "Report of the Committee on Local Authority and Allied Personal Social Services", Chairman; Seebohm F, Cmnd 3703, London; HMSO, p270 (para 294).

48. Walker,A (1981) op.cit., (reference 1), p549.

49. As indicated earlier on in this Chapter, the underprovision of certain residential and institutional services necessarily led to more care in the community; although the quality of 'care' was highly questionable, because although residential places were on the decline there was no corresponding increase in community-based facilities. Lappin

refers to community care as 'a myth which puts more patients at risk than can be rehabilitated and more strain on families than they can reasonably be expected to cope with' (Lappin A (1970) op,cit,, (reference 1), p589).

50. See, for example, the comment made over 20 years ago, where Bell says that 'one of the first principles of social policy must be to develop community services which strengthen and support the extended family system' (Bell,K M (1965) op,cit,, (reference 3), p424). See also reference 40 above.

51. See Tinker,A (1984a) op,cit,, (reference 1), Chapter 10.

52. Shaw,J (1971) "On our Conscience - the Plight of the Elderly", Harmondsworth: Penguin, p139. This was reiterated by the DHSS in 1978: 'There is no doubt that active participation from the community as a whole will be necessary if the concept of community care is to be fully realised' in Barnes,J and Connelly,N, Eds (1978) op,cit,, (reference 3), p10.

53. Conservative Research Department (1970) "Serving the Old" Old Queen Street Paper No, 13, 21st January 1970, p8.

54. Townsend,C (1981) op,cit,, (reference 44), p6.

55. Jones,K, Brown J & Bradshaw J (1983) op,cit,, (reference 38), p112.

56. Goldberg,E,M and Connelly,N (1982) "The Effectiveness of social Care for the Elderly" London: Heinemann, p45 (see Chapter 2, "Recent Trends in Community Care" pp40-50). Similarly, Scull called the movement to community care 'a leap of faith' (See Scull,A in Bean,P, Ed, (1983) "Mental Illness: Changes and Trends" Chichester: John Wiley, p335); Earlier, Bell had called it 'an article of faith' (Bell,K M (1965) op,cit,, (reference 3), p419); 'the concept of the caring community is a myth and,,,saying that the community must care for its elderly,,,is a device for evading responsibility for those patients' (Richards,C (1981) "Old people and the myth of community care" in *World Medicine* Vol 16,'Part 13, 4th April 1981 pp35-39, see p36). Abrams stated that 'there can be little doubt that extensive and effective community care is uncommon and improbable in our type of society' (Abrams,P (1978) in Barnes J and Connelly,N, Eds, op,cit,, (reference 3), p79). The Audit Commission was candid: 'care in the community is far from being a reality in many places,,,Progress has been slow and uneven across the country; and the near-term prospects are not promising. In short, the community care policy is in danger of failing to achieve its potential' (Audit Commission (1986) op,cit,, (reference 11), p2,13).

57. Webb,A and Wistow,G (1983) in Loney,M, Boswell D & Clarke J, Eds, op,cit,, (reference 11), pp214-215.

58. Kuenstler commented that 'Community care,,,should not be thought of only as a new

approach to problems of treatment and care,,,but also to take care that as few people as possible become liable to,,,defects and handicaps,,,if care is community care it can at the same time be an effective form of prevention" (in World Health Organisation, op,cit,, (reference 11), p13),

59, These range of policies are similar to what Webb and Wistow call 'service policies' (see Webb,A and Wistow,G (1982) "Whither State Welfare. Policy and Implementation in the Personal Social Services, 1979-1980" R,I,P,A Studies No 8, London; RIPA, p14),

60, See the Chapter by MacIntyre,S in Dingwall R, Health C, Reid M and Stacey M, Eds, (1973) op,cit,, (reference 7),

61, Quoted in Allsop,J (1984) op,cit,, (reference 1), p109,

62, Quoted in Packwood,T in Anderson D C, Ed (1980) op,cit,, (reference 1), p67,

63, See MacIntyre S (1973) in Dingwall R, Health C, Reid M and Stacey M, Eds, op,cit,, (reference 7) speaks similarly of an 'organisational perspective' which seeks to reduce social and economic costs of caring to the community, Webb A and Wistow G (1982) op,cit,, (reference 59) refer to 'resource policies' in the personal social services, which are concerned with the range, level and distribution of public funds (p14),

64, Hawks,D (1975) op,cit,, (reference 5), p276,

65, This is a feature of what Webb and Wistow call 'governance policies' - policies which define the role of the State, central and local government, statutory and non-statutory services, the organisation and management of service (see Webb,A and Wistow,G (1982) op,cit,, (reference 59), p14, pp31-34),

66, Compare Webb,A and Wistow,G (1982) op,cit,, (reference 59), p14, pp53-55 - their service/output policies,

67, This has been argued by Hall,P, Land,H, Parker,R and Webb,A (1975) in "Change, Choice and Conflict in Social Policy", London; Heinemann, see p490,

68, See MacIntyre S (1973) in Dingwall R, Health C, Reid M and Stacey M, Eds, op,cit,, (reference 7), p52,

69, Tinker,A (1984b) "Staying at Home, Helping Elderly People" London; HMSO, page 5 para 1, Allsop confirms - 'The general overarching objective of community care has been to maintain individuals in their own homes wherever possible' (Allsop,J (1984) op,cit,, (reference 1), p108),

70, Thus Townsend quotes the Minister of Health in 1958,'the underlying principle of our services for the old should be this; that the best place for old people is in their own homes with help from the home services if need be' (Townsend,P (1964) "The Last Refuge" London; Routledge and Kegan Paul, p196),

71, This has been emphasised on and off from the late 19th Century onwards, Yet as early as

1947 it was 'pointed out that the provision of domiciliary services when added to the cost of old age and supplementary benefit may often raise the cost of preserving the independence of old people much above the cost of care in Home or Institutions' (Nuffield Foundation (1948) "Old People: Report of a Survey Committee on the Problems of Ageing and the Care of Old People", *B,S Rowntree (Chairman)*, 1st printed 1947, Published for the Nuffield Foundation by Oxford University Press, pp49-50),

72. For example, the reports of Miss Mason in the Annual Reports of the Local Government Board (see Chapter One); the emphasis of the Curtis Committee (Home Office (1946) "Report of the Care of Children Committee" Cmd 6922, London: Home Office); the Seebohm Report op,cit,, (reference 47); the work of John Bowlby and Jack Tizard in the 1950's and 1960's,

73. Since, 'to remain in a familiar and personally controlled environment, in touch with the everyday concerns and demands that make up 'normal living', is beneficial to the individual, It promotes motivation and mobility, interest, independence and self-determination; qualities which are associated with achieving health or resolving social difficulties' (Packwood,T (1980) in Anderson D C, Ed, op,cit,, (reference 1), p67, my emphasis); 'The activity and decision making of life at home provide a physiotherapy and occupational therapy which it is almost impossible to recreate' (Muir Gray J,A and Graves J (1976) "What hope for the elderly in 1984?" in *CHC News*, July 1976, No 9, pp6-7), Meacher describes the family circle and network of friends and neighbours as a 'therapeutic framework' and a 'powerful preventative therapy' (Meacher,M (1970) "The old; the future of community care" in Townsend,P, Ed, "The Fifth Social Service: a critical analysis of the Seebohm Proposals" London: Fabian Society p80-109, see p102 and p106 for quotes); Klein speaks of the community being seen as a source of mental health 'ensuring the self-development, safety and fulfilment of all its citizens' (Klein D,C (1968) "Community Dynamics and Mental Health" New York: Wiley),

74. May says; 'One object of community care is to give the patient the support of community life, and to avoid segregating him from normal social contacts' (May A,R in Freeman,H, Ed (1964) op,cit,, (reference 28), p112), See reference 73 above and 75 below,

75. The argument is that people benefit from normal social interaction and social exchange - community care 'rests on an ideal that individuals have a right to life which is as "natural" or "normal" as possible in terms of the social context in which most of us have been born, reared and spent our adult lives (O,Stephenson (1980) op,cit,, (reference 40), p9); community care is 'to do with sustaining individuals in need of support in their own homes and therefore within that network of people, places and things which are familiar and comfortable to them' (Johnson,M and Challis,D in DHSS, Ed

(1983) op,cit,, (reference 5), p94). Tinker argues that the movement away from institutional care was based on a 'growing recognition that people had a right, where possible, to live among ordinary people in society and not to be in a separate institution. The institution was seen as a barrier to normal living" (Tinker A (1981) op,cit,, (reference 1), pp37-38).

76. Thus, Brearley speaks of a continuum of care along which each old person has a right to be at a point appropriate to his/her own needs, but 'It should not be assumed that all old people are better off, or happier, in their own homes; for some a residential home may be more therapeutic or at least as satisfactory than a lonely, isolated existence in a cold, deteriorated house, without the money to improve conditions' (Brearley,C,P (1975) op,cit,, (reference 13), p101). See also references 13 and 37.

77. For example, in terms of the range of the appropriate range of services offered, community care is described as a form of care which 'does not set out to exclude the hospital and institution from the framework of services but rather to consider how the institutions can be organised as part of a much wider network of systems of care' (Spencer J C in World Health Organisation, (1970) op,cit,, (reference 35), p164, emphasis in original). See also references 13, 34-37 inclusive in general.

78. Thus, in terms of continuity, 'If elderly people are to remain safely and happily in their own homes, it is important that the various community services should work more closely so as to provide continuity of care without duplication or gaps,,,the provision of community care depends on co-ordination and collaboration among various individuals, organisations and professional groups' (Personal Social Services Council/Central Health Services Council (1978) op,cit,, (reference 13), p14, 48).

79. For example, appropriate care 'depends on the balance between the medical and social needs and also the possibilities of whether either or both of these can be effectively provided for in his own home' (Williams,I (1979) op,cit,, (reference 45), p68). On this basis, the argument can be extended - what is appropriate in terms of social needs, may not be appropriate from the perspective of medical needs - perspective of needs may be complementary, but they may also be conflicting.

80. Brotherston comments 'When does the provision of services in the community to keep the old person at home become non-productive or counter-productive? It is not merely an economic issue; there are also questions of social costs. It is possible so to prolong the community responsibility of a family with an elderly person as to lead to a breakdown of the family,,,there is undoubtedly a point at which community care ceases to be the right answer' (Brotherston,J Bin Kinnaird,J, Brotherston J B & Williams J, Eds (1981) op,cit,, (reference 11), p21); 'If community care is to be effective it must

keep the right people out of institutions, and it must do so without creating more misery than it prevents' (Isaacs,B, Livingstone M and Neville Y (1972) op,cit,, (reference 31), p91),

81. So, it may be that a range of considerations are weighed in determining client 'treatment', however, the basis on which those considerations are appropriately compared is unclear; 'Care or treatment at home is not necessarily preferable to care in hospital. Every environment must be judged on its own merits in terms of the effect it has on patient's behaviour and clinical condition, as well as the effect of the patients' behaviour on those with whom he lives and works' (Bennet D in World Health Organisation, (1970) op,cit,, (reference 7), p92), See reference 7 in general.

82. For example, just taking a single key principle of community care policy - to maintain the independence of people for as long as possible - the complexity of implications of pursuing this principle alone are teased out in some detail in reference 88 below. Clearly, as the text and Table in this Chapter indicate, the different philosophical approaches used to underpin community care can also conflict, in that they suggest a range of perceptions of need, and solutions to those needs, a range of priorities and cardinal principles to be upheld. For example; 'The apparently simple commitment to community care in fact conceals a variety of different policies with disparate and possibly contradictory planning implications. Different perspectives variously emphasise client need; the redistribution of state expenditure (between for example, health services and personal social services) and the optimal use of resources. None of these are necessarily compatible' (Henwood,M and Wicks,M (1984) op,cit,, (reference 46), p3). The dilemma of this position is that there is an apparent widespread support on the virtue of community care policy, masking widespread dissensus. This point has been recently made; 'Beyond the recognition that the days of the largest hospitals are over, there is nó consensus on community care. One of those who submitted evidence to us were oppposed to the basic principles of community care' (House of Commons (1985a) op,cit,, (reference 1), para 28, pxvii),

83. DHSS (1981c) op,cit,, (reference 38), para 2,4, pp8-9,

84. This view is typified in the following statement; 'To the politician, "community care" is a useful piece of rhetoric; to the sociologist, it is a stick to beat institutional care with; to the civil servant, it is a cheap alternative to institutional care which can be passed to the local authorities for action - or inaction; to the visionary, it is a dream of the new society in which people really do care; to social services departments, it is a nightmare of heightened public expectations and inadequate resources to meet them,' (Jones,K, Brown J and Bradshaw J (1983) op,cit,, (reference

38), p102). Thus, '"Community care" is a multi-purpose phrase which means difeerent things to different people and in different contexts' (House of Commons (1985) op.cit., (reference 1), Vol 1, para 2, p2); 'Community care has been a major policy objective for many years, underwritten and supported by a considerable degree of political consensus; a policy which apparently unites politicians; planners; professionals and a wide range of pressure groups, It has been a conspicuous objective of both Conservative and Labour governments since the second world war,,,The term "commmunity care" has been assimilated (largely uncritically) into current policy jargon, whilst precise objectives and understanding of both the term and its implications remain elusive' (Henwood,M and Wicks,M (1984) op.cit., (reference 46), p3, brackets in original).

85. Thus, for example, as Chapter One and Three have shown, both institutional and community care have been promoted for the same reasons; individual health and well-being. Similarly the move away from the two broad types of care has been sought on the basis of the harm done to individuals being cared for.

86. See Walker,A in Glennerster,H, Ed, (1983) op.cit., (reference 13), p159.

87. Scull,A (1984) op.cit., (reference 5), p162.

88. See for example, Elkan,S (1967) op.cit., (reference 1), pp282-284. Exploring this idea, below are some examples of how the notion of 'independence' has been interpreted and understood as a key principle of community care policy. To begin with, in terms of independence, what kind of independence sought, up to which point should independence be maintained (see reference 79 above). Thus, on the one hand is the promotion of independence: 'The major objective in planning services for the elderly must be to promote and prolong their maximum independence. The best way to have people looked after is to keep them capable of looking after themselves' (Brotherston,J Bin Kinnaird,J, Brotherston J B and Williams J, Eds (1981) op.cit., (reference 11), p14); 'A central aim of most policies - central and local - is to preserve or restore the independence of elderly people' (Tinker,A (1983) "Improving the quality of life and promoting independence of elderly people", Chapter 4, pp47-68 in DHSS, Ed (1983) op.cit., (reference 5), p53). But this view can be applied differently; 'the objectives of maintaining independence for as long as possible are clearly established. The trouble is how to do it; the central dilemma is how to have a personal and careful assessment of need, and then to present in a co-ordinated way the help considered to be right for that person at that time and yet avoid the creation of dependency by limiting choice to the individual concerned' (Gatherer,A,A in Shegog,R,F,A, Ed, (1981) "The impending crisis in old age. A challenge to ingenuity" Oxford: Oxford University Press, p55); 'older persons should not be pressurised to act more independently than they are

able to,,,Too frequently we assume that independence, capacity to function autonomously, and self-help are unquestionable virtues, while dependency, especially on the government or on institutional care as opposed to one's self or kin or peers is a matter to be embarrassed about or ashamed,,,Such a strong emphasis on independence is excessive' (Etzioni,A (1977) "Old People and Public Policy" in Reisman,F, Ed, (1977) "Older Persons", Sage Contemporary Social Science Issues No 40, London; Sage Publications pp38-51, see p40); 'The objective is not to assert independence as preferable to dependence - a common assumption, It is to work out a balance which is right for each individual and to do as little as possible through our social institutions to undermine aspects of independence which are valued by the old person concerned' (Stephenson,O (1984) "Caring and Dependency", Chapter 7, pp128-142 in Hobman,D, Ed "The Impact of Ageing: Strategies for Care"), London; Croom Helm, p141), As Brearley asserted, 'the old person's right to independence must not blind us to their right to be dependent - to interact with and be supported by others' (Brearley,C,P (1980) "Welfare Goals" in Dickenson,M, Ed, "Living in the 80's. What Prospects for the Elderly?" Published Papers from Age Concern Seminar in Oxford 1979, Mitcham; Age Concern England, pp6-27, see p10), Brearley put this view elsewhere; 'The current approach to providing care for the elderly is based on the assumption that all older people have a right to remain independent, It is not always plain what is meant by 'independence', Often it seems to refer to the right of an individual to remain in his own home for as long as possible,,,In another sense, to remain in her own home may give,,,a greater sense of self-direction and control over life activities,,,A more suitable word than independence might be individuality, To maintain individuality the elderly client has a right to a degree of self-determination, in so far as his wishes and needs are compatible with those around him, and a right to dignity and respect' (Brearley,C,P (1975) op,cit,, (reference 13), p6), Similar difficulties are encountered when examining the concepts of client choice and rights,

89, Clarke,M (1976) "Community as Dustbin" in *New Society*, 29th July 1976,

90, Clarke,M (1982) "Where is the Community which cares?" in *British Journal of Social Work*, Vol 12, pp453-469, see p463, For similar sentiments, see the article by Lappin,A (1970) in *New Society* op,cit,, (reference 1),

91, Richards,C (1987) op,cit,, (reference 56), see p39,

92, For an explication of the notion of banner goals, see Algie J (1975) "Banner Goals and Social Scenarios", Chapter 2, pp21-46 in "Social Values, Objectives, and Action", London; Kogan,

Appendix A: Notes and References to Chapter Four

1. Seebohm F, Chairman, (1968), "The Report of the Committee on Local Authority and Allied Personal Social Services", Cmnd 3703, (The Seebohm Report), London; HMSO, Chapter XVI,
2. Aves G,M, Chairman, (1969), "The voluntary worker in the social services", (The Aves Report), London; Bedford Square Press and George Allen and Unwin,
3. Hansard (1971), "Parliamentary Debates, House of Commons", 1970-71, Vol 809, November 29th to December 4th, Col 847,
4. See also Circulars 19/71 and 53/71 which encouraged the growth of these services plus recreation facilities, information, advice, transport and boarding out services,
5. DHSS (1976a) "Priorities for Health and Personal Social Services in England: A Consultative Document", London; HMSO, para 1,2, p8,
6. Glennerster H (1983), "Planning for Priority Groups", Oxford; Martin Robertson, p57, emphasis in original,
7. DHSS (1971a), "National Health Service Reorganisation: Consultative Document", London; HMSO, p13,
8. DHSS and Welsh Office (1973), "Reorganisation of the National Health Service and Local Government in England and Wales. A report from the Working Party on Collaboration between the NHS and Local Government on its activities to the end of 1972", London; HMSO, para 1,1,
9. ibid,, paras 5,57 - 5,61,
10. DHSS and Welsh Office (1974), "Reorganisation of the National Health Service and Local Government in England and Wales. Report from the Working Party on Collaboration between the NHS and Local Government on its activities from July 1973 to April 1974", London; HMSO, para 6,4, brackets in original,
11. So said the DHSS in its memorandum of evidence to the Public Expenditure Committee in 1972 (reference at end of para), The memo speaks of 'differing professional views' as to the aims and objectives of services for the elderly (para 11) and says 'General aims for the services can be formulated in terms such as "to enable the elderly to maintain their independence and self-respect"'; 'to enable them, so far as they are able and willing, to take part in and contribute to the normal range of social life of their community'; 'to enable them to live in their own homes for as long as they wish and are reasonably able to do so'; 'to provide for essential needs which the elderly, with the support of their friends and families, cannot meet for themselves'; 'to provide treatment and care of an appropriate standard for those suffering from chronic disabilities'; 'to restore patients with illness or disability to as heathy a state as possible', At this level of generality the possibility of conflict between the ideals

embodied in different aims arises, Thus, a chronically sick old person may wish to stay at home though he could be cared for more easily or economically in a residential home or hospital, It is necessary also to have general regard to the welfare of the old person's family when setting aims, and this can be in conflict with what is best for, or desired by, the old person himself', See House of Commons (1972), "Relationship of Expenditure to Needs', Minutes of Evidence to Public Expenditure General Sub-Committee by DHSS on 23rd May 1972 (Session 1971-72), pp3-4,

12. Tizard J and Grad J (1961), "The Mentally Handicapped and their families", London; Oxford University Press; See also King R,D, Raynes N,V and Tizard J (1971), "Patterns of Residential Care: Sociological Studies in institutions for handicapped children", London; Routledge and Kegan Paul,

13. DHSS (1971b), "Better Services for the Mentally Handicapped", Cmnd 4683, London; HMSO, see para 40 (ii), p9 & para 278, p57,

14. ibid,, para 40 (viii) & (xv), pp9-10, Contact with the wider community, beyond immediate family, was therefore very important; ibid,, paras 185-188, pp37-38; paras 277-278, 281 & 285-296, pp57-60,

15. ibid,, paras 40 (ix), p9; para 124, p28; para 264, p55, Thus, co-ordination was 'essential' and to be achieved through 'effective joint planning' (paras 264-265, p54),

16. ibid,, para 281, the title describes the voluntary sector as supplementary to the statutory sector, Bayley refers directly to this - see Bayley M (1973), "Mental Handicap and Community Care", London; Routledge and Kegan Paul, pp343-344,

17. DHSS (1971b) op,cit,, (reference 13), para 198,

18. DHSS (1972) "Services For Mental Illness related to Old Age", HM(72)71, London; HMSO, see paras 31-33, p8,

19. For example, adyice from central government (DoE Circular 88/75) emphasised the overriding importance of field and domiciliary services to the point of advising delays in commissioning, or even closing, residential homes, except for children, Further shifts in expenditure from the NHS to the personal social services were pursued subsequently through the 'Priorities' documents (see reference 36 below),

20. NHS Reorganisation Act, 1973, Section 10,

21. Castle B (1975) "Speech to the National Association of Health Authorities", 11th July 1975,

22. Castle B (1975) "Speech to the Local Authorities Association", 28th November, 1975, brackets mine,

23. DHSS (1975) "Better Services for the Mentally Ill", Cmnd 6233, London; HMSO, para 3 (p ii) and para 2,8 (p14),

24. The desired shift in expenditure between statutory authorities was noted (ibid., para 6, p ii); the reliance on community support was expressed later (ibid., para 2.24, p18). In general terms, the document stated that due to the need for financial stringency, the document was not to be applied so as to generate demands for higher levels of service, but rather that it was to be seen as a long-term strategy document (see paras 8-10, pp iii-iv).

25. Personal Social Services Council (1975), "Living and Working in Residential Homes", London; PSSC, para 42.

26. The disincentives for independent sector residential homes to exist, at a time when the frail elderly population was rising, put pressure, inevitably, on public sector part III accommodation, despite the desired policy shift towards domiciliary rather than residential services (see reference 19 above). The PSSC (op.cit., (reference 25)) was sceptical about the comparative cheapness of community care, as compared to residential care, stating that the latter 'may cost less than community care' (para 59). The document also pointed out that to develop services on an economic rather than a social care basis would undermine many existing principles of service provision (see p25).

27. PSSC (1975), op.cit., (reference 25), paras 50-51. Compare reference 11 above.

28. Thus, the document specifies the nature of, and the reasons for, residential homes policy (PSSC (1975), op.cit., (reference 25), paras 49-52). These are listed below, since they could have applied equally to community care policy.

a. Historically, policies and services responded to the interests of different groups and to the emergence of different needs through time, causing;

- lack of co-ordination between legislative measures;
- lack of co-ordination between provision for different groups.

b. Owing to the permissive nature of some legislation (and I would also add the lack of enforcement of mandatory duties of local authorities);

- implementation has depended upon the interpretation by local authorities of their duties, resulting in a lack of consistent national standards;
- variations in the extent of responsibility assumed by local authorities has led to a 'lack of fundamental ordering of priorities'.

c. Partly as a result of services responding to specific needs of different client groups, and partly due to the piecemeal development of policy;

- no fundamental philosophy exists on which to base provsion for individuals receiving care in the community;
- a comparable lack of stated or written objectives exist against which community care services should be provided;

- co-operation between statutory and voluntary organisations at national and local level are inhibited;
- the aims and objectives of particular services and their relationships to other services are often unstated, if not unknown, with the result that the roles of staff, and expectations of staff and clients, are confused, apparently conflictual, or lacking in specific purpose;
- the general public, similarly, has little precise understanding of the aims of this field of the personal social services,

29. PSSC (1975), op.cit., (reference 25), pp25-26.
30. DHSS and Development Group with Social Work Service (1976), "A Lifestyle for the Elderly", Report of a Seminar held 18-20th July 1974, London; HMSO, p36. Compare reference 11 above.
31. ibid., p39.
32. ibid., p38, brackets mine.
33. See H.M Treasury (1976), "Public Expenditure to 1979-80", Cmnd 6393, London; HMSO.
34. See H.M Treasury (1975), "Public Expenditure to 1978-79", Cmnd 5879, London; HMSO, brackets mine.
35. From the 1976 Public Expenditure White Paper, quoted in para 1.13 of the priorities document (see reference 36 below).
36. DHSS (1976a), op.cit., (reference 5), the Preface (p iii).
37. Thus, national guidelines were not imposed. Central government was to 'establish and promote certain essential national priorities, while the local agencies of government should have the maximum scope for making their own local choices in the light of their local needs' (DHSS (1976a), op.cit., (reference 5), Preface, p iii).
38. DHSS (1976a), op.cit., (reference 5), para 1 (p1) & para 5.14 (p41). A similar emphasis was put on the earlier White Paper on services for the mentally ill (DHSS (1975), op.cit., (reference 23), paras 11.16-11.17, p86).
39. DHSS (1976a), op.cit., reference 5, para 1.15, p11. This point was endorsed in the 1976 Circular, DHSS (1976b), "Joint Care Planning: Health and Local Authorities", Circular HC(76)18/LAC(76)16, March 1976.
40. DHSS (1976a), op.cit., (reference 5), para 9, p2; see also para 5.3, p38.
41. See, for example, (DHSS (1976a), op.cit., (reference 5), para 1.2, p8.
42. For example, primary health care was expanded to: (a) improve preventative and curative services for the elderly; (b) to allow for increased demand from the elderly; (c) to reduce demand on acute hospital services. (DHSS (1976a), op.cit., (reference 5), para 3.6, p17).

43. DHSS (1976a), op.cit., (reference 5), para 11, p3 (1st quote, see also para 4.16, p27); and para 1.2, p8 (2nd quote). This second point was reiterated for the elderly in particular - see para 5.3, p38.

44. DHSS (1976a), op.cit., (reference 5), para 5.11, p40.

45. Residential services were to be increased (see DHSS (1976a), op.cit., (reference 5), paras 5.18-5.19, p42), as well as some forms of hospital provision (see DHSS (1976a), op.cit., (reference 5), paras 5.20-5.25, pp42-44). In terms of the latter, services were to take the form of 'the promotion of a more active approach towards the treatment of the elderly in hospital' (DHSS (1976a), op.cit., (reference 5), para 5.3, p38). Thus, 'the elderly would benefit from the emphasis on community services and the aim of releasing acute hospital facilities for geriatric use' (DHSS (1976a), op.cit., (reference 5), para 12, p3) - more geriatric services and community hospitals.

46. DHSS (1976a), op.cit., (reference 5), para 10.4, p72. Elsewhere it was stated that 'the contributions - of time, ideas and money - that people voluntarily make to the running of the services will be more than ever important. Health and local authorities should give every support to voluntary bodies in their work of harnessing community effort' (DHSS (1976a), op.cit., (reference 5), para 1.23, p13).

47. DHSS (1976a), op.cit., (reference 5), paras 5.9-5.10, p40.

48. DHSS (1976a), op.cit., (reference 5), para 10.4, p72.

49. DHSS (1976a), op.cit., reference 5, para 10.13, p74.

50. Hansard (1976), "Parliamentary Debates, House of Commons", Vol 912, Fifth Series, Oral Answers, May 25th 1976, col 261.

51. See the Circular mentioned in reference 39.

52. DHSS (1977a), "Joint Care Planning: Health and Local Authorities", Circular HC(77)17/LAC(77)10, May 1977.

53. DHSS (1977b), "Conference on the Elderly: 26 July 1977. Background Paper", London: DHSS, para 8.

54. Services such as those provided by the voluntary sector, housing, transport, education services, town planning and income support schemes - ibid., paras 12, 54-77.

55. ibid., para 14.

56. ibid., see paras 48 & 50. It was added that the 'potential of voluntary effort can be maximised by greater collaboration between statutory and voluntary bodies' (para 50).

57. ibid., para 22.

58. ibid., para 39. Effective hospital treatment meant active treatment, rehabilitation and the use of community hospitals (see paras 32 and 43). Compare reference 45 above.

59. ibid., para 20.

60. DHSS (1977c), "Priorities in the Health and Social Services. The Way Forward", London; HMSO, para 2,7, p9.

61. For example, community service development 'will vary from place to place depending on economic restraints, local choice and differences in the existing levels of provision' - ibid, para 2,8, p9 (see also para 1,2, p1).

62. ibid,, para 2,1, p8.

63. ibid,, para 2,7, p9, brackets mine.

64. ibid,, para 2,10, p10.

65. That is, more active treatment and rehabilitation in general hospitals, plus the use of community hospitals where possible for long-term needs; ibid,, paras 2,15-2,17, pp11-12; 2,21, p14; 3,6-3,8, pp19-20. By now this theme was becoming quite common; see reference 58 and 45 above.

66. ibid,, para 2,11, p10.

67. ibid,, paras 2,11, p10; para 3,16-3,17, p26.

68. ibid,, para 2,8, p9.

69. ibid,, para 2,15, p11. See reference 24 for similar comments about financial restraint affecting the implementation of community care policy.

70. Personal Social Services Council/Central Health Services Council (1978), "Collaboration in Community Care - a Discussion Document", London; HMSO, p48. The document makes a point, as its title suggests, of emphasising the importance of collaboration to community care policy (see pages 6-8).

71. ibid,, p48.

72. ibid,, p48.

73. ibid,, pp48-49.

74. ibid,, p47.

75. ibid,, p49.

76. ibid,, see pp49-53.

77. Personal Social Services Council (1978), "Policy Issues in Residential Care: A Discussion Document", London; PSSC, see section III, p33-43.

78. ibid,, p56.

79. DHSS and Welsh Office (1978), "A Happier Old Age. A discussion document on elderly people in our society", London; HMSO, see the Foreword, pp4-5.

80. ibid,, the Foreword, p6.

81. ibid,, para 6,4, p39. Thus, the document, more explicitly than previous documents, placed greater responsibility for providing care on the fit elderly, the family, volunteers and informal carers (ibid,, paras 2,4, 2,7-2,8, pp12-13).

82. ibid,, para 8,1, p40, As in earlier documents, reference was made to the importance of joint planning (ibid,, para 18,2, p40),

83. ibid,, para 8,4, p41, In 1978 the Wolfenden Committee published a report on the future of voluntary organisations, exhorting the government to make maximum use of their resources (Lord Wolfenden (1978), "The Future of Voluntary Organisations, *Report of the Wolfenden Committee*, London; Croom Helm, see p193),

84. DHSS and Welsh Office (1978), op,cit,, (reference 79), see paras 7,4-7,12, pp37-39, Compare reference 65 above, In terms of community care philosophy, the document stated that 'An important objective of the health and personal social services is to enable elderly people to maintain independent lives in the community for as long as possible' (DHSS and Welsh Office (1978), op,cit,, (reference 79), para 6,1, p32),

85. DHSS and Welsh Office (1978), op,cit,, (reference 79), para 8,7, p42,

86. Barnes J and Connelly N (1978), "Social Care Research", London; Bedford Square Press, See Chapter by the DHSS, pp1-17 - "The DHSS Perspective" - see p5,

87. ibid,, p10, The DHSS stated that 'Voluntary effort is very important,,,the strategy (for caring for elderly people at home) must necessarily span the interface between this effort and what is provided by the statutory services' (p14, brackets mine),

88. For example, to help achieve community care 'high priority is being given to the development of domiciliary provision and the encouragement of measures designed to prevent or postpone the need for long-term care in hospital or residential homes' (ibid,, p13),

89. ibid,, p13,

90. The 1979 Conservative Party Manifesto in "The Times Guide to the House of Commons", London; Times Books, p292,

91. Jenkin P (1980),,"Speech to Age Concern Conference", 7th February 1980, Compare with a speech by Barbara Castle to the Local Authority Association", (op,cit,, reference 22) in which she stated that 'Nor am I going to tell you that everyone should stand on their own two feet,,,This is nonsense,,,The fact that we attempt to provide services for families and individuals who cannot manage on their own and the fact that people are no longer expected to suffer without asking for help and support is one of the marks of a civilised society, This is social progress',

92. Jenkin P (1980), op,cit,, (reference 91),

93. See Jenkin P (1979), "Speech to Residential Care Association", 31st October 1979,

94. "Royal Commission on the National Health Service", (1979), Chairman; Sir A Merrison, Cmnd 7615, London; HMSO, para 6,26, p58,

95. The Report continued; 'Team work is of central importance in community care (since) a

patient may need the support and services of several different workers, who may be employed by health authorities or local authorities' (ibid,, (1979), paras 6,26-6,27, pp58-59, brackets mine).

96. ibid,, para 6,63, p70. See also Chapter 22 - Conclusions and Recommendations, para 22,18, p358.

97. ibid,, para 6,61, p69; para 6,33, p62.

98. For example, The Royal Commission noted that although 'Local authorities are exhorted to offer "care in the community" for all those groups for whom "curative" medicine is inappropriate and institutional care is increasingly thought to be undesirable,,,Until a redistribution of funding from NHS to community care takes place, however, and new methods are found for direct financial support to local authorities,,,local authority provision will inevitably been variable and inadequate' (ibid,, Appendix 6, para 4,5, p446). A Working party of the DHSS at this time spoke of community care being a good example of a policy where 'objectives are neither clearly defined nor operationalised ,,,The Department seems to mean different things by this concept at different times', The Working Party emphasised the fact that in this context, 'The elderly have,,, continued to get a poor deal from "community care"' (DHSS (1980b), "Report of the Working Party on Inequalities in Health", London; HMSO, p234). Compare reference 28.

99. DHSS (1981a) "Care in Action. A Handbook of Policies and Priorities for the Health and Personal Social Services in England", London; HMSO, See opening letter by Patrick Jenkin to Chairmen and members of District Health Authorities introducing the document.

100. Thus, the document stated that in future the Governments' role was 'essentially strategic', as a result, its 'guidance will be less detailed and precise than in the past', reflected in the fact that 'a small number of direct controls' of local government were 'being reduced' (ibid,, para 4,2-4,3, p19).

101. ibid,, paras 4,5-4,6, p20. The elderly remained one of the four priority groups.

102. ibid,, para 4,7, p20.

103. ibid,, para 3,1, p15.

104. ibid,, para 3,4, p16.

105. ibid,, para 3,9, p17.

106. ibid,, para 4,9, p21.

107. ibid,, para 5,3, p32.

108. ibid,, para 5,4(a), p32.

109. Hence, the accent, as before, was to provide active treatment and rehabilitation in hospitals (ibid,, para 5,4(b), p32). See also references 84 and 65 above.

110. ibid,, para 4,13, p22. No help could be anticipated from the private sector, since

'little interest' had been shown in providing support services for people living in their own homes (ibid., para 6,7, p42). However, the benefit of developing primary health care services was that the public sector could draw on 'the resources of the family, neighbours and voluntary groups', rather than maintain an 'over-reliance on the services of full-time professionals' (ibid., 4,11, p22).

111. The studies were: DHSS (1981b), "Report of the Study of the Acute Hospital Sector", London: HMSO; DHSS (1981c), "Report of a Study on the Respective roles of the General Acute and Geriatric Services in the Care of the Elderly Hospital Patient", London: HMSO; DHSS (1981d), "Report of a Study on Community Care", London: HMSO.

112. ibid., para 1,1 (i), p1. The Study recognised that the concept of community care was used in a variety of ways and could therefore be misinterpreted (DHSS (1981d), op.cit., (reference 111), Chapter 2, see para 2,1, p7).

113. ibid., para 1,1 (ii), p1. For example, those on the margins of institutional care and community care (called 'boundary groups'), despite increases in community services, there was no recognisable shift away from hospital and residential care (ibid., Chapter 4, pp22-44).

114. ibid., para 1,1 (iii), p1. It was noted that 'The level of certain domiciliary services and the frequency with which people attend day hospitals and day centres...do not suggest that...sufficiently intensive packages of care are being offered, particularly to those with no informal or neighbourhood network to support them' (ibid., para 7,2, p67). In this respect, the isolated elderly were called 'a particular problem' (ibid., para 7,13, p71). The administration of early discharge schemes, day hospital, day centres etc, which reduced/avoided institutional care, was inhibited by lack of professional support and lack of clarity as to the use of these facilities (ibid., Chapter 5, pp45-51).

115. ibid., para 1,1 (v), p1. Thus, the cost-effectiveness of community care vis-a-vis hospital and residential care was questioned (ibid., Chapter 3, pp12-21); intensive home care was not regarded as a cheap option in comparison (ibid., para 4,22, p30).

116. Thus, in terms of the "boundary groups", 'there would appear to have been little if any movement away from long-term hospital or residential care' (ibid., para 4,17, p26).

117. ibid., the Foreword, para (3) v, pii.

118. ibid., para 7,1, p66.

119. ibid., para 3 (iii) pi, para 4,63 (iii), p44, para 7,10-7,12, pp70-71.

120. ibid., the Foreward, para 3 (iii), pi, and para 6,1, p52.

121. ibid., para 1,3, p2.

122. ibid., para 1,4, p2.

123. ibid,, para 4,8, p24 and para 4,63 (iv), p44,

124. ibid,, para 7,2, p67,

125. The Report of the Study on Community Care stated that 'If Departmental policies continue to seek a move away from long-term hospital care where this is appropriate to people's needs and wishes,,,ways must be found to ensure that the balance of resources between the NHS and the PSS reflects the desired rate of change in responsibilities' (ibid,, para 7,6, p69). The Consultative Document - DHSS (1981e), "Care in the Community. A Consultative Document on Moving Resources for Care in England", London: DHSS - suggested a number of ways in which such a resource shift could take place. The Study on Community Care also, as noted (see reference 113), concerned itself with the care of people on the margins of institutional care/community care - again this was a major concern of the 'Care in the Community' document,

126. ibid,, para 1,1,

127. ibid,, para 1,2,

128. For example, the document stated that 'Most serious problems arise in transferring resources to enable docial service departments - part of local government - to take responsibility for people at present in hospital for which the NHS has responsibility' (ibid,, para 2,2),

129. ibid,, para 2,3, See also para 7,1, point 5,

130. Hansard (1981), "Parliamentary Debates, House of Commons", Vol 1000, Fifth Series, Written Answers, 3rd March 1981, col 91,

131. Glennerster H (1983), op,cit,, (reference 6), p67,

132. DHSS (1981f), "Growing Older", Cmnd 8173, London: HMSO, para 1,9, p3; para 6,7, p37,

133. ibid,, para 6,10, p38,

134. ibid,, para 1,9, p3,

135. ibid,, see para 1,11, p3 which stated that the support and care of elderly people was a responsibility which 'must be shared by everyone'. Throughout this White Paper reference is made to the need to underpin family and community support to elderly people - to do otherwise was wrong, not just uneconomic (see Foreword, p iii; paras 1,9-1,11, p3; para 6,7-6,10, pp37-38; paras 7,2-7,3, p43; paras 9,22-9,23, p64),

136. ibid,, para 6,10, p38,

137. ibid,, para 6,12, p39,

138. ibid,, see paras 1,10-1,11, p3; para 6,12, p39; para 9,6, p59; para 9,23, p64,

139. ibid,, para 9,6, p59. See also para 1,9, p3; paras 7,2-7,3, p43, paras 9,7-9,11, pp59-60; para 9,14, p61,

140. ibid,, para 1,9, p3, emphasis in original,

141. ibid., see paras 6.8-6.10, p38; para 6.13, p39; para 7.15, pp46-47; para 8.9, p52.

142. ibid., para 2.1, p6.

143. ibid., paras 7.2-7.3, p43.

144. Hansard (1984), "Parliamentary Debates, House of Commons", Sixth Series, 22nd February 1984, Vol 54, col 887. In the same debate Michael Meacher M.P. responded; 'not only are there more elderly patients, not only are there many being pushed back into the community without adequate community care, but local authorities are being forced by cuts,,,to chop community care for the elderly,,,at the very time when,,demand for community care is rising faster than it has for many decades' (ibid., col 880).

145. House of Commons (1985a), "Second Report from the Social Services Committee, Session 1984-85: Community Care with special reference to adult mentally ill and mentally handicapped people", Volume 1, Report together with Proceedings of the Committee, House of Commons Paper 13 - I, London; HMSO, paras 8-9, p x; paras 27-28, p xvii, emphasis mine. Here the Committee identified ways in which the term 'community care' was used;

i) to save money by removing people from hospital;

ii) to emphasise the care of familes and volunteers, rather than that of the State;

iii) to describe the transfer of responsibilities from the NHS to local authorities.

The Committee also defined the general principles of community care;

i) a preference of home life over institutional life;

ii) the pursuit of normalisation and integration, and the avoidance of separate provision and segregation;

iii) a preference for small over large;

iv) a preference for local services over distant services.

More generally, the DHSS in its evidence to the Committee stated that '"Community care" is a multi-purpose phrase which means different things to different people and in different contexts' (ibid., para 2, p2)

146. There were several different definitions of community care put forward in evidence to the Committee which the Committee said 'we deprecate as confusing and misleading' (ibid., paras 9-10, p x). Some of these definitions are given below;

(i) As described in Chapter 4 of this Thesis, the DHSS stated that community care was 'a multi-purpose phrase which means different things to different people and in different contexts. It may be used descriptively for the range of services provided outside institutions; or it may be used in terms of objectives,,,The objectives, explicit or implicit, in statements about community care range form the very specific to the all encompassing'. The DHSS suggested some community care objectives;

- to be cared for at home, rather than in hospital or a residential home

- to support and relieve carers;
- to deliver appropriate help so as to minimise disruption to ordinary living;
- to provide cost-effective care which meets the needs and wishes of those helped;
- to integrate resources and deliver them locally, flexibly to local people,

(See the Memorandum submitted by the Department of Health and Social Security in House of Commons (1985b), "Second Report from the Social Services Committee, Session 1984-85: Community Care with special reference to adult mentally ill and mentally handicapped people", Volume II, Minutes of Evidence (4 April-3 July 1984), House of Commons Paper 13-II, London; HMSO, paras 2-3, p2), See also paras 18-20, pp6-8 in Volume 2,

(ii) Similarly, the Spastics Society noted that 'There is currently very little agreement about the meaning of "community care"', noting that guidance from the DHSS implied that 'a very wide spectrum of provision is encompassed in this terms', The Society included residential units in its own definition 'provided that such units do not stand apart from the rest of the community', Community care placed emphasis on the provision of 'the necessary individual support systems', 'concentrating resources into flexible services to meet a variety of needs' (ibid,, paras 2,1-2,2, p106 - the Memorandum submitted by the Spastics Society),

(iii) MIND noted that without adequate resources community care 'will remain a romantic theory', The term 'had become devalued and unconvincing', MIND described community care as 'about giving people the greatest autonomy with appropriate sup dependent upon their needs and wishes, Community care should be a humanising trend to reintegrate people back into the neighbourhoods from whence they came, or to remake or enhance their social networks if living in the community' (ibid,, para 3, pp122-123 - the Memorandum submitted by MIND),

(iv) Another definition of community care was 'a move away from isolated, institutional care to *locally based care* in an individual's neighbourhood if practical and in a *domestic setting*, It is the repalcement of care received in a large institution by a wide range of services and facilities, provided for in one's locality' (see the Memorandum submitted by the National Association of Health Authorities in House of Commons (1985c), "Second Report from the Social Services Committee, Session 1984-85: Community Care with special reference to adult mentally ill and mentally handicapped people", Volume III, Minutes of Evidence (4 July-21 November 1984) and Appendices, House of Commons Paper 13-III, London; HMSO, para 1, p548),

(v) Lastly, it was commented that 'The term community care is imprecisely defined, it can mean everything and nothing,,,The objective must be to avoid institutionalisation and dependency, wherever that is possible,,,the term,,,is appropriately used to

describe a commitment to provide services to support families and informal carers wherever possible, to use substitute family care where the family is unable or unwilling to make provision, and to use admission to hospital and residential care only where absolutely necessary,,,the prime purpose of community care must be to prevent people being admitted to hospital inappropriately because of a breakdown in their network of family and social care,,,community care must respect and value the needs of individuals, give opportunity for choice and independence' (ibid,, paras, 4,0-4,2, 4,4, 4,6, pp631-632),

147, House of Commons (1985a) op,cit,, (reference 145), para 11, p x,

148, Audit Commission for Local Authorities in England and Wales (1986) "Making a reality of community care", London: HMSO,

149, Audit Commission for Local Authorities in England and Wales (1986) "Audit Commission Review: Making a reality of community care", December 1986, London: Audit Commission, See also House of Commons (1988) "Twenty Sixth Report from the Committee of Public Accounts Session 1987-88. Community Care Developments", London: HMSO, This latter document acknowledged that 'Government policy is that the elderly,,,should be cared for in their own homes or in the local community whenever this is right for them' (para 1); the Report also referred to barriers and the consequent ineffectiveness of Joint Planning arrangements (paras 14,20) and that therefore overall progress towards community care was 'slower than the DHSS would have liked' (para 35),

150, Griffiths R, Sir (1988) "Community Care: Agenda for Action", March 1988, London: HMSO,

151, Department of Health (1989a) "Kenneth Clarke's Statement to Parliament on Future Arrangements for Community Care", Press Release 89/298, 12th July 1989,

152, Department of Health (1989b) "Caring for People. Community Care in the next decade and beyond", Cm 849, London: HMSO,

153, Department of Health (1989c) "Working for Patients", Cm 555, London: 1989,

154, Department of Health (1989b), op,cit,, (reference 152), Chapter 6, pp47-52,

Appendix 5: Notes and References to Chapter Five

Note: The journal referred to as 'Housing' was of that title up to July 1974, and from May 1978 onwards. In the intervening period (July 1974 - April 1978 inclusive) it was re-titled as 'Housing Monthly'.

1961-1963

1. Powell David J D (1963), "Modern Geriatric Care" in *'Nursing Times'*, 20th December 1963, pp1594-1596.
2. Wofinden R C (1961), "Housing the Aged and Infirm" in *'Housing'*, December 1961, Vol 23 (3), pp103-110. The article stated that 'It was generally agreed in medical circles that elderly people should be kept at home as long as possible rather than in Part III accommodation or a hospital'.
3. Lafitte F (1960), "Priorities in Social Welfare" in *'Social Service Quarterly'*, Spring 1960, Vol 33 (4), pp145-148 and Elphick E (1961), "Hostels as part of Community Care for the Mentally Disordered" in *'The Almoner'*, November 1961, Vol 14 (8), pp361-366.
4. See the commentary (1962a) "Future of the Mental Hospital", in *'British Medical Journal'*, 6th October 1962, pp904-905. Similarly, the point was made that community mental health services 'are still very much in their infancy' - see the commentary (1962b)"The future of Britain's hospitals, Present state of services in the community" in *'Nursing Mirror'*, 9th February 1962, pp375-376.
5. Thus, it was stated that 'If the Government wish community care to succeed, they will have to provide the resources for such a service', see Ferguson R S (1961), "Side Effects of Community Care", in *'The Lancet'*, 29th April 1961, pp931-932. A social work commentator added that if 'The distant goal of community care could be achieved if the community cared sufficiently to pay for it', see Gough E (1963), "Conference Report, The Distant Goal", in *'The Almoner'*, May 1963, Vol 16 (2), pp46-47.
6. See Ferguson R S (1961) in *'The Lancet'*, op.cit., (reference 5).
7. Thus, the Lancet made the point that 'despite public advocacy of the principle of maintaining the elderly in their own homes, there was no evidence of the switch in priorities which would be necessary if this principle were to be applied in practice' - see a news item "Priorities in Practice" in *'The Lancet'*, 20th May 1962, p1122. More generally, a medical journal noted that the care in the community section of the Hospital Plan was 'full of pious hopes and unwarranted assumptions' - Parliamentary Correspondent (1962), "Commons Debate The Hospital Plan" in *'British Medical Journal'*, 9th June 1962, pp1633-1635. Another doctor referred to the Plan as 'a huge facade,..At best,..an ambitious scheme which could not possibly be realised, and its worst,..simply a political document' (Vaughan Jones J A L (1962), "Proceedings of Council" in

Supplement to the *'British Medical Journal'*, 7th April 1962, pp119-122).

8. Annotations (1963), "Community Care" in *'The Lancet'*, November 9th 1963, pp990-991.

9. See Gough E (1963) in *'The Almoner'*, May 1963, op.cit., (reference 5); an article stated that 'Policy is already committed to this reorientation, but its implications have scarcely been studied' - Lafitte F (1960) in *'Social Service Quarterly'*, op.cit., (reference 3); reference was made to the 'superficial practice of community care' in Barnes M (1965), "Summary of the Conference, An Account of the concluding session conducted by Robin Huws Jones" in *'Social Work'*, April/July 1965 (Double Issue), Vol 22 (2/3), pp29-30.

10. McDougall K (1960), "Community Care of the mentally ill" in *'Social Service Quarterly'*, Spring 1960, Vol 33 (4), pp150-154. The article suggested three meanings; that the family looks after its mentally ill members; that the general public would provide some caring support; that the local authorities would provide care. The article continued, stating that the basis of community care was that 'the community shares the burden' - regarded as a dubious notion.

11. Editor (1961), "Care in the Community" in *'Social Work'*, April 1961 Vol 18 (2), pp2-3; Carstairs G M (1965), "New tasks for Community Care in our Changing Society" in *'Social Work'*, April/July 1965 (Double Issue), Vol 22 (2/3), 1965, pp4-5; Barnes M (1965) in *'Social Work'*, op.cit., (reference 9).

12. See Lafitte F (1960) in *'Social Service Quarterly'*, op.cit., (reference 3); Editor (1965), "Care in the Community; the fiction, the reality and the future" in *'Social Work'*, April/July 1965 (Double Issue), Vol 22 (2/3), 1965, pp2-3.

13. Thus, a housing article referred to the fact that 'elderly people hated to be uprooted from the surroundings to which they had become accustomed', but later in the same article it was stated that 'it is so easy for the children's health to suffer through trying to carry (the),,,burden of caring for elderly parents,,,we are going to have to ask families to carry yet another burden over and above the one many are carrying at the moment by helping to care for elderly relatives; elsewhere, 'there is a limit beyond which we cannot go in fulfilling this sort of policy' - see Wofinden R C (1961) in *'Housing'* op.cit., (reference 2). A medical article expressed similar concern about the involvement of the 'community' in care - Editor (1966), "Does the Community Care" in *'British Medical Journal'*, "Does the Community Care?, 17th September 1966, No 5515, pp655-656). See also reference 12 above.

14. For example; 'The caretaking professions need to help members of the community to become involved with the sick and the delinquent, and with their ailing relatives' (Carstairs G M (1965), in *'Social Work'*, op.cit., (reference 11)). This perspective was

given elsewhere - 'The community social worker may have to forgo the satisfaction of direct therapy for a part of his working week and instead help the "community to care", being in the original sense of the word a "social worker"' (Goldberg E M (1965), "Working in the community; what kind of help do people need?" in *'Social Work'*, April/July 1965 (Double Issue), Vol 22 (2/3), 1965, pp6-18); 'The basis of community care lay in home care where the burden of responsibility for the patient was shared between the patient's family,..and professional workers' (Bayley M (1965), "Helping the family" in *'The Almoner'*, February 1965, Vol 17 (9), pp294-296); see also Barnes M (1965), in *'Social Work'*, op.cit., (reference 9).

15. The article continues; 'Each long-term patient or resident should not be seen as a medical or social failure', adding that 'One fears, however, that many doctors do less medically than they might because the age of the patient suggests that it is not worth doing' see Kemp R (1963), "Old Age a Regret" in *'The Lancet'*, 2nd November 1963, pp897-898. The same author referred earlier to a 'cold-shouldering' of elderly people by doctors, the fact that 'concern for old people has been largely expressed by lay rather than medical conscience' as a result, it was commented that 'It is especially regrettable that the management of old people has fallen so largely to the doctor'; 'doctoring' played a 'minor part' in meeting the 'human needs of old age', thus doctors, the author argued, 'still need to work out a positive policy for elderly patients', Kemp R (1962) "Old Age is not a disease" in *'The Lancet'*, 13th January 1962, pp94-96. Another letter admitted that doctors were often more interested in the age of a patient rather than his/her illness as a criteria for admission to hospital - The letter pointed out several reasons why old people were 'lacking medical attention', see a letter (Wood P R T (1961a), "Geriatric Services"in *'British Medical Journal'*, 30th September 1961, p893).

16. See, for example, the letter by Greenwood J M (1961), "Beds for Chronic Sick", in *'British Medical Journal'*, 26th August 1961, p581; see the comments made by Dr O Mosos (1962), in the section "Chronic Sick" of the report to the Annual Representative Meeting in the Supplement to the *'British Medical Journal'*, 28th July 1962, p50; one article referred to the suggestion that 'a better basis for hospital planning would be a regrouping of patients according to their medical and nursing requirements', adding that 'age has become the predominant influence which determines the type of hospital to which a patient is admitted' - see McKeown T, Mackintosh J M & Lowe C R (1961), "Needs and Beds", in *'The Lancet'*, 15th April 1961, pp818-820; another article referred to the fact that for doctors, 'there is more to be done for ageing people than holding a watching brief', doctors were to 'be quite sure of the diagnostic facts before writing

off the older patient as irreversible' - see Kemp R (1962) in *'The Lancet'*, op.cit., (reference 15); Arnold J & Exton-Smith A N (1962), "The Geriatric Department and the Community" in *'The Lancet'*, 15th September 1962, pp551-553. Lastly, a letter referred to current health services for old people being caught in a 'maelstrom of prejudice' (see the letter by Wood P T R (1961b), "Geriatric Services" in *'British Medical Journal'*, 23rd December 1961, pp1707-1708).

17. Nisbet N H (1962) "Experiment in Mutual Aid between a Geriatric Unit and Local Authority Home" in *'The Lancet'*, 28th April 1962, pp903-904; another article in respect of hospital beds noted (in his critique of this approach) that 'The aim must be to use beds only for patients who need care and treatment' - see Exton-Smith A N (1962), "Progressive Patient Care in Geriatrics" in *'The Lancet'*, 2nd February 1962, pp260-262. The same model was referred to elsewhere; McKeown T, Mackintosh J M & Lowe C R (1961), in *'The Lancet'*, op.cit., (reference 16). There was some questioning of this approach within at least one medical journal - Kemp R (1962) in *'The Lancet'*, op.cit., (reference 15).

18. See Powell David J D (1963) in *'Nursing Times'*, op.cit., (reference 1). A social work article stated that 'Many new ideas are being discussed about the diagnosis of the older client, but little has been done either to incorporate these ideas into the treatment process' (Milloy M (1964), "Casework with the Older person" in *'Social Casework'*, October 1964, Vol 45 (10), pp450-456). The comment was also made that 'Geriatrics...is one of the most exciting branches of medicine and social work in a geriatric unit can be very rewarding' (Bagnall M K (1963), "The choice of an Old People's Home" in *'The Almoner'*, September 1963, Vol 16 (6), pp161-164).

19. Thus, an article described discharge criteria as based partly on a determination of 'the kind of social milieu which can contain the patient and his family, and similarly, what kind of social milieu the patient can be discharged to without endangering his recovery' (Goldberg E M (1961), "The social worker in the Sixties" in *'Social Work'*, October 1961, Vol 18 (4), pp17-36). Reference was also made to the need to balance 'the right of the individual to determine his own destiny and to make his own choices, and the right of society to watch that these individual choices do not harm the interests of others' (Butrym Z T (1963), "Introduction to a Discussion on Casework with Geriatric Patients" in *'The Almoner'*, February 1965, Vol 15 (11), pp325-332).

In housing journals, reference was made to the need to take account of elderly people's views in the location, type and structure of housing for elderly people - Ministry of Housing and Local Government (1962), "Housing for The Old; Old People's Housing Preferences at Chatham" in *'Housing Review'*, January-February 1962, Vol 11 (1), pp11-

14; a key speaker at the 1961 Annual Conference of the Institute of Housing stated that 'I am very sympathetic to the point of view that old people should be consulted as to what sort of accommodation they want, where it should be and how it should be equipped,,,I always regard the provision of,,,services in aged persons' households as much in the interests of the health of the people helping the aged persons themselves' - Wofinden R C (1961) in *'Housing'*, op,cit,, (reference 2).

A medical article added; 'In community care there is a tendency to join in the race to see who can admit fewer patients and discharge them more quickly, but what do the patients themselves,,,think about it?' (Ferguson R S (1961), in *'The Lancet'*, op,cit,, (reference 5)).

20. For example, a nursing commentator made reference to 'wide variations' in domiciliary services - see the commentary (1962) in *'Nursing Mirror'*, op,cit,, (reference 4). Another article criticised local authority services; 'though the social needs of the elderly are an accepted local authority responsibility, this is discharged in an uneven and inadequate way ,,,the care which some authorities give is never complete, while many areas are barren indeed', referring to 'examples of gross social neglect' Kemp R (1962) in *'The Lancet'* op,cit,, (reference 15).

21 See the news item in Editor (1961), "Facts and Hopes", in *'The Lancet'*, 1st April 1961, p727 - this short commentary stated that co-operation between agencies responsible for elderly services was 'disheartening'; another commentary referred to the governments' 'well worn theme' of emphasising co-operation to ensure that 'elderly people get what they need' see Editor (1961), "Needs of Old People" in *'British Medical Journal'*, pp1022-1023. In terms of social work journals, an article stated that 'Systematic liaison between local authorities and the hospital and general practitioners seems to be rare', see Editor (1961), in *'Social Work'*, op,cit,, (reference 11). General problems in relation to co-ordination were raised in another article; Goldberg E M (1965), in *'Social Work'*, op,cit,, (reference 11).

22. See Kidd C B (1962), "Misplacement of the elderly in hospital" in *'British Medical Journal'*, 8th December 1962, pp1491-1495. This article pointed out that misplacement led to higher morbidity amongst elderly people.

23. For example; 'Too often there is a no-man's land' between hospital and part III accommodation 'and a lack of provision for old people who satisfy the requirements of neither' (Nisbet N H (1962) in *'The Lancet'*, op,cit,, (reference 17)).

24. The article stated that 'Collaboration of central government, local authorities and health and welfare services is indispensible to avoid duplication of effort and to maintain a proper balance of accommodation between those who are capable of living on

their own, or with a measure of assistance, and those who require to be accommodated in residential homes, geriatric units and the like' - Smith M A (1966), "Housing Problems of Older Persons - The Management Point of View" in *'Housing'*, July 1966, Vol 2 (2), pp17-24. In respect of the roles of sheltered housing and residential care, (the text quote) see Affleck B D M (1968), "Housing the Aged" in *'Housing'*, May 1968, Vol 4 (1), pp18-20. A separate article argued that warden serviced flats represented 'an alternative to placing frail old people in residential homes' - Isaacs B (1966), "Housing for the Old People - Medical Aspects' in *'Housing'*, July 1966, Vol 2 (2), pp25-29. Another article suggested that sheltered housing could 'become a bridge to part III accommodation' (Bradley M (1961), "Grouped Bungalows with some Shared Accommodation and with a Warden's Services" in *'Housing Review'*, March-April 1961, Vol 10 (2), pp46-47).

25. McDougall K (1960) in *'Social Service Quarterly'*, op.cit., (reference 10). This article argued there were three different meanings of community care for the mentally disabled; 'it means that families will have to look after their mentally ill members'; 'an increase in the number of members of the general public who will take an interest in the mentally ill'.

26. Barnes M (1965) in *'Social Work'*, op.cit., (reference 9).

27. Thus, in the nursing journals it was remarked that - 'the mentally disordered person should live at home in the community where possible...(hence) The aim of enabling the mentally disordered to take their part in the life of the community' - See Editor (1963), "Community Care" in *'Nursing Mirror'*, 19th April 1963, p61.

28. See Ferguson R S (1961), in *'The Lancet'*, op.cit., (reference 5) which referred to mental illness patients in the community as 'the unsheltered patient' who could be 'extremely destructive of familial stability and happiness', by comparison the author felt that such patients were 'perfectly well and are socially adjusted in an asylum...They can live comfortably and without distress in an institution'. A commentary in another medical journal referred to the fact the behaviour of the elderly mentally disordered could make them 'unacceptable in residential homes and an intolerable burden for the family at home...they need constant supervision and competent, sympathetic nursing. In short, they qualify for long-term hospital care. Where will they go?...large numbers of mentally disturbed old people are being cared for by members of their families at great sacrifice of liberty and peace of mind. It is not reasonable that the hospital service should abdicate this responsibility' see Editor (1962) "Mental Disorder in Old Age" in *'The British Medical Journal'*, 8th September 1962, p662. Finally another article concluded that although mental patients

may be clinically ready for discharge 'it is highly undesirable that they should be discharged on these grounds unless suitable accommodation exists', reference was also made to the lack of family and social support as preventing early discharge (Cooper A B & Early D F (1961), "Evolution in the mental hospital" in *'British Medical Journal'*, 3rd June 1961, pp1600-1602). A social work article commented that 'To some it means that families will have to look after their mentally ill members and will not be able to leave them in mental hospitals indefinitely,..While in no way wishing to belittle the importance of individuals and families shouldering their responsibilities, the basis of "community care" is that the community shares the burden' - see McDougall K (1960), in *'Social Service Quarterly'*, op.cit., (reference 10).

29. Kemp R (1963) in *'The Lancet'*, op.cit., (reference 15).

30. See Sidey A T (1962), "What is to become of the Old?" in *'Nursing Times'*, 21st September 1962, pp1213-1214. Another article expressed uncertainty as to whether or not the confused elderly should be in hospital, a special or ordinary part III home - see Notes and News (1963) "Homes for the confused elderly" in *'The Lancet'*, 28th December 1963, p1391.

31. Burn J L (1962), "Senile Dementia" in *'Nursing Times'*, 23rd November 1962, pp1491-1492.

1971-1974

32. Thus, it was stated that 'for the vast majority of the elderly their own home is the best place' (Barrowclough F (1974), "Continuing care for the elderly" in *'Nursing Mirror'*, 30th August 1974, pp59-61); old people were 'very much happier in their own homes' (Hardy S (1971), "Day Care for the elderly" in *'Nursing Mirror'*, 15th January 1971, pp18-19). Another article stated that 'domiciliary help for old people must be encouraged, and no doubt is preferred by most of them' (Cowan E (1972) "Dis-service to the elderly" in *'Nursing Mirror'*, 29th December 1972, p28). Similarly, another author stated that helping elderly people to remain at home, even if ill, was 'what most of them would prefer' - see Agate J (1971a), "Ethical questions in geriatric care - 1" in *'Nursing Mirror'*, 5th November 1971, pp17-18.

Housing articles supported these views; 'Most older people want to live independently for as long as possible' (Housing Review (1970), "Housing Old People - Reference Sheet" in *'Housing Review'*, November-December 1970, pp159-160); 'it is accepted that most elderly have a strong preference for maintaining independent living,..rather than living in an institution' (Bennett L C (1974), "Housing for the elderly" in *'Housing'*, January 1974, pp8-13).

33. See the 1974 Editorial, "Finance and the Health Service" in *'British Medical Journal'*,

25th May 1974, pp398-399.

34. As the commentary noted, 'given the overwhelming evidence that it is precisely the elderly who use high-cost NHS resources,,,is it right to switch the emphasis away from this sector?' (Commentary (1974) "Old Age or Mental Health?" in *'British Medical Journal'*, 30th November 1974, pp487-488).

35. See the letter by Paulley J W & Hughes J P (1973), "How many acute beds do we really need?", in *'British Medical Journal'*, 6th January 1973, p49. A social work article commented that the run down of mental handicap institutions 'was issued long before any examination of community care alternatives was made', concern being motivated by the fact that 'they are not at present stimulating economically viable needs' (Towers B (1973), "Mental Handicap' in *'Social Work Today'*, 5th April 1973, Vol 4 (1), pp8-9). In terms of the run down of mental hospitals, an editorial spoke of many ex-patients wandering homeless in the community, thus 'It is hard to believe that such an existence of aimless destitution is preferable to the organised and structured life in a well-run mental hospital, even taking into account the hazards of so-called institutionalization' (Editor (1973), "Rootless Wanderers" in *'British Medical Journal'*, 7th July 1973, pp1-2).

36. For example, one medical article spoke of the geriatrician and hospital social worker as 'very much a part of community care' (Hodes C (1973), "Care of the Elderly in General Practice", in *'British Medical Journal'*, 6th October 1973, pp41-42). A nursing journal referred to community care involving the traditional psychiatric hospitals, psychiatric units and day hospitals - 'all indicators of the preference for treatment in the community rather than institutions' (Bryant S & Sandford F (1972) "Psychiatric nursing in the community" in *'Nursing Mirror'*, 2nd June 1972, p37 & 39). Another article called for recognition that 'the hospital is part of the community' - Campbell W & Thomson L B (1972), "Part of the Community John Connelly Hospital" in *'Nursing Times'*, 23rd November 1972, pp1486-1489.

37. For example, one article stated that community care was under-resourced, requiring mor than 'lip service to become effective'. This article continued; 'community care will not be created and sustained without certain inputs in terms of resources, manpower, administrative machinery and finance' (Lansley J (1973), "Caring for the Old" in *'Social Work Today'*, 5th April 1973, Vol 4 (1), pp21-25). An editorial commented that 'Community care itself is already suspect in some quarters as a cheap means of preserving the status quo' (Editor (1970), "Editorial" in *Social Work Today'*, May 1970, Vol 1 (2), pp3-4).

On the medical side, a short commentary noted results of previous research which showed

'alarming inadequacies in the hospital and domiciliary services for the elderly' - see Commentary (1972) "The elderly - at home or in hospital?" in *'The Lancet'*, 26th February 1972, pp479-480. Similarly, in a nursing article it was argued that the demand for residential care was directly related to the inadequacy of community care services (Cowan E (1972), in *'Nursing Mirror'*, op.cit., (reference 32)). Another nursing article commented that 'existing community services are often quite unable to avoid breakdown in the care of patients' leading to 'excessive demand for admission to geriatric units'. The article continued; 'because the required help is unavailable with the existing pattern of community care, he (the patient) has to remain in hospital'. Thus, for example, the fact that after care services closed after 5pm and at week-ends indicated that 'such services are not specifically geared to the needs of patients on return home from hospital' (Barrowclough F (1974), in *'Nursing Mirror'*, op.cit., (reference 32)). In terms of the latter perspective, a further medical article referred to the fact that admissions to hospital were often due to a 'lack of community care' rather than to investigate a clinical need (Isaacs B (1971), "Geriatric Patients: Do Their Families Care?" in *'British Medical Journal'*, 30th October 1971, pp282-286). In this respect, see references 68 and 69 below.

38. For the quotation, see Shearer A (1970), "Crossing the Silence Barrier. Journalist's Challenge to Social Workers" in *'Social Work Today'*, July 1970, Vol 1 (4), pp35-38. The article continued; 'If the ideal of community care is to be realised, the community must be told what it is in for'. Another social work article argued that 'There is little doubt,,, that the small family today is ill equipped to cope with the care of the elderly' even though 'the family remains the most important source of care for old people' (Wilson D (1973), "Old Age" in *'Social Work Today'*, 20th September 1973, Vol 4 (13), pp399-400).

One medical article was in sympathy with this view, making reference to the stress placed on families through community caring and also pointing out that admissions to hospital were often because of lack of 'the exhaustion of community care', adding that in general the growth in the elderly population 'has created unprecedented strain on our family and social system' - Isaacs B (1971) in *'British Medical Journal'*, op.cit., (reference 37). A medical commentary noted that shortages in service for the elderly had led to 'an immense burden of care borne by their relatives'; accordingly it was reported that 'too much reliance should not be placed on the often-expressed hope that "the community should cope with the elderly"' - see the Commentary (1972a) in *'The Lancet'*, op.cit., (reference 37).

39. Thus, the correspondent suggested that 'relatives are not made to take enough

responsibility' (see the letter by Fletcher M (1971), "Old Age", in *'Nursing Mirror'*, 1st October 1971, p28),

40. Editor (1971) "Physician or Clinical Undertaker? in *The Lancet'*, 15th May 1971, p1002,

41. For example, see Todd J W (1973) "Priorities in Medicine" in *'The Lancet'*, 19th May 1973, pp1106-1110 and Wright W B (1973), "Misuse of Doctors in the care of the elderly" in *'The Lancet'*, 4th August 1973, pp252-253, which argued that the creation of the specialty of geriatrics had meant other doctors avoided the needs of the elderly. A similar scenario was presented in a 1974 editorial which argued that geriatrics was medicine - "Geriatrics is Medicine" in *The Lancet'*, 13th April 1974, p663,

42. See Arie T (1971), "Morale and the Planning of Psychogeriatric Services", in *'British Medical Journal'*, 17th July 1971, pp166-170, which commented that 'By contrast with the urgency of the need there is a practically total reluctance on the part of our young graduates to go into geriatric work'. This article continued in the vein of the quotation; 'A chronic unit in a hospital willy-nilly sets itself standards similar to an acute unit. It measures success by the traditional aspirations of acute medicine - curing and discharging patients' as a result, 'small wonder that few doctors and for that matter few trained nurses want to work in long-stay hospital units',

43. For example, an article stated that 'education in geriatric care and recruitment to the specialty is influenced by the "image" created by our work, the appropriate image is more likely to emanate from hospitals dealing with "total patient care" than "disposal" problems' (O'Brien T D, Joshi D M & Warren E W (1973), "No apology for Geriatrics" in *'British Medical Journal"*, 3rd November 1973, pp277-280). See also a report of the Marsden lecture by Sir Keith Joseph in which the BMJ recorded the view that 'The acute and non-acute sector offer vastly different stimuli to medical enthusiasm, for understandable reasons' (Joseph K (1973), "Sir Keith Joseph Surveys the NHS; Achievements and Failures" in *British Medical Journal'*, 1st December 1973, pp561-562),

44. See, for example, the encouragement given in one article to broaden the input of doctors in the care of elderly people - Wright B (1973) in *'The Lancet'*, op.cit., (reference 41). On the positive side, the comment was made that 'It has become a truism to say that the medical problems of an elderly patient cannot be treated without having regard to such things as housing, mobility and social isolation' (see Commentary (1973) "What do the elderly need?" in *'The Lancet'*, October 13th 1973, p833-834). Another article argued that an assessment of an old person should include medical, psychological and social factors - Hodkinson H M (1973a), "Rehabilitation of the Elderly" in *'British Medical Journal"*, 29th December 1973, pp777-778. The encouragement of a more imaginative application of diagnostic skills and treatment in the care of the

elderly was evident in other journals. See, for example, Isaacs B (1973), "Treatment of the 'irremediable' elderly patient" in *'British Medical Journal'*, 8th September 1973, pp526-528, the author argued that 'The treatment of the irremediable is both a worthy objective and an accurate description of much modern medicine,,,professional satisfaction can be found by the skilled and perceptive treatment of "the irremediable"'; see O'Brien T D, Joshi D M & Warren E W (1973), in *'British Medical Journal'*, op.cit., (reference 43); Hodkinson H M (1973b), "Non-specific Presentation of Illness" in *'British Medical Journal'*, 13th October 1973, pp94-96, which referred to non-specific diagnosis in the old 'as a diagnostic challenge. If this attitude is adopted, medical work with the elderly becomes a fascinating, exacting, and rewarding discipline'. In general, see also Hodes C (1973) in *'British Medical Journal'*, op.cit., (reference 36); Hodkinson H M & Jefferys P M (1972), "Making Hospital Geriatrics Work" in *British Medical Journal'*, 2nd December 1972, pp536-539; Adams G F (1974), "Eld Health" in *British Medical Journal'*, 28th September 1974, pp789-791.

45. Thus, it was stated that 'Because they are insufficiently involved in the remedial and social aspects of geriatrics, general practitioners and junior doctors in geriatric units do not play their full part in the case of the elderly' (Wright B (1973) in *'The Lancet'*, op.cit., (reference 41)); see also Commentary (1972b), "Geriatrics to the fore" in *'The Lancet'*, 9th September 1972, p523 which referred to 'the greatest difficulty' in the care of the elderly as being 'the attitude of our own profession' (i.e the medical profession), and stated that 'Many consultant physicians tend to be interested only in the clinical problems of the elderly and not to accept responsibility for organising total patient care, with long-term rehabilitation and continuing nursing care where this is needed'.

46. See Rands V H (1972), "Geriatric Nursing Services" in *'Nursing Times'*, 24th August 1972, pp1054-1057; the nursing profession exhibited a similarly negative attitude to geriatrics - see Adams G F (1973), "Geriatric Nursing Standards" in *'The Lancet'*, 8th September 1973, pp553-555; see also a supporting letter to this article - Morton E V B, Williams I E I & Wilson T S (1973), "Geriatric Nursing Standards" in *'The Lancet'*, 3rd November 1973, p1025. Another writer stated that in terms of geriatric nursing, 'as far as the nurses are concerned, the feelings of the patient don't count a great deal', adding that 'This type of nursing unfortunately very often attracts the uncouth, ignorant and authoritarian types of senior staff' - Hansen J (1972), "The elderly in hospital" in *'Nursing Mirror'*, 8th December 1972, p36.

47. See a wide range of articles in the nursing journals; in *'Nursing Times'*, the following articles sought to give a positive perspective of geriatric nursing - Harnor J (1971),

"Morale in Geriatric Rehabilitation", 9th December 1971, pp1525-1526; Rands V H (1972) op.cit., (reference 46); Rankine R & Walsh R (1972), "A fresh approach to geriatric nursing", 19th October 1972, pp1310-1312; Jefferys P M (1973), "A New geriatric Service", 29th March 1973, pp402-404; Clark M L (1973a), "Advance the advanced", 1st November 1973, pp1452-1453; Unwin F T (1973) "Coping with Geriatrics", 13th December 1973, pp1692-1693. In the *'Nursing Mirror'* Callow D L (1973), "Towards a happy old-age", 27th July 1973, pp14-16; Griffiths G M (1973), "Geriatrics - more than just basic nursing care", 31st August 1973, p30.

48. See Butcher H (1971), "Sociologically Speaking; Old Age - Forgotten Age", in *'Social Work Today'*, March 1971, Vol 1 (12), pp44-45.

49. The article viewed it 'as more realistic' to view elderly people 'as a group of clients who may be of varying ages and who will have a wide variety of different needs demanding a variety of different solutions' - Brearley C P (1972) "Waiting for Old Age" in *'Social Work Today'*, 14th December 1972, Vol 3 (18), pp7-19.

50. For example, Bumagin V E (1972) "Challenge of working with old people" in *'Social Work Today'*, 14th December 1972, Vol 3 (18), pp15-17; Lansley J (1973) in *'Social Work Today'*, op.cit., (reference 37); Halliburton P M & Wright W B (1974), "Towards better geriatric care" in *'Social Work Today'*, 16th May 1974, Vol 5 (4), pp107-108.

51. Millard P H (1971), "Policies for the Population" in *'Nursing Times'*, 2nd September 1971, pp1075-1079. As the author prefaced this remark; 'Is it right to plan to look after the old in homes and hospitals when they want to be at home?'.

52. Thus, it was suggested that 'provided they (the elderly people) are not in pain or distress, and provided the family can manage reasonably', then the wishes of the elderly person should be respected (Agate J (1971b), "Ethical questions in geriatric care 3, Family conflicts in the management of old people" in *'Nursing Mirror'*, 19th November 1971, pp40-41). The same author made similar points in a separate article - Agate J (1971c), "Ethical questions in geriatric care 2, Rights and Obligations of elderly patients" in *'Nursing Mirror'*, 12th November 1971, pp42-43. This article suggested, however, that it was difficult to determine the cut-off point in terms of maintaining elderly people at home - each case was to be assessed on its merits - 'the patient has a right within reason to determine his own future, and the right to decide where she goes, what happens to her property, and when'. Another article commented that 'A service for the elderly must be community orientated and geared to support as many old people in the community as possible - compatible with a reasonable standard of existence' (Whitehead J A (1971) "Myths of mental illness in the elderly" in *'Nursing Mirror'*, 27th August 1971, pp18-20). As a social work article stated that the term

independence 'is frequently used to describe being within the community rather than in an institution. But does independence lie in remaining in the home you have lived in for sixty years yet being unable to get down the garden, to the toilet or to use the gas cooker or light a fire and therefore being totally reliant on others for food, warmth and other personal services? Or does it lie in having a single room in a spotless, pupose built home and being free from worries about food, warmth and stairs?'. The author in contrasting these two positions then comments 'Neither choice seems to have much to do with physical independence and the meaning of dependence or independence must be related to individual circumstances. Perhaps independence in this sense is closer to individuality and the maintenance of self-direction' - Brearley C P (1972) in *'Social Work Today'*, op.cit., (reference 49). In the situation of a person thought by other to require admission to hospital, then 'there may be conflict between the patient's wishes to be in X and his need to be in Y. Then, surely, medical and nursing considerations have to take precedence' (Agate J (1971a) in *'Nursing Mirror'*, op.cit., (reference 32), emphasis in original). Lastly, it was remarked that 'the (elderly) patient has a right within reason to determine his own future'. The proviso "within reason" was interpreted to mean that the elderly patient had no right to a place in hospital 'if the need had ceased'; no right to 'disrupt the lives of others around them'; no right to 'insist on doing things which might endanger others'; no right to forgo the duty 'to accept reasonable treatment, food and drink' (Agate J (1971c) in *'Nursing Mirror'*, op.cit., (reference 52)).

53. The misery resulted from 'the application of personal standards,,,in the assessment of the viability of an old person in the community and her needs' (Whitehead J A (1971), in *'Nursing Mirror'*, op.cit., (reference 52)).

54. Westbrook K (1972) "Coping with Relatives" *'Nursing Mirror'*, 2nd June 1972, pp38-39.

55. Agate J (1971b) in *'Nursing Mirror'*, op.cit., (reference 52). Another article admitted that 'being a professional does not mean that you always know best' (Whitehead J A (1974), "Helping Old People with Mental Illness" in *'Nursing Mirror'*, 22nd March 1974, pp76-77). Similarly, a further author noted that professional advice 'no matter how well meant, can only be offered' (Chisholm M K (1972a) "The health visiting scene; I. The health visitor's field of work" in *'Nursing Mirror'*, 17th March 1972, pp33-34).

56. Brearley C P (1972), in *'Social Work Today'*, op.cit., (reference 53).

57. In full, the article stated that 'At no point in social work practice is this dilemma of conflicting values greater than in clashes between the rights and interests of different people intimately interwoven in the same situation. Probably the most acute form of this conflict in social work arises in relation to the rights of parents versus

the welfare of the child', The article continued to indicate the fact that there were no simple answers to this dilemma, although in general the social worker would uphold 'the individual's rights to a major say in how he shall live his life' (Younghusband E (1970) "Social work and Social Values" in *'Social Work Today'*, September 1970, Vol 1 (6), pp5-13). For example, an author of a nursing article illustrated one area where conflict between client and carer might arise; in terms of receiving back home a relative discharged from hospital, 'Relatives sometimes become resistant, suspicious, apprehensive, or even aggressive when it becomes apparent that their elderly relative may be able to leave hospital' (Barrowclough F (1974) in *Nursing Mirror*, op.cit., (reference 32).

58. ibid., the point was made that 'No profession is more deeply involved in the problems of the rights and responsibilities of the individual and those of society, nor so close to the practical problems of implementing the great democratic ideals of liberty, equality and justice,, the ultimate aim of social work would be to promote the dignity and worth of the individual', Another article described social work as 'a helping profession where the science ethic is not predominant, the emphasis is on humanity not efficiency' (Rice D (1972) "A Conflict of Values" in *'Social Work Today'*, 10th August 1972, Vol 3 (10), pp2-4).

59. It was said that 'social workers are,,,more tolerant towards deviants, inadequate and isolated people, the failures, the misfits, and the awkward customers, than in the community in general' (Younghusband E (1970) in *'Social Work Today'*, op.cit., (reference 57).

60. For example, one author attributed 'the beginnings of,,,today's tragedies of old people dying neglected and alone' to the development of social work (Grisbrook P (1973) "What hope for future social services" in *'Nursing Mirror'*, 22nd June 1973, p12).

61. Mitchell R (1974a), "Medical Model v, Social Model" in *'Nursing Times'*, 28th November 1974, pp1851-1853. In terms of the allocation of resources, for example, it was commented that the clinical imperative fro patient throughput, the existence of "swap" arrangements and bartering between hospital clinicians and part III homes, the admission and discharge criteria for residential resources, all meant that an old person's wishes to stay put were 'largely irrelevant' (Brearley C P (1972) in *Social Work Today'*, op.cit., reference 52).

62. The editorial referred to the 'failure of local authorities to provide hostels and other accommodation that would allow patients to be discharged from hospital to the community' (Editor (1974) in *'British Medical Journal'*, op.cit., (reference 33).

63. The article continued, commenting that residential accommodation should be available to

elderly people 'not merely as a second best substitute for proper living' (Cowan E (1972) in *'Nursing Mirror'*, op.cit., (reference 32)).

64. Muir Gray J A (1975), "Housing for the Elderly" in *'Housing Monthly'*, July 1975, Vol 11 (7), pp28-29. Similarly, a later article noted that 'We do not think that it is too extravagent to say that the concept of sheltered housing has been the greatest breakthrough in the housing scene since the war' (Underwood J & Carver R (1979), "Sheltered Housing, How have things gone wrong - what's coming next?" in *'Housing'*, March 1979, pp8-10); see also Underwood J (1979), "Quality is not enough!" in *'Housing'*, July 1979, Vol 15 (7), pp12-13.

65. However, it is notable that a later housing article reported that research indicated that the majority of elderly people did not want to live in sheltered housing (Muir Gray J A (1976) in *'Housing Monthly'*, op.cit., (reference 38)).

66. Housing articles referred to 'upheaval and frustration, mentally and physically, to an elderly person' arising from transferring elderly people between accommodation (Smith M A (1966) in *'Housing'*, op.cit., (reference 24)); 'it is worth considering alternative policies, particularly with a view to avoiding moving people about at a time of life when it is difficult to adjust one's living habits, and to maintaining as much independence as possible' (Fox D (1971), "The Needs and ways of Meeting Them" in *'Housing Review'*, July-August 1971, pp98-101). A further article suggested that 'if we keep on providing housing which only meets the immediate needs of elderly people, we must also maintain a policy of moving them to and for at a time of life when this is particularly undesirable' (Fox D (1974), "Housing Needs for the elderly" in *'Housing Monthly'*, November 1974, Vol 10 (4), pp 3-8). But a social work article highlighted the dangers of relocating elderly people - Yawney B A & Slover D L (1973), "Relocation of the elderly" in *'Social Work'*, May 1973, pp86-95.

67. For example, 'Experience showed that old people generally preferred bungalows, dispersed on estates where they could take part in the life of the community...Aged persons do not favour segregation' (see Wofinden R C (1961) in *'Housing'*, op.cit., (reference 2)); 'the elderly...hate being segregated too much from the everyday life of the community' (Turner J (1968), "Housing the Elderly" in *'Housing'*, May 1968, Vol 4 (1), pp15-17); 'wherever possible ...(old people) should be accommodated in familiar surroundings where they could participate in the life of the community' (Webb M M (1970), "Housing Old People" in *'Housing Review'*, July-August 1970, pp114-116). However, one author of a housing article stated that the growth of sheltered housing would 'create a society in which old people would be segregated in more and more special houses for the elderly' (Isaacs B (1969), "Housing for Old People - The

Viewpoint of a Geriatrician" in *'Housing'*, November 1969, Vol 5 (4), pp18-22). A later article sat on the fence; 'Some research shows that the elderly prefer to be with their own while other research shows that they prefer a variety of ages around them' (Tinker A (1977), "What sort of housing do the Elderly want?" in *'Housing Review'*, May-June 1977, pp54-55); on this topic another journal was to not that 'The golden rule is that there is no golden rule' (Muir Gray J A (1976), "Housing for Elderly People, Heaven, Haven and Ghetto" in *'Housing Monthly'*, June 1976, Vol 12 (6), pp12-13). It was argued elsewhere that the idea that elderly people were 'best housed as part of the normal community' was 'losing ground'. There was even some support for the argument that 'complete segregation is desirable' (Fox D (1971), in *'Housing Review'*, op.cit., (reference 66)). These views were repeated three years later; see Fox D (1974), in *'Housing Monthly'*, op.cit., (reference 66).

68. See Brearley C P (1972) in *Social Work Today'*, op.cit., (reference 52). See also reference 37 above.

69. In a letter it was commented that elderly people were being increasingly admitted to hospital 'because the community support them' but the 'the hospital will not be able to return them to the community because of this lack of support', as a result 'I see us paying enormous sums to keep people in the wrong place at the wrong time for entirely the wrong reasons' - see Burston G R (1974), "State of the Economy and the Geriatric Services" in *'British Medical Journal'*, 14th December 1974, p652. A similar view was expressed in Commentary (1971) "Mixture as Before" in *'British Medical Journal'*, 18th December 1971, p700.

70. See the comments of Dr A McGregor (1971) "Report of a Royal Society of Health Congress; The health and social services in the 70's" in *'Nursing Mirror'*, 30th April 1971, pp10-12. A social work article highlighted a large range of factors which militated against adequate collaboration between social workers and doctors; differences of approach, perceptions of each other's roles, differences in work tempo, authority and accountability links, organisation of profession, records and confidentiality. This article referred to 'a basic difference in orientation between these two groups. This situation fosters a potential for bad communication, differences in perception of needs and priorities, and the action to be taken in response to these'. The lack of role clarity of such professionals led 'to confusion, frustration, gaps in the provision of services and mutual recrimination'. As a result of these and other the other factors mentioned, 'inter-professional hostility' resulted, based on 'feelings of mutual frustration and impatience' (Ratoff L, Rose A & Smith C R (1974), "Social Workers and GPs" in *'Social Work Today'*, 14th November 1974, Vol 5 (16), pp497-500).

71. See Clark J (1973b), "Who's afraid of integration?" in *'Nursing Times'*, 23rd August 1973, p1104, the author commented that 'If social workers do not know what health visitors do they are not alone'. The role of health visitors vis-a-vis social workers was raised in a number of articles. For example, see McGregor A (1971) in *'Nursing Mirror'*, op.cit., (reference 70) which noted the view that 'a role must be found for the health visitor', elsewhere it was suggested that health visitors were involved 'to some extent in social care' but not 'in any way sub-standard social workers', although later it was added that one doctor confronted 'with any social problem' would turn 'first to his health visitor'; another article referred to the fact that 'The social worker, too, may sometimes appear to be encroaching on the health visitor's field of work' (Chisholm M K (1972a) in *Nursing Mirror'*, op.cit., reference 55. At this time, there were a range of special features attempting to clarify the role of the health visitor; see a range of Occasional Papers by Hunt M (1972a), "The dilemma of Identity in Health Visiting 1' in *'Nursing Times'*, 3rd February 1972, pp17-20 which stated that 'There seems to be a common feeling among health visitors that their role is difficult to interpret to others', reference was made to them being 'jacks of all trades'; Hunt M (1972b) "The dilemma of Identity in Health Visting 2' in *'Nursing Times'*, 10th February 1972, pp23-24; Clark J (1972a) "1. What do Health Visitors do?" *'Nursing Times'*, 27th July 1972, pp117-119 commented that 'Uncertainties about roles and responsibilities have led to widespread anxieties among health visitors about about their position in the community health services and their relationships with other branches of the social services'; Clark J (1972b) "2. The 'new breed' Health Visitor", in *'Nursing Times'*, 3rd August 1972, pp121-122. Another article highlighted the confusion as to the roles of the community psychiatric nurse, the health visitor, district nurse and social worker (Leopoldt H (1974), "The role of the Psychiatric Community Nurse in the Therapeutic Team" in *'Nursing Mirror'*, 19th April 1974, pp70-72); see also Corbally M (1971), "Who should visit the aged?" in *'Nursing Mirror'*, 10th September 1971, pp14-15; another article referred to an obvious 'overlap' between the work of the social worker and the community nurse (Mitchell R (1974b), "Institutional psychiatry v. community psychiatry" in *'Nursing Times'*, 14th November 1974, pp 1769-1771). More generally, one nursing article had made the point that 'inter-professional relationships are of paramount importance in bringing effective care to the patient' (see Izzard R C F (1972), "The GP and the Family Health Team: 2. Observations on Interprofessional relationships" in *'Nursing Times'*, 11th May 1972, p574).

Similarly, early housing articles indicated similar difficulties of collaboration between housing and social service departments - see Tattersall V (1974), "Links

between Housing and Social Services I" in *'Housing Review'*, January-February 1974, pp9-11; Brown E (1974) in *'Housing Review'*, op.cit., (reference 48). Similarly, in two medical articles it was claimed that there was little difference in the roles of health visitors and social workers - Special Correspondent (1974a), "Rural Views", in *'British Medical Journal'*, 15th June 1974, pp595-596; Special Correspondent (1974b), "City Problems" in *'British Medical Journal'*, 22nd June 1974, pp659-660.

72. Jones J I (1971), "Bridges linking health and care in the '70s - 2, Public Health Services" in *'Nursing Mirror'*, 1st October 1971, pp12-16.

73. See *'British Medical Journal'* articles; Special Correspondent (1974a), op.cit., (reference 71); Special Correspondent (1974b), op.cit., (reference 71); Special Correspondent (1974c), "Seaside Problems", 29th June 1974, pp720-721; Special Correspondent (1974d), "A social worker speaks", 6th July 1974, pp36-37; Special Correspondent (1974e), "Psychiatric Aspects", 13th July 1974, pp109-110; Special Correspondent (1974f), "A paediatric opinion", 20th July 1974, pp164-165.

74. Griffiths A (1974), "Psychogeriatric liaison health visitor" in *'Nursing Times'*, 31st January 1974, pp152-153. Another article mentioned that in terms of mental health patients, that 'No one would deny that to keep these patients in the community for even a few months is a tremendous achievment and is well worth while' - Johnson M L (1972), "Mental health revolution" in *'Nursing Mirror'*, 17th March 1972, p26. Elsewhere it was stated that 'the majority of old people also object very strongly to being removed from their homes' (Whitehead J A (1971), "Myths of mental illness in the elderly" in *'Nursing Mirror'*, 27th August 1971, pp18-20). A letter in a medical journal referred to the 'modern emphasis,,,on maintaining the elderly and demented in the community' (Butler P R (1973) "Priorities in Medicine" in *'The Lancet'*, 9th June 1973, p1311.

75. For example, an author said that elderly infirm people should remain in the community if possible, provided this was 'compatible with a reasonable standard of existence' (Whitehead J A (1971) in *'Nursing Mirror'*, op.cit., reference 74). One article suggested, for example, that 'When old people start wandering out of their house at night,,,"shop" at 2,a,m, turn on gas taps, spill paraffin around the home and become hostile to kindly neighbours, it becomes obvious that the time is approaching when they will be admitted to a geriatric hospital' (Unwin F T (1973), "Coping with Geriatrics' in *'Nursing Times'*, 13th December 1973, pp1692-1693). Another author suggested that 'Provided the,,,facilities are adequate,,,the patient can be nursed at home', thereby suggesting that it was the type of services and accommodation available which should determine community care (Young J P R (1974) "Psychiatric morbidity in the elderly" in *'Nursing Mirror'*, 23rd August 1974, pp60-62).

76. Mitchell R (1974c), "Senile Disorders" in *'Nursing Times'*, 22nd August 1974, pp1305-1307. The author added that 'Many patients can remain at home if use is made of all the support systems now available'.

77. This article continued; 'Most old people would prefer to remain in their own homes and, indeed, most families would not wish to see them "put away"' - see Barker A & Black S (1971), "An Experiment in Integrated Psychogeriatric care" in *'Nursing Times'*, 11th November 1971, pp1395-1398.

78. Brearley C P (1972) in *'Social Work Today'*, op.cit., (reference 52). In comparing the advantages of institutional and community-based psychiatric care there was some dabate as to which method was better; 'There are faults on both sides. Institutional care is blamed for,,, encouraging dependence on authority and enphasising too much,,,the "medical model" of psychiatry,,,community care programmes are criticised as grand theory because the community does not care, and families and patients are left to suffer in silence, with untold damage being done to family life,,,community care programmes are often seen as an excuse for loose, uncritical thinking, with the abdication of responsibility'. The author then asked, 'Do these approaches need to be seen as totally antithetical? Could they not be seen as genuine alternatives,,,Could there not be times when it is therapeutically better and necessary to provide old-fashioned "asylums" that is a secure, warm, understanding place,,,We need to know which option is best in given circumstances' (Mitchell R (1974d) "Advances in Psychiatry. Institutional psychiatry v community psychiatry" in *'Nursing Times'*, 14th November 1974, pp1769-1771). Elsewhere a medical journal stated that poor levels of community support for discharged mentally ill people mean that 'these people could fare no worse, and could well fare better, in a mental hospital' (see Commentary (1971) "The Need for Mental Hospitals" in *'The Lancet'*, 27th February 1971, pp438-439).

79. As was said 'the idea that it is "good for" the patient to be cared for within the community and it is "good for" the community to learn to care for their ill and handicapped ,,,can be carried to unwarranted lengths' (Jones J I (1971) in *'Nursing Mirror'*, op.cit., (reference 72)). A 1971 medical commentary noted that 'the policy of discharging patients as soon as they had lost their positive symptoms was not in their best interests, many patients needed much longer stays in hospital' (see the 1971 commentary in *'The Lancet'*, op.cit., reference 78).

80. See McNally D J (1972), "Whither Mental Health? in *'Nursing Mirror'*, 24th November 1972, pp36-37. One writer stated in terms of the elderly mentally infirm, that 'the outlook for the future looks pretty grim' (see the Commentary (1973) "Care of elderly people with dementia" in *'British Medical Journal'*, 24th February 1973, p434). Another

article suggested that if elderly infirm people were to be maintained at home the 'improved community care appears to be needed' (Barker A & Black S (1971) in *'Nursing Times'*, op.cit., reference 77).

81. Stewart M, Kerr B & Dunlop W (1974), "Psychiatric Nurse in the Community" in *'Nursing Mirror'*, 5th July 1974, p84. Similarly, an author of a letter to a medical journal stated that elderly people were admitted to hospital increasingly because of the poverty of community services, and were being kept in hospital for the same reason (see Burston G R (1974) in *'British Medical Journal'*, op.cit., (reference 79)).

82. See the comments of Dr H Levitt in Robinson W A (1972), "Mental Health and the Community" in *'Nursing Times'*, 16th November 1972, p1452. This article referred to community care as a 'treacherous, seductive phrase'. A separate article stated that 'More patients could be settled into community care if more money was available for building purpose-built homes' (Mitchell M (1974d) in *'Nursing Times'*, op.cit., (reference 78)). Another author stated that 'There are fears that psychiatric hospitals will become geriatric ghettoes where old people are dumped and then forgotten about' (Whitehead J A (1974), "Community and hospital services in Brighton" in *'Nursing Mirror'*, 29th August 1974, pp1340-1341).

83. Olsen R (1972), "From the Medical Journals" in *'Social Work Today'*, 14th December 1972, Vol 3 (18), pp19-20; Tucker D (1972), "Number of Mental Hospital Beds" in *'The Lancet'*, 4th November 1972, p921. See also the short commentary in a medical journal which referred to the 'crying need' for better reception facilities for such patients and 'Adequate provision is long overdue for this to meet this pressing need' - see Commentary (1973) "The unacceptable patient" in *'The Lancet'*, 3rd November 1973, pp1011-1012.

84. See Jones J I (1971) in *'Nursing Mirror'*, op.cit., (reference 72).

85. Another commentator warned that 'Relatives were found to be under the greatest strain where the elderly person had some form of mental abnormality' (see Commentary (1972a) in *'The Lancet'*, op.cit., (reference 37)). See also Arie T (1973a), "Dementia in the Elderly; Management" in *'British Medical Journal'*, 8th December 1973, pp602-604. Another commentary "Care of Elderly People with Dementia" stated that 'the outlook for the future looks pretty grim" in *'British Medical Journal'*, 24th February 1973, p434. By contrast, another article suggested that 'Relatives should be encouraged to care for their old folks for as long as possible' - see Mitchell M (1974e) "Rehabilitating Psychogeriatric Patients" in *'Nursing Times'*, 18th July 1974, pp1123-1124.

86. Williams E I E & Wilson T S (1974), "A psychogeriatric service in West Cornwall" in *'Nursing Mirror'*, 26th April 1974, pp59-63.

87. See the 1973 commentary in *'The Lancet'*, op.cit., (reference 83) which referred to the notes of an elderly confused person consisting 'largely of referrals and appeals to other specialists and administrators for the removal of the patient, and their negative responses ...one cannot read this account without forming the impression that the bed rather than the patient was the important subject at issue...(there was) widespread dissension between the psychiatrists and geriatric physicians over the ultimate proportion of their respective responsibilities in this field'.

88. This article also referred to the elderly mentally infirm as an 'unwanted group', see White D M D (1972), "Psychogeriatrics - what next" in *'The Lancet'*, 29th July 1972, pp223-224. Another article added that 'many doctors and social workers cannot formulate a "psychogeriatric" problem in any other terms but as the need to get it instantly off their hands' (Arie T (1973b), "Dementia in the Elderly: Diagnosis and assessment" in *'British Medical Journal'*, 1st December 1973, pp540-543).

89. Arie T (1973b) in *'British Medical Journal'*, op.cit., reference 88. A separate article referred to the elderly mentally infirm as an 'unwanted group' - see White D M D (1972) in *'The Lancet'*, op.cit., reference 88.

90. See, for example, the short 1972 commentary "Psychogeriatric care", in *'The Lancet'*, 8th July 1972, p73-74, which referred to the problem 'that many of the mentally impaired elderly must at present be sent arbitrarily to geriatric or psychiatric units, depending on the availability of beds and not on any clinical differentiation'.

91. This article pointed out that the responsibility for the elderly mentally infirm was unclear with the responsibilities of different agencies not necessarily bearing any relation to each other. The position was perceived as no better just within the health service - the elderly mentally infirm 'may also fall between the geriatric physician and the psychiatrist, both of whom tend to believe that these patients are really the responsibility of the other' - see White D M D (1972), in *'The Lancet'*, op.cit., (reference 88). See also the 1972 commentary in *'British Medical Journal'*, op.cit., (reference 90) which stated that 'In attempting to define the responsibility of psychiatrists for the care of the elderly they differentiate between the acute organic brain syndromes...which are allocated to the province of the geriatric physicians, and the functional psychiatric disorders, which are accepted as the responsibility of the psychiatrists', but 'The chronic brain syndromes...are not easy to allocate to an appropriate speciality'. See also a series of letters in the *'British Medical Journal'*: Dunn T B (1971) "Psychogeriatric Services", 31st July 1971, pp308-309; Davies M H (1971), "Psychogeriatric Services", 11th September 1971, p641; Severman M (1971), "Psychogeriatric Care", 14th August 1981, p435; Nicol L G (1971), "Psychogeriatric

Care", 14th August 1981, p435; Nicol L G (1971), "Psychogeriatric Care", 21st August 1971, p478. See also the commentary in *'British Medical Journal'*, op.cit., (reference 90), which referred to the 'wandering, active patient with chronic brain syndrome but without psychotic or behavioural disturbance' as a patient 'apt to be seen as a medical problem by the psychiatric, a psychiatric problem by the geriatric physician, and a hospital problem by the hard-pressed welfare-home attendant'. See also Arie T (1971) in *'British Medical Journal'*, op.cit., (reference 42).

92. See the 1971 commentary in *'The Lancet'*, op.cit., (reference 78) - which stated that mental hospitals were 'in danger of being destroyed without an adequate substitute being provided'.

93. See the 1972 commentary in *'British Medical Journal'*, (reference 90). Another article argued that 'very few' of the EMI needed hospital care at all - Arie T (1971) in *'British Medical Journal'*, op.cit., (reference 42).

94. Arie T (1973) in *'British Medical Journal'*, op.cit., reference 88. See also Ratoff L (1972), "Seebohm and the mental health services" in *'Social Work Today'*, 2nd November 1972, Vol 3 (15), pp3-6.

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96. See the three "priorities" documents; DHSS (1976) "Priorities for Health and Personal Social Services in England: A Consultative Document", London; HMSO; DHSS (1977) "Priorities in the Health and Social Services. The Way Forward", London; HMSO; DHSS (1981) "Care in Action: A Handbook of Policies and Priorities for the Health and Personal Social Services"", London; HMSO. The two elderly-specific documents were; DHSS and Welsh Office (1978) "A Happier Old Age", London; HMSO and DHSS (1981) "Growing Older", Cmnd 8173, London; HMSO. Other community care documents to note in this period were; DHSS (1981) "Care in the Community. A Consultative Document on Moving Resources for Care in England", London; HMSO and DHSS (1981), "Report of a Study on Community Care", London; HMSO.

97. For example, it was commented that 'the personal social services are woefully unprepared to face up to,,,(the) implications' of an ageing population since 'Sheltered housing, domiciliary care and residential accommodation are all inadequate' (Bamford T (1978a), "Comment; Getting right the balance of care' in *'Social Work Today'*, 2nd May 1978, Vol 9 (34), p1). Community care was described as 'the rallying cry of progressives and politicians' which was undermined by 'shortcomings of provision' which had 'constantly threatened the laudable principle' (Editor (1982), "A slogan without a programme" in 'Community Care', 25th March 1982, No 404, p1. Another article reported

'That community care,,,is not what it was, is one of the few topics on which professionals, irrespective of their profession, agree when they meet to discuss the problems of elderly people' (Armstrong J (1976), "Must our old folk always sit it out alone?" in *'Community Care'*, 27th October 1976, pp21-23). See also Wheatley V (1980), "Relative stress" in *'Community Care'*, 28th August 1980, pp22-23. A separate article put a simliar view; although 'A geriatric unit can get people ready to go back into the community,,,the community is not ready to cope with (them)' (Brown L (1976), 'The caring way out of the "swap"', *'Community Care'*, 3rd March 1976, pp17-19). Community caree had been pursued, it was argued, 'despite indications of the inadequacy and inappropriateness of many of the services concerned' (Stewart G & Stewart J (1979), "The self-help phenomenon" in *'Social Work Today'*, 7th August 1979, Vol 10 (47), pp14-16). Another article argued that 'Closing homes and transfering resources from residential care to field and domiciliary practise may seem to be a way of keeping people out of institutions by providing more, less costly care in the community. But unless radical changes are made in the style of community care offered, there is no evidence to suggest the expression of existing field work services will do anything more than process more people more quickly through the system, with, evidently, less residential units to pick up the "failures" and help them back on their feet' (Ward L (1977) "The centre way to caring", in *'Community Care'*, 5th October 1977, pp18-20). See also Plank D (1978), "Old people's homes are not the last refuge" in *'Community Care'*, March 1st 1978, pp16-18.

See also Salvage J (1980), "Crisis of Costs?" in *'Nursing Mirror'*, 12th June 1980, pp31-33 which recorded the view that 'the biggest impact of the cuts is on the services the community is getting', later stating that 'Acute hospitals are trying to ease the problem of long waiting lists of speeding up "patient throughput": many patients are discharged early, to be looked after in "the community" by understaffed primary care care and social services teams, or by relatives', adding that 'There is an increasing danger of old people remaining in hospital for an unnecessarily long time, and being discharged without adequate provision to get them on their feet at home'.A separate article commented that 'It has become fashionable to emphasise the importance of independence, freedom of choice, dignity and the ability to live at home supported by health and social services, with relatives and volunteers playing an important role. For many old people without family support, or for those cared for by ageing relatives, such opportunity is an idealistic day dream for both the individual and his or her carers. The stark reality is often unsuitable accommodation, with poor or no access to public buildings or transport services, leading to isolation and loneliness' (Manley R

(1982), "Look back in anger" in *'Nursing Mirror'*, 4th August 1982, pp38-40). Domiciliary care for the elderly was viewed by one geriatrician as 'economic' simply because 'the level of care provided becomes increasingly inadequate' (Opit L J (1977), "Domiciliary care for the elderly sick - economy or neglect?" in *British Medical Journal*, 1st January 1977, pp30-33).

98. Reference was made in one article to the 'consistent failure to translate fine principles into practice' in respect of community care policies, adding that the 'rising numbers of elderly,,,militate against any easy transfer of resources to community based services' - Bamford T (1976), "Priorities document - reality or rhetoric?" in *'Social Work Today'*, 19th October 1976, Vol 8 (3), p1. Elsewhere it was argued that unless 'positive initiatives are launched in the community', then community care for the mentally ill and elderly would become 'not a concept to be welcomed, but a cheap and wholly disgraceful con' (Editor (1976) "Why directors now need to start planning for the future" in *'Community Care'*, 31st March 1976, No 104, p1). One nursing article commented that in terms of generating 'a shift towards community care for the elderly', the 1976 'Priorities' document 'scores rather low marks' (Bosanquet N (1976), "Forgotten Groups" in *'Nursing Times'*, 1st April 1976, p480). From a medical perspective, the response in the medical journals was no better, see for example, Knox E G (1976), "Priorities for Health, A manipulative document?" in *'The Lancet'*, 9th October 1976, pp790-792 which referred to the priorities document as a 'manipulative,,,a confused,,,and harmful paper'.

One social work article criticised the 1981 "Care in the Community" initiative: 'the Government's unwillingness to match resources to words implicitly denies the rights it expounds, turns fine words into pious mouthings and shows again the chronic unwillingness for central government to act decisively'. The 1981 document represented a 'cruel setback to the hopes,,,of those seeking better community care' (Editor (1982), "No care in the community" in *'Community Care'*, 5th August 1982, No 423, p1).

99. Knox E G (1976) in *'The Lancet'*, op.cit., (reference 98); an editorial refers to the philosophy of the document as 'defeatist' and a 'policy of despair' - see Editor (1976), "A policy of despair" in *'British Medical Journal'*, 3rd April 1976, pp787-788; finally, another medical source referred to the comments of Ross A P J (1976) in an edited version of comments made at a BMJ day conference on the priorities document - "Priorities" in *'British Medical Journal'*, 12th June 1976, pp1447-1454, which stated that the document represented a 'recipe for disaster'.

100. See Parliamentary Correspondent (1978), "Mr Ennals Sticks to his Priorities" in *'The Lancet'*, 4th March 1978, p511. One contributor at a Conference stated that he

was 'troubled' at 'the lack of emphasis on the importance of hospitals' associated with the Priorities document, another stated that 'What terrifies me in the document is a phrase like "the necessity to keep people out of hospital" - see edited version of comments made at a BMJ day conference on the priorities document - in *'British Medical Journal'*, op.cit., (reference 209). These concerns re-emerged following the publication of the 1977 sequel to the 1976 priorities document; a commentary regarded the squeezing of the acute sector as 'obdurate politics' (see the 1977 commentary "Obdurate politics" in *'British Medical Journal'*, 24th September 1977, pp785-786).

101. See the brief introductory comment to "Care in the Community" in the Community Care Supplement to the *'Nursing Times'*, 27th May 1976, piii. Elsewhere, reference was made to the NHS 'only belatedly recognising this shift,,,that primary care and the "chronic" services need a greater share of resources,,,the acute services have always had the lion's share of the resources' - Manley R (1982) in *'Nursing Mirror'*, op.cit., (reference 97); 'in the minds of those who allocate resources geriatric medicine is given a much lower status than the acute specialties' (Dent R V (1977) "Geriatric care in hospital" in *'Nursing Times'*, 29th September 1977, pp1507-1509); 'planners now recognise,,,that primary care and the "chronic" services need a greater share of resources' (Salvage J (1980), in *'Nursing Mirror'*, op.cit., (reference 97)).

102. See the 1977 editorial, "After-care, still an after thought" in *'Community Care'*, 27th July 1977, No 172, p1.

103. One conclusion reached by the author, as a result of such policy ambiguity was that 'despite reiterated commitment of successive governments, the policy of community care remains precarious' (Walker A (1981) "When there's someone to help you, there's no placed like home" in *'Social Work Today'*, 20th January 1981, Vol 12 (20), pp10-13); see also reference 97 above.

104. The following statements illustrate the perceived vagueness of community care in social work journals; it was commented that there was 'little guidance at policy level on the precise nature of "community care"' for a number of client groups (Hudson B (1980), "Investment in people" in *'Community Care'*, 26th June 1980, pp24-26); despite 'ever-increasing emphasis' placed on community care by successive governments, the phrase remained a 'much vaunted but little understoof term' (Rossiter C & Wicks M (1982), "The future of family care" in *'Community Care'*, 23rd September 1982, pp19-20); reference was made to ministerial 'lip service' paid to caring for elderly people in the community' since in respect of community care, 'the looseness of their definitions has allowed them to take comfort in their achievements', hence community care policies were an example of where 'the shoddiness of government planning really shows through'

(Editor (1979), "Waging a war for the elderly" in *'Community Care'*, 22nd March 1979, No 256, p1); 'Transforming the concept of community care into reality' had, it was argued, 'preoccupied governments', but proved to be 'an elusive goal' (Harbridge E (1981), "Can community care win the resources tug-o-war?" in *'Community Care'*, 16th July 1981, pp12-14); although supported by 'so broad a political spectrum', community care amounted to 'an article of belief' (Stewart G (1978), "The politics of community care" in *'Community Care'*, 23rd August 1978, pp24-25); it was argued that 'unless we define what we mean,,,then community care will come to be,,,a slogan without a programme' (Editor (1982), "A slogan without a programme" in *'Community Care'*, 25th March 1982, No 404, p1).

105. See the letter by Cooper R G (1976a) under the general title "Can geriatrics survive?" in *'British Medical Journal'*, 12th June 1976, pp1464-1465. For example, the letter stated that 'We know little about them (the elderly) medically because we have been trained to deal well with acute, short-term problems and to deal even better with them if their solution holds promise of personal kudos'. A separate article referred variously to the elderly presenting to doctors what was perceived as 'an insoluble problem', since 'Many physicians too readily assume that the maladies of old age are irreversible'. More generally, the low status accorded to geriatric specialty meant that this part of medicine was staffed by a 'motley crew' of doctors. The author of this article tried to counter such negative stereotyping, arguing that 'the clinical, problems of old age can provide a stimulating challenge' (Cape R D T (1979), "Geriatric Medicine; System or Science?" in *'The Lancet'*, 27th October 1979, pp892-893).

106. Both comments were made in letters under the general title "Can Geriatrics Survive?"; the first comment in a letter by Wasty S S H (1976) in *'British Medical Journal'*, 12th June 1976, p1466; the second comment in the letter which followed this by Fleetwood J (ibid). As a result of such attitudes reference was made to the exclusion of old people to certain wards (see the letter by Hart C (1976), in *'British Medical Journal'*, 3rd January 1976, p41).

107. See the letter by Cooper R G (1976b) in *'British Medical Journal'* op.cit., (reference 105). An article stated that 'universal improvement in the care of the elderly will not take place unless there is a change of attitude towards the medical care of the elderly' (Working Party of the Royal College of Physicians of London (1977) "Medical care of the elderly" in *'The Lancet'*, 21st May 1977, pp1092-1095). An article added that for the elderly 'The present arrangements seem to me to be arbitrary, inefficient, unsatisfactory, and uneconomic' (Leonard J C (1976), "Can geriatrics survive?" in *'British Medical Journal'*, 29th May 1976, pp1335-1336).

108. Barrowclough F (1982) "Be prepared" in *'Nursing Mirror'*, 24th February 1982, pp36-39. For example, it was claimed that nurse training created 'patient-client dependency and depersonalisation - the antithesis of individuality, dignity and choice propounded by theorists' (Manley R (1982) in *'Nursing Mirror'*, op.cit., (reference 97)); reference was made to the 'disease and hospital-orientated' ethos in such training courses (see the summary report on a working group organised by the World Health Organisation (1977) "Nursing care of the elderly" in *'Nursing Mirror'*, 24th March 1977, pp40-41).

109. Garland M H (1977), "The challenge of geriatric medicine" in *'Nursing Mirror'*, 3rd November 1977, pp15-16. Another author said that in terms of old people 'I am concerned about whether they are seen as fully responsible adults or as something rather less' - Baker D E (1978) "Future care for the elderly" in *'Nursing Times'*, 9th February 1978, pp237-238. A further article referred to 'passive euthanasia', where the old were the victims of 'manslaughter through neglect' (see Hetherington R J (1979), "Fallacies in Geriatrics", in *'Nursing Times'*, 26th April 1979, pp718-719). A series of articles made wide-ranging comments about the relationship between nursing and the care of elderly people. In terms of training, it was stated that 'Basic nurse training prepares the learner for bedside nursing which is physical in plan and short-term in management. This is not adequate preparation for the care of the majority of elderly people in hospital' (Kemp J (1978), "Planning hospital care" in *'Nursing Times'*, 2nd February 1978, pp198-199); 'unfortunately very little' of medical education is about the care of the elderly (Bosanquet N (1976) in *'Nursing Times'*, op.cit., (reference 98)); 'The nurse is not prepared by traditional nurse-training programmes for dealing with the highly complex personal and social relationships and influences which exist with regard to the care of the elderly, and systems of care are often applied which are based on those of acute wards. Specialised training for the care of old people remains restricted and continues to be considered as a low priority' (Barrowclough F (1977) "The Elderly in Institutions" in *'Nursing Mirror'*, 15th December 1977, pp27-28); the same author added some years later that 'nursing is taught as a disease-oriented, technical activity,,,such training fails to help the nurse develop the skills, knowledge and attitudes appropriate to the care of older people' (Barrowclough F (1982) in *'Nursing Mirror'*, op.cit., (reference 108)).

110. Fellows G & Marshall M (1979), "Services for the homeless elderly" in *'Social Work Today'*, Vol 10 (35), 8th May 1979, pp16-17.

111. This was reported in the news section; Community Care (1976), "Casework for elderly is 'non-existent'" in *'Community Care'*, 8th September 1976, p7. See also Baldock P (1977), "Social Work with the elderly" in *'Social Work Today'*, 12th April 1977, Vol 8 (27), p1,

who commented that 'social workers put the elderly low down on their list of preferences for kinds of work', saying that 'The reasons for disliking work with elderly people are manifold'; Wilkes R (1978) "General philosophy and attitudes to ageing" in *'Social Work Today'*, 25th July 1978, Vol 9 (45), pp14-16; reference was made to 'the reluctance to work with old people' by social workers (Hobman D (1977), "Personal View; Ageing and the social worker" in *'Social Work Today'*, 25th January 1977, Vol 8 (16), pp11-12); the same author stated that 'many social workers shy away from old people' (Hobman D (1978a), "The Elderly; Encountering death in old age" in *'Social Work Today'*, 5th September 1978, Vol 10 (2), p19).

112. See the news item, Community Care (1981), "Bias against the elderly" in *'Community Care'*, 21st May 1981, p5; see also the two news reports by Draper J ("The old suffer as 'Colwell' fears linger" & "No 'pay-off' in work with aged?" in *'Community Care'*, 9th November 1977, p4); Nicholson N & Paley J (1981), "What are the principles of practice? in *'Community Care'*, 30th July 1981, pp19-20. Another article referred to the 'relative neglect of the elderly by the social work profession' - Challis D & Davies B (1980), "Bringing better community care" in *'Social Work Today'*, 5th February 1980, pp14-15.

113. Hobman D (1977) in *'Social Work Today'*, op.cit., reference 111; Baldock P (1977), in *'Social Work Today'*, op.cit., (reference 111); Hobman D (1978b), "The elderly; where does the social worker stand?", in *'Social Work Today'*, 7th February 1978, p15; Marshall M (1979), "Fighting the fight against ageism" in *'Social Work Today'*, 18th December 1979, Vol 11(16), p16; Muir Gray J A (1980), "Time to dispel Ageism" in *'Social Work Today'*, 5th February 1980, Vol 11 (22), p1; Marshall M (1980), "Slow progress on the mental health front" in *'Social Work Today'*, 5th February 1980, Vol 11 (22), p16; BASW Conference (1979), "Possibilities for the elderly" in *'Social Work Today'*, 9th October 1979, p21.

114. For example, it was stated that home care was based on the belief that 'elderly people are happier if they can be supported in their own homes for as long as possible'; leading to the view that residential care was 'largely inappropriate' (Jones G (1979) "Future Models for Old People's Homes" in *'Social Work Today'*, 30th October 1979, Vol 11 (9), pp23-24). One author believed that local authority and voluntary sector administrators 'all subscribe implicitly or explicitly to the primacy of community care' (De Paul V (1980), "Old and Alone" in *'Community Care'*, 13th November 1980, pp19-20). One article stated that 'the government should declare an unequivocal commitment to reverse the emphasis of social policy in old age from care in institutions to care in the wider community', arguing that care outside institutions 'should not be based on considerations of cost-effectiveness or on the well documented pathologies of

institutional life, but on the urgent need to give priority to developing preventative services and to keep the individual within the therapeutic framework of the family circle and the sorrounding network of friends and neighbours' (Clough R (1978) "In residence; residential homes in the community" in *'Social Work Today'*, 21st February 1978, Vol 9 (25), p18), Another article referred to the fact that 'it has been widely accepted that a combination of informal care provided by the community and the state is preferable to care in an institution' - Wilkin D, Evans G & Jolley D (1978), "Better care for the elderly" in *'Community Care'*, 6th May 1982, pp22-24.

Supporting elderly people in the community was a matter on which 'all parties agree' (Brown L (1976), in *'Community Care'*, op.cit., (reference 97)). There was reference elsewhere to a 'party political consensus' to community care; Stewart G (1978), in *'Community Care'*, op.cit., (reference 104); in another article with the same co-author, reference was made to the fact that community care was viewed as a 'good thing', as 'beyond criticism' (Stewart G & Stewart J (1979) in *'Social Work Today'*, op.cit., (reference 97). It was stated that 'the answer must be for older people to stay in the communities they know well - amongst their friends, in familiar sorroundings' (Editor (1974), "Old Age is not the time to pull up one's roots" in *'Community Care'*, 15th May 1974, No 7, p1). See also Heptinstall D (1976), "Home Sweet Home" in *'Community Care'*, 27th October 1976, pp28-30 - this article questions the general approach to re-house elderly people in special accommodation arguing that each person's needs should be assessed individually.

Elsewhere the comment was made that 'There is no place like home and it is right that every effort should be made to enable elderly people to continue to live in their own homes for as long as possible if they so wish' (Sterenborg Y (1982), "From home to home" in *'Nursing Times'*, 22nd-29th December 1982, pp2191-2193). Another nursing article stated that 'the policy which we follow in this country of trying to maintain the elderly in their homes as long as reasonably possible is probably correct' - Dent R V (1977) in *'Nursing Times'* op.cit., (reference 101). Another author put it differently; 'Community care is something that nobody is against' (Bosanquet N (1977), "Community care for the elderly" in *'Nursing Times'*, 26th May 1977, pp791-792); 'There is general agreement that very old people should have the right to remain in their own homes' (Westworth B (1982), "A change of balance" in *'Nursing Mirror'*, Community Forum 7, 21st July 1982, ppviii-x, xii); 'Despite the problems, most old people wish to live in their own homes' (Keywood O (1978a) "Preparing the elderly to return home (part 2)" in *'Nursing Mirror'*, 14th September 1978, pp38-40. Similarly a letter in a medical journal stated that 'I vigorously support the view that home is the best place to live

out one's life' - see Jolley D J (1976) 'Admission of old people to hospital" in *'British Medical Journal'*, 18th September 1976, p696,

115, One author associated home care with 'woefully inadequate levels of care,,,in situations of personal risk, distress and miserable environment,,,the level of care for elderly people living in their own homes was substantially lower than in old people's homes or in sheltered housing' (Plank D (1978) in *'Community Care'*, op,cit,, reference 97); one author compared the fact that old people in hospital 'no expense was spared and personal care was lavished on them', but in the community old people 'strived to maintain adequate health and social standards, often in difficult circumstances' but received 'a minimum of attention' - a disparity which was 'traumatic and inexplicable' for old people (Cooper J (1981), "Patient Thinking" in *'Nursing Mirror'*, 12th August 1981, pp26-27); a social work article argued that 'The advantages of domiciliary support over residential care should not be overstated' (Hudson B (1977) "The inevitable provision" in 'Community Care', 13th July 1977, pp14-16; similarly, another article recorded the view that 'It is wrong to think that residential care equals bad and community care equals good' - Brown A (1977), "Home care can be for the best" in *'Community Care'*, 23rd November 1977, p7; community care was 'no panacea,,,by no means a cheap alternative to institutional provision' (Wilkin D, Evans G & Jolley D (1978) in *'Community Care'*, op,cit (reference 114)); home could mean 'a well appointed house with every comfort, and a loving family who are delighted to have the opportunity to show how much they care, Or,,,a damp and firty cottage with a harrassed and unhappy relative grudgingly do her "duty"', as the author went on to ask 'Do patients and their relatives necessarily prefer that care should be given in the home rather than in hospital? There is no simple answer to this, because the term "hospital" in the question can mean so many different things' (Watkin B (1976), "Community Care" in *'Nursing Mirror'*, 28th October 1976, p42); lastly a nursing article argued that although most old people wished to remain at home doing so could isolate them - 'the home which once spelled independence and freedom becomes a lonely prison of solitary confinement' (Keywood O (1978a) in *'Nursing Mirror'*, op,cit,, reference 114,

116, For example, one social work article argued that community care occurred by default owing to under-provision of residential care; 'Residential institutions have just overflowed into the community, And the solution now, whether the community likes it or not, is community care', so the author continued, 'It is time we moved beyond the negative reaction to residential institutions which fostered community care policy during the 1960's,,' (Stewart G (1978), in *'Community Care'*, op,cit,, (reference 104)), Another article saw the use of institutions as deterrants and asylums as a

situation which 'controlled thinking about community care' because 'a great deal' of community care had not developed from a perspective which saw community care as 'a major social goal in its own right'; it had 'nearly always been an offshoot from an institutional focus' (Meredith G (1978), "Care in the community - the cheap alternative" in *'Social Work Today'*, 25th July 1978, Vol 9 (45), p6). Community care was perceived as a reactionary policy, the 'hallmark' of which was 'to be hostile towards the idea of residential provision' in the place of which was 'some badly thought out notion involving "community care"' (Hudson B (1978), "No place like home" in *'Community Care'* 19th April 1978, pp20-21); community care - the 'watchword in helping the old' - was a product of 'Residential environments (being roundly attacked, both their cost and (their) harmful effect' (Hudson B (1977) in 'Community Care', op.cit., reference 115). Other articles viewed community care as a *fait accompli* related to the lack, or over-use of residential homes. As was stated, 'at present the old people's homes are receptacles for the failures of community care' (Muir Gray J A (1976), "The dilemma of residential care" in *'Community Care'*, 27th October 1976, pp24-25); one nursing article spoke of the 'inappropriate' placement of old people in institutions 'as a result of severe limitations of alternative accommodation in a supportive community setting...The support and care required by many old people to enable them to live in an adequate situation outside an institution are often lacking' (Barrowclough F (1977) in *'Nursing Mirror'*, op.cit., reference 109).

117. This article stated that 'Official policy and much professional opinion regard the rehabilitation of elderly patients for a return to life in the community as a means of containing, if not solving, a growing problem. Whether costs would be saved and the elderly happier and better cared for has yet to be proved'. See Keywood O (1978b), "Preparing the elderly to return home" *'Nursing Mirror'*, 7th September 1978, pp42-44.

118. See Clough R (1978) in *'Social Work Today'*, op.cit., (reference 114).

119. One nursing article noted that 'Problems arise when relatives are unwilling or unable to look after the patient...(because) the patient is alone in the house all day and is liable to endanger herself, the patient is demanding and manipulative, there are children and other members of the family to consider' - MacDonald B (1981) "A change of plans" in *'Nursing Mirror'*, 23rd September 1981, pp24-26, brackets mine. Another author was more blunt; community care policies were 'embarked upon with very little consideration of the ability or the willingness of the community to absorb them and support them...I doubt very much if the community is going to thank those who insist on rubbing its nose in problems it would rather forget. Community care is going to be more of an uphill struggle than the glib pronouncements of Ministers seem to imply' (Watkin

B (1976) in *'Nursing Mirror'*, op.cit., reference 115). See Barrowclough F (1977) in *'Nursing Mirror'*, op.cit., (reference 109) who stated that 'relatives will be suspicious of active policies which restore activity and the possibility of a return home,,,Old people, and their relatives, are inclined to think of a hospital or a home as a place of last resort and as a place where they will die. The possibility of a return home is seldom accepted,,,Existing practices and attitudes tend to encourage the retention of old people in institutions'; one article described community care as a 'laudable shift from the institution' which should not become 'a penny-pinching exercise leading to the neglect of the elderly and the subjection of their relatives and friends to,,,undue strain' (Baker D E (1978) in *"Nursing Times"* op.cit., reference 109); 'the crucial thing is always to try to prevent the patient's disabilities either acutely or chronically overloading those who are helping with his care' (Godber C (1979a) "Don't overwhelm the family!" in *'Nursing Mirror'*, 26th July 1979, pp30-32).

A social work article stated that community care 'can be bandied around with euphoric optimism and a failure to face reality,,,an overburdened family or a community ill-equipped to carry the load of responsibility for the care of the old, are victims of this shibboleth' (Worth D (1975) "I'm not poor, I'm not old and I'm not her dear" in *'Community Care'*, 17th December 1975, pp12-13); another article stated that 'the traditional community no longer exists in any significant form,,,the gargantuan task facing the framers of a community care policy is to,,,recreate localised and reciprocal informal networks,,,Common sense would indicate that such a feat of social engineering is not possible' (Hudson B (1980) in *'Community Care'* op.cit., (reference 104)); another article in sympathy with this view spoke of the 'uncaring community' (Manning M (1977) "Into the uncaring community" in 'Community Care', 6th April 1977, pp49-50); although the governments' 'favoured policy direction', community care was 'confirming the (enforced) responsibility of the community for its own welfare' (Stewart G & Stewart J (1979), in *'Social Work Today'*, op.cit., (reference 97), brackets mine).

120. For example, the social worker role was described by a government Minister as seeking to 'help people help themselves' (Patrick Jenkin quoted in Stewart G & Stewart J (1979), in *'Social Work Today'*, op.cit., (reference 97)); another article saw the role of the social services department as to 'make the best use of community resources,,,be a supplement to the community,,,strengthen that network of care,,,promote mutual aid' (Bamford T (1979) "Comment; A crisis of confidence" in *'Social Work Today'*, 4th September 1979, Vol 11 (1), p1); another author reported that she 'remained convinced that enabling should be the core activity of social work agencies (Taylor J (1979) "Possibilities for the elderly" in *'Social Work Today'*, 9th October 1979, Vol 11 (6),

p2); this was akin to the view that social workers should teach the community 'to learn to care' (Brown L (1976) in *'Community Care'*, op.cit., (reference 97)); more generally another author remarked that community care was a philosophy in which 'What is needed is faith in the latent ability of 'ordinary people" to help themselves and help each other' (Gladstone F (1979) "Voluntary action in a changing world; the middle way forward" in *'Community Care'*, 15th November 1979, pp22-24).

121. See Muir Gray J A (1978a), "The breaking point" in *'Community Care'*, 21st June 1978, pp14-16. A news article suggested that social services' needed to support carers because 'the removal of community and family support' from the elderly would put 'a considerable strain on the social service department' (see the 1978 commentary "Where the families do the social work' in *'Community Care'*, 25th January 1978, p6).

122. Darlington B (1981), "It all Depends" in *'Nursing Times'*, 26th March 1981, p538 which stated; 'people at home,..have the right to refuse to be shuttle-cocked around town'.

123. See Watkin B (1982), "Hospitals at home" in *'Nursing Mirror'*, 2nd February 1978, p10.

124. See Chisholm M K (1977) "The nurse's responsibility when caring for the elderly" in *'Nursing Times'*, 29th September 1977, pp1509-1510 which stated that 'creative, personal participation for the old,..is to be preferred to passive partaking of services'; see also another article by the same author - Chisholm M K (1976), "Caring services for the elderly" in *'Nursing Mirror'*, 27th May 1976, pp62-64; Cairns J (1980), "Maintaining the individuality of the long-term patient" in *'Nursing Times'*, 23rd October 1980, pp1891-1892. Care options available to old people were based on the 'assumptions and opinions of others' (Stapleton B (1979), "Avoiding residential care for the old" in *'Community Care'*, 10th May 1979, pp14-16. It was stated that 'old people should be consulted about what they want,..What is important is that old people are allowed to exercise more choice and are invited to become involved in policies affecting their own future. So often presumptions are made about how they should live without any reference to the elderly themselves' (Editor (1974), "We must improve the quality of life for old folk" in *'Community Care'*, 4th December 1974, No 36, p1). One author remarked that in terms of care available to elderly people, 'little has been mentioned of how well provision accords with the wishes or dignity of old people,..Social policy concerned with the elderly has been largely confined to platitudes about the merits of community care' - De Paul V (1980), in *'Community Care'*, op.cit., (reference 114).

Similarly, a housing article mentioned that 'The elderly person should be able to feel able to be in control of any decision made or any action taken (about housing)' (Aedile (1978) "The housing needs of the elderly" in *'Housing'*, December 1978, Vol 14 (12), pp2-3); another article stated that 'Surely the views of the people we serve must be

the most important of all' (Atkins B W (1979), "A Middle Way for the Elderly" in *'Housing Review'*, November-December 1979, Vol 28 (6), pp156-158).

125. Dent R V (1977) in *'Nursing Times'*, op.cit., (reference 101); see also O'Rawe A M (1982) "Self-Neglect - A challenge for Nursing" in *'Nursing Times'*, 17th November 1982, pp1932-1936. Another article suggested that old people shouldn't be denied the right to live and die as they like - see Bennett J (1977) "There's no place like home' in *'Community Care'*, 23rd November 1977, p24.

Letting people having choices included the choice to 'sit about listlessly' and little else; this contradicts the philosophy on engagement or normalisation - as was asked, 'Who is normalisation best for? For us who set the standards by which the normal shall be recognised, and for whom the normalisation of others may mean less expenses, less work and certainly being asked to give less attention' - (Manning M (1976), "A world of their own" in *'Community Care'*, 14th January 1976, pp19-20). Another article stated, normalisation means 'enabling people,,,to share,,,the opportunities, joys and indeed sorrows which their own culture accepts as making up ordinary life' (Shearer A (1976), "Personally Speaking" in *'Community Care'*, 11th February 1976, p10); 'The old are quite as entitled as the young to lead stimulating, interesting and independent lives' but admitted that 'some social workers feel that the shame and guilt inspired by such newspaper revelations have denied some old people their basic human rights to live - and die - in their own chosen manner' (Morris P (1975), "Killing them with kindness"? in *'Community Care'*, 27th August 1975, pp15-17); 'Independence is what community care is about,,,Independence contains the idea of self-fulfillment. It also contains that of normality, as a counter weight. Self fulfillment must not go beyond the socially accepted bounds of eccentricity or the patient will be defined as deviant' (Pritlove J (1978), "What future for the mentally ill' in *'Community Care'*, 12th April 1978, pp20-22). See also Muir Gray J A (1979), "The principle: forcing old people to leave their homes" in *'Community Care'*, 8th March 1979, pp19-20.

126. For example, see Harris D (1977), "The right to live,,,or die" in *'Social Work Today'*, 13th December 1977, Vol 9 (16), p1; see also Younghusband E (1978), "The right to die" in *'Community Care'*, 29th March 1978, pp16-17. One article commented that 'Important to the concept of independence is the recognition that residents (of homes) must be allowed to live their lives in their own way as long as they do not adversely affect others' - Heptinstall D & Sienkiewicz M (1982), "Management in elderly person's homes" in *'Community Care'*, 27th May 1982, pp17-20. See also Gray Muir J A (1978a) in *'Community Care'*, op.cit., (reference 121). For a general discussion on the topic of rights, there were a series of articles by Paul Brearley in *'Community Care'* (1979a),

"Gambling with their lives?", 8th November 1979, pp22-23; (1979b) "Gambling with their lives? - calculating the odds", 15th November 1979, pp24-25; (1979c) "Gambling with their lives? - sharing the risks", 29th November 1979, p25; Hopkins T (1981), "Rights for the retired" in *'Community Care'*, 10th December 1981, pp2-3, Compare Walden D (1981), "The elderly at risk" in *'Community Care'*, 5th November 1981, pp18-19,

127. See the letter by Post F (1976) in *'British Medical Journal'*, op.cit., (reference 127) which suggested that if an old person was mentally fit then their wish to remain at home should be respected despite inconvenience caused, Not so for old people suffering from severe mental disorder or physical illness; they should be admitted due to the higher risk of self-injury and greater stress on carers, However, the social services' principle that 'there should be no interference with the client', meant that 'There is a point in the client's declining abilities,,,where unless the client has a service available to accept he becomes deprived,,,(hence) There may be an uneasy or hostile relationship between the client and the dispenser of a service is the client does not want to accept it, The relationship may be looked upon by the client as an interference or intrusion'; alternatively, if the client rejects a service he might be classed as 'unreasonably difficult' (Lodge B & Parker F (1980) "The resident's role in residential homes for the elderly" in *'Nursing Times'*, 21st August 1980, pp1495-1498),

Other articles indicate that the placement of elderly people in types of care settings was related to factors such as the availability of, and allocation criteria for, types of care provision; for example, see the section entitle 'The wider perspective' which referred to the silting up of hospital and part III beds which led to 'a reappraisal of housing policies concerning the elderly' and the acceptance of 'a more highly dependent group of tenants,,,thereby releasing hospital beds for those needing medical and nursing support' - Day J B & Epps B (1979), "Rescue service for the elderly" in *'Housing'*, August 1979, Vol 15 (8), pp12-15, See also Fox D (1979) "The housing needs of the elderly, What should we be planning for the future, now?" in *'Housing'*, March 1979, Vol 15 (3), pp5-7, this article referred to part of the 'success' of sheltered housing as indicated by 'assisting social service and area health authorities to concentrate their resources to others in greater need',

One article commented that 'Decisions are often made about the future of old people without any involvement of the patient themselves, There is an implied assumption that professional staff know best what decisions should be made', It was also argued that compulsory admission of old people to institutions took place 'more for the benefit of relatives and community workers than because the old person is incapable of making decisions or is presenting a hazard to public safety,,,the liberty of an old person who

fails to achieve the standards of cleanliness and behaviour considered desirable by doctors, health visitors, social workers, can quietly be taken away'. The article made similar points in terms of decisions to discharge (Barrowclough F (1977) in *'Nursing Times'*, op.cit., (reference 116). In crises a medical article noted that it was easy to make decisions about the future of elderly people on the basis of self-neglect, risk and family circumstances, but not with reference to the old person themself (Baker A A (1976), "Slow euthanasia - or 'she will be better off in hospital'" in *'British Medical Journal'*, 4th September 1976, pp571-572). A further nursing article stated that 'Paternalistic decision-making on behalf of the elderly must end' (Westworth B (1982) in *'Nursing Mirror'*, op.cit., reference 114; decisions taken about elderly people were 'governed by factors which the person had no control over or influence upon' - for example, this article mentioned, 'Many decisions relating to the future care of elderly people seem to be political or administrative and governed by circumstances' (See Wilding K (1979) "Choosing part III" in *'Community Care'*, 16th August 1979, pp20-21). A nursing article recognised that the basis on which client outcomes were decided could clash; 'there is a conflict between the idea of a "patient centred" approach and the reality of community-wide demands on services; and between the idea of professionally co-ordinated care and the people's right to reject it' (Roberts I (1978) "Planning care at home" in *'Nursing Times'*, 26th January 1978, pp154-156). A final article suggested that 'We must accept that we cannot, and should not, try to force our standards on the elderly' (Bennett J (1977) in *'Community Care'*, op.cit., reference 125).

128. See Forder A (1981) "Help or tacit conspiracy?" in *'Social Work Today'*, 8th September 1981, Vol 13 (1), pp11-13; it was also argued that 'Sometimes, local communities and the medics will put pressure on individuals to be removed from their homes because they are an embarrassment...It is the imposition of different standards of living on old people, however benevolently motivated, that infuriates social workers' (Morris P (1974), "Are Sheffield's old folks still on our conscience?" in *'Community Care'*, 1st May 1974, pp15-17).

129. See Shearer A (1976) in *'Community Care'*, op.cit., (reference 125).

130. For example, Baker A A (1976) in *'British Medical Journal'*, op.cit., (reference 127).

131. See Westworth B (1982) in *'Nursing Mirror'*, op.cit., (reference 114). Another author added that freedom of choice 'brings with it an element of risk' (Simson M (1977), "Freedom in the Home" in *'Community Care'*, 15th June 1977, p21); another article stated that 'Elderly people are at liberty, as we all are, to fall down, get run over, or suffer an accident when living at home' (Muir Gray J A (1976) in *'Community Care'*, op.cit., (reference 116).

132. See Brearley P (1979d), "The elderly; Understanding Risk" in *'Social Work Today'*, 3rd April 1979, Vol 10 (31), p28.

133. Barrowclough F (1977) in *'Nursing Mirror'*, op.cit., (reference 109).

134. For example, falls of elderly people in hospitals and part III homes were treated as failures and resulted in people being discouraged from physical independence; see Issacs B (1979a), "Don't get up - you'll fall!" in *'Nursing Mirror'*, 18th October 1979, pp40-43; Isaacs B (1979b), "Don't let her walk - she'll fall!" in *'Nursing Mirror'*, 25th October 1979, p26-27; Morris E V, Isaacs B & Brislen W (1981) "Falls in the elderly in hospital" in *'Nursing Times'*, 26th August 1981, pp1522-1524.

135. Smith C (1976), "Accidents and the elderly" in *'Nursing Times'*, 2nd December 1976, pp1872-1874. A separate article commented that 'Active and independent patients appear to be most at risk (of falls)...The prevention of all falls is not an appropriate objective...Instead the primary aim should be the promotion of patient activity within acceptable limits of safety' - see Morris E V, Isaacs B & Brislen W (1981), in *'Nursing Times'*, op.cit., (reference 134).

136. The article continued; 'There must...be a breaking-down of barriers and full co-operation between all agencies...too much well-intentioned activity tends to be done in an unco-ordinated way' - Aedile (1978), in *'Housing'*, op.cit., reference 124.
Similarly, due to 'the indivisibility of medical, nursing needs' in old age then 'attempts to maintain or restore health and independence can be effective only through co-ordinated work of different professional groups' - Roberts I (1977), "Should geriatric nursing be a specialty?" in *'Nursing Times'*, 6th October 1977, pp1566-1568; another author stated that 'There is a need for closer co-operation netween caring professionals' - Savage B J & Wright A L (1977), "Shared care of the elderly" in *'Nursing Times'*, 31st March 1977, pp465-468.

137. Olsen R (1979a) "Comment; Social Work with the mentally disordered" in *'Social Work Today'*, 3rd July 1979, Vol 10 (42), p1.

138. It was commented that 'local authorities are unable to afford the cost of locally financed community care. Until such interchangeability is made possible, community care will never be a viable proposition' - Webb D (1977), "A student's critique of Britains Mental Health Services" in *'Community Care'*, 28th September 1977, pp20-21; reference was also made to local authorities not being able to offer 'the range of services which are needed to cope with the new chronic population'; the position was expected to worsen 'unless policies and practices are radically reformulated' (Huxley P (1982), "The return of the 'single lunatic'" in *'Community Care'*, 20th May 1982, pp12-13).

139. Frost D (1976), "The district nurse", *'Nursing Times'*, Community Care Supplement, 27th

May 1976, ppv-viii. See also Hudson B (1976), "The Community Psychiatric Nurse and the Social Worker" in *'Nursing Times'*, Community Care Supplement, 27th May 1976, pp18-22 which questioned whether the community psychiatric nurse and psychiatric social worker roles were interchangeable, stating that there was 'considerable overlap' between the two professionals. Another article referred to role overlap resulting from the 'Repeated failure on the part of social services to fulfil their function can give rise to situations where it is less trouble for the nurse to remedy the deficiency itself' - see the commentary "Problems of conscience" in *'Nursing Times'* 31st March 1977, p469.

140. Frost D (1976), "The District Nurse" in *'Nursing Times'*, op.cit., (reference 139) which put the view that 'undoubtedly the largest communication gulf occurs with the social services', reference was also made to a 'breakdown of communication' (between the nursing and social work professions), and the author noted that 'Ideally, the functions of nurse/midwife, health visitor and social worker should overlap a little if dangerous gaps in service are not to appear. The overlapping function, however, should not be so great as to undermine or duplicate another's contribution'.

141. See Latto S (1980), "Help begins at home" in *'Community Care'*, 24th April 1980, pp15-17 ; Payne C (1977), "Dusting up on community care" in *'Community Care'*, 6th July 1977, pp16-17; Berry E (1976), "Is your home help really necessary?" in *'Community Care'*, 22nd September 1976, p18; Thompson J (1977), "Are Health Visitors really all the same?" in *'Community Care'*, 29th June 1977, pp16-17; Goldberg E M (1978), "Reviewing services for the old" in *'Community Care'*, 6th December 1978, pp27-30; Hyman M (1981), "Between Two Stools" in *'Community Care'*, 13th August 1981, pp18-19.

142. See Acheson E D (1982), "The impending crisis of old age; a challenge to ingenuity" in *'The Lancet'*, 11th September 1982, pp592-594. Thus, it was commented that 'The respective roles of the warden, the staff of the social services, and the domiciliary nursing services are far from clear and the client sometimes suffers as a result'.

143. The health visitor's role was unclear; see Muir Gray J A (1978b), "Nursing the elderly: who should do what?" in *'Nursing Mirror'*, 18th May 1978, pp42-44, which stated that 'The time is now ripe for a further review of health visiting'; Mead A M (1976), "The Health Visitor" in *'Nursing Times'*, Community Care Supplement, 27th May 1976, ppxi,xiv & xvii which stated that 'The role of the health visitor is a difficult one to define'. See the case studies of patients in Watt G M (1982), "A family-oriented approach to community care for the elderly mentally infirm", in *'Nursing Times'*, 15th September 1982, pp1545-1548.

144. Wilkin D & Jolley D (1978), "Mental and physical impairment in the elderly in hospital and residential care 2" in *'Nursing Times'* (Occasional Paper), 26th October 1978,

p124. One author referred to problems impeding collaboration with the health service, and doctors and social workers - see Bamford T (1978), "Collaboration with the health service" in *'Social Work Today'*, 28th November 1978, Vol 10 (14), p1.

Similar problems existed with housing and social service authorities; an article referred to 'distrust' between housing and social work departments (Morris J (1976), "Housing and Social Work - The Joint Approach Today" in *'Housing Review'*, May-June 1976, Vol 25 (3), pp66-67); see the section 'Differences in working arrangements' in Fox D (1978), "The conflict between housing and social work" in *'Housing'*, April 1978, Vol 14 (4), pp10-12; an article referred to 'basic differences in orientation between housing and social services departments' (James L & Bytheway B (1979), "Is sheltered housing an alternative to part III accommodation?" in *'Housing'*, February 1979, Vol 15 (2), pp24-25); 'Too often there is poor co-ordination and co-operation between the main agencies responsible for the provision of services for the elderly,., because of the complex and cumbersome nature of these organisations, the problems of communication,., and their chains of responsibility' (Underwood J & Carver R (1979), "Sheltered housing. How things have gone wrong - what's coming next?" in *'Housing'*, June 1979, Vol 15 (6), pp14-16); lastly, an article referred to 'the respective role of housing and social service departments in looking after the elderly' as 'another cause of confusion' (Ash J (1982), "Confronting 'Agism' in Housing" in *Housing Review'*, July-August 1982).

In the medical journals it was stated that 'a co-ordinated central policy for the elderly which embraces social and health care and accommodation has never existed', hence reference was made to the 'disjointed way in which the various services are provided' Acheson E D (1982), in *'The Lancet'*, op.cit., (reference 142). More specifically, another author referred to 'frequently marked hostility between health-service staff and social workers' - Opit L J (1976), "Care of the elderly sick at home. Whose responsibility is it?" in *'The Lancet'*, 20th November 1976, pp1127-1129.

145. Forder A (1981) in *'Social Work Today'*, op.cit., (reference 128).

146. Thus, a housing article called for; 'much greater agreement' between agencies responsible for services to elderly people 'as to the way in which these are developed and used', Good co-operation implied 'agreement,.,as to the cut-off points and general operational policies'; it was added that 'co-operation,.,must really be the key to any improvement in our services for the elderly in the future' (Godber C (1979b), "Collaboration in sheltered housing' in *'Housing'*, April 1979, Vol 15 (4), pp10-11). Another housing article stated that co-operation would be enhanced by agreement between the relevant agencies 'about the criteria for selection to different forms of accommodation' (Tinker A (1980), "Housing the elderly near relatives; Some questions

housing staff have asked" in *'Housing'*, August 1980, Vol 16 (8), pp12-13). It was argued that one solution to inter-agency and intra-agency conflict was the 'general adoption of a series of cardinal objectives' (Browne B (1979), "The old need care not compensation" in *'Community Care'*, 12th April 1979, pp22-23); a nursing article indicated that co-ordinated professional care required 'a commonly shared ethical basis' for the provision of health care (O'Rawe A M (1982) in *'Nursing Times'*, op.cit., (reference 125)). Good co-operation was also linked to having an understanding of 'each other's capacity and policies and the demarcation of their respective responsibilities' (Morris J (1976), in *'Housing Review'*, op.cit., (reference 156)).

147. Editor (1979), in *'Community Care'*, op.cit., (reference 104). For example, an article noted that 'the demand for residential care will continue to grow, against the better wishes of many of the professionals concerned, and the elderly themselves'; the same author commented that there was 'a vicious cirle of a lack of an effective community care system,,,leading to a greater demand for residential care, which in turn meant less resources for community services,,,(hence) it is important that the resources of the social services department are not all tied up in one kind of provision which gives no choice to individuals in need' - see Stapleton B (1979), in *'Community Care'*, op.cit., (reference 116). One article predicted that 'there is little scope in social services expenditure for major cuts in residential provision' (Bamford T (1976), in *'Social Work Today'*, op.cit., (reference 98)). Another author noted that 'we must move away from emphasis on residential care and begin to use our resources to seriously underwrite community care programmes' - see Olsen R (1978), "Health and Welfare: The needs of the elderly" in *'Social Work Today'*, 21st February 1978, Vol 9 (25), p17.

148. Wilkin D, Evans G & Jolley D (1982), in *'Community Care'*, op.cit., (reference 121); also Crine A (1982), "Pushing back the boundaries" in *'Community Care'*, 21st October 1982, pp24-27.

149. Browne B (1979), in *'Community Care'*, op.cit., (reference 146). Residential care was seen elsewhere as being 'an integral part in community care' (Muir Gray J A (1976), in *'Community Care'*, op.cit., (reference 116); part of 'neighbourhood and community life' (Heptinstall D (1982), "Residential homes are 'part of the community'" in *'Community Care'*, 20th May 1982, p5). Another article argued that 'Residential homes are a part of the 'wider community'" - Clough R (1978) in *'Social Work Today'*, op.cit., (reference 114). Similarly, a 'sensitive form of residential provision' was viewed as part of community care (Hudson B (1978) in *'Community Care'*, op.cit., (reference 116). Thus, an article argued that residential care was 'too easily dismissed as an unsatisfactory alternative for people for whom it is the best solution' (Hobman D (1976), "Making

resources pay dividends" in *'Community Care'*, 27th October 1976, pp16-19).

150. See Draper J & Fry A (1977), "Residential, community care overlap to grow" in *'Community Care'*, 30th November 1977, p6. Another article said that 'the use of a local authority residential home as a resource centre may fit political and professional needs, but what will it do to the quality of life of existing residents, or primary carers and of staff?" (McCoy P (1982), "An answer to "Growing Older"', in *'Community Care'*, 5th August 1982, pp18-19). The resource centre model was credited with avoiding the 'negative assumptions that the former (community care) is good and prevenetative, the latter (residential care) bad and institutional' (Clough R (1978) in *'Social Work Today'*, op.cit., (reference 114), brackets mine). See also reference 116.

151. Plank D (1978) in *'Community Care'*, op.cit., (reference 115), brackets mine. Another author stated that 'to draw valid conclusions between hospital and community care is not possible. There are too many variables, both in terms of money and human happiness' (Keywood O (1978b) in *'Nursing Mirror'*, op.cit., (reference 114)).

152. Muir Gray J A (1976), in *'Community Care'*, op.cit., (reference 116).

153. See the letter by Roberts C (1977), "More thought for the elderly" in *'British Medical Journal'*, 30th April 1977, p1156, which stated that 'It is common knowldege that many residents of part III accommodation should not be there in the first instance' (in relation to the sick and infirm elderly); another letter suggested that when 'a person reaches the degree of disability at which this level of domiciliary care (7 days a week) is no longer adequate she may be too disabled for part III accommodation' - Muir Gray J A & Rodgers J S (1981), "Long-term care of old people" in *'British Medical Journal'*, 21st February 1981, p649; another letter referred to part III containing 'inappropriately placed' frail elderly people (Martin A & Bailey R (1981), "Caring for the aged" in *'British Medical Journal'*, 27th June 1981, p2132); 'Unfortunately, it is now increasingly likely that only the frailest persons will go into part III and that very soon they will become undistinguishable from nursing homes' (Overstall P W (1982) in *'British Medical Journal'*, 3rd April 1982, pp1040-1041). An article questioned the role of residential homes in caring for the EMI - Pasker P, Thomas J P R & Ashley J S A (1976) "The elderly mentally ill - whose responsibility?" in *British Medical Journal'*, 17th July 1976, pp164-166). See also Masterton G, Holloway E M & Timbury G C (1981), "Role of local authority homes in the care of the dependent elderly: a prospective study" in *'British Medical Journal'*, 22nd August 1981, pp523-524. An article stated that 'It is well known that patients in geriatric custodial care and social service residential care frequently have the same degree of handicap and need for nursing or medical services' (Opit L J (1976) in *'The Lancet'*, op.cit., (reference 144)).

154, See Bowling A & Bleathman C (1982), "Beware of the Nurses" in *'Nursing Mirror'*, 29th September 1982, pp54-58. A social work article referred, for example to elderly patients in geriatric wards being 'in many ways indistinguishable from the frailer people in old people's homes' - see Braverman A & Baldock P (1980), "An end to the old people's swop shop" in *'Social Work Today'*, 29th July 1980, Vol 11 (45) pp16-18.

155, Harrison J F (1981), "Geriatric Medicine and disabled living" in *'British Medical Journal'*, 24th October 1981, pp1096-1098. In contemplating a shift away from residential care to care in the community, one article suggested that 'even if it were financially attractive it could still be bought at terrible human cost to those who care' (Editor (1982), in *'Community Care'*, op.cit., (reference 98)). Thus, there were doubts as to whether the social costs of community care were acceptable. One article asserted that the 'community' could cope with more dependent elderly people rather than leave them in hospital, given the benefit of augmented home nursing (Gibbins F J, Lee M, Davison P R, O'Sullivan P, Hutchison M, Murphy D & Ugwu C N (1982) "Augmented home nursing as an alternative to hospital care for chronic elderly invalids" in *'British Medical Journal'*, 30th January 1982, pp330-333).

156, Butler A (1980), "Profile of the sheltered housing tenant" in *'Housing'*, June 1980, Vol 16 (6), pp6-8. See also Middleton L (1982), "Time to move" in *'Community Care'*, 9th December 1982, pp17-18. Similarly, role 'confusion,,,exists on the purpose of sheltered housing'; this article added that 'similar confusion exists between residential care and geriatric hospitalisation' - see Fox D (1978), in *'Housing'*, op.cit., (reference 144). A medical article letter suggested that 'one of the greatest problems at present is to utilise sheltered housing for the needs for which it was originally intended' (Cayley A C D (1976), "Quality of Life" in *'British Medical Journal'*, 5th June 1976, p1406). From another perspective, the nursing journals put a range of views; one article suggested that sheltered housing was 'on the borderline of the social services' and that 'great hopes are riding on sheltered housing' (Bosanquet N (1977) in *'Nursing Times'*, op.cit., (reference 114)); another article referred to sheltered housing negatively as 'geriatric ghettoes' (Thomas L (1980), "Geriatric ghettoes" in *'Nursing Times'*, 2nd February 1980, p314).

157, James L & Blytheway B (1979) in *'Housing'*, op.cit., reference 144.

158, For example, one article referred to 'a substantial overlap' between old people in part III and sheltered housing (Bamford T (1981), "When a sheltered life is the good life" in *'Social Work Today'*, 20th January 1981, Vol 12 (20), pp14-15); see also Community Care (1977), "Why wardens should come out from the shelter" in *'Community Care'*, 23rd March 1977, pp20-21 - this article stated that sheltered housing was 'increasingly seen

as the panacea for the problems Britain's elderly population imposes on community services', As a result of this, 'Wardens are misused by professionals', See also Casemore J & Fox D (1980), "The sheltered alternative" in *'Community Care'*, 11th January 1980, pp23-24; Harbridge E (1980), "Very Sheltered Housing - a better option" in *'Community Care'*, 24th July 1980, pp22-23, An article commented that sheltered housing was 'coming to resemble old people's homes' and therefore able to forestall transfer to such homes, adding that 'there is general recognition of the fact that the role of sheltered housing has moved nearer to that of part III' - James L & Blytheway B (1979), in *'Housing'*, op,cit,, (reference 144), A medical article stated that 'there is much misplacement of old people into part-III and other special accommodation' (see Working Party of the Royal College of Physicians of London (1977), in *'The Lancet'*, op,cit,, (reference 107)),

159, Fox D (1979b) "Sheltered housing; a national policy, locally executed" in *'Housing'*, December 1979, Vol 15 (12), pp18-20; this author referred to the 'success of keeping old people alive' (Fox D (1979a) in *'Housing'*, op,cit,, (reference 127)), Sheltered housing had become silted up because elderly people were not moved on to alternative accommodation, Relocating elderly people out of sheltered housing was not always an easy decision, Thus, a decision to move an old person out of sheltered housing for the good of other tenants or the warden, or indeed to move them into such housing because of increasing dependency was dependent on whether 'the success of any scheme is more important than the wishes of the individuals to remain undisturbed' (Fox D (1978) in *'Housing'*, op,cit,, (reference 144)),

160, The preface to this comment was that 'No one service is free to develop and plan its facilities without taking into account the constraints and pressures from the whole structure of agencies providing care' (Dodd K, Holden A & Reed C (1979), "A census of elderly people in care" *'Social Work Today'*, 31st July 1979, Vol 10 (46), pp10-13),

161, See for example, Wilding K (1979) in *'Community Care'*, op,cit,, (reference 127) and Plank D (1978), in *'Community Care'*, op,cit,, (reference 97),

162, Plank D (1978), in *'Community Care'*, op,cit,, (reference 97), Pursuing a similar argument a medical journal stated that: 'When the service for the care of the elderly fails, the effects are felt throughout the Health Service, The general practitioner cannot then admit his deserving patients into appropriate accommodation, the hospital consultant finds his beds blocked by patients no longer requiring his particular skill, waiting lists get longer, and there is increasing pressure on the social services; so close is the relationship throughout that a small breakdown anywhere is widely felt' see Working Party of the Royal College of Physicians of London (1977), in *'The Lancet'*,

op,cit,, (reference 107). A nursing article made a similar point, remarking that old people stayed 'longer than medically necessary, thus blocking available beds' in hospitals, 'Due to the shortage of places in local authority residential homes' (West J (1976), "Modern geriatric unit - Tolworth Hospital' in *'Nursing Mirror'*, 4th March 1976, pp67-69).

163. Hobman D (1978c), "Caring for Old People" in *'Social Work Today'*, 17th October 1978, Vol 10 (8), pp25-26; an earlier article made exactly the same point but continued; 'There are those occupying expensive hospital beds; who ought to be at home. By the same token, there are those struggling against the odds who would respond to hospital treatment or derive a real sense of satisfaction and fulfillment in residential care' - (Hobman D (1976), in *'Community Care'*, op,cit,, (reference 127)). See Working Party of the Royal College of Physicians of London (1977) in *'The Lancet'*, op,cit,, (reference 107) which acknowledged that 'The vast majority of the elderly who are acutely ill will be admitted to general wards' although in principle 'No reason can be seen to perpetuate the division based on age alone between the acute care of general medical and geriatric patients'.

164. Acheson E D (1982) in *'The Lancet'*, op,cit,, (reference 142).

165. For example, on a general level, a social work article alleged that 'the experts (social workers, doctors, nurses) spend much time trying to fit old people into services that exist' - Wilkes R (1978) in *'Social Work Today'*, op,cit,, (reference 111); a point made in respect of the homeless elderly - 'too often individuals are made to fit into resources available' - Fellows G & Marshall M (1979) in *'Social Work Today'*, op,cit,, (reference 110).

166. Pasker P, Thomas J P R & Ashley J S A (1976) in *'British Medical Journal'*, 17th July 1976, op,cit,, (reference 153).

167. In theory, each part of the care system responded to a particular range of needs. In practice, this system broke down; 'the "sequential" theory' (of need) wasn't working' - i,e the notion that 'the elderly people can be divided into separate groups and that they will stay that way, or else be happy to progress in sequence from category one (active elderly) to category 2 (more frail) to part III (care and attention) to geriatric ward (chronically ill)' as their needs changed (see Casemore J (1980) in *'Community Care'*, op,cit,, (reference 158)); 'it was assumed that elderly people would conveniently fall into Category 1 and Category 2, that they would progress from one accommodation to another, including an inevitable output to institutional care' - Fox D (1979a) in *'Housing'*, op,cit,, (reference 184). To contrast with this perspective, for example, it was argued that 'physical, emotional and social needs of the elderly are

closely interwoven and cannot adequately be considered in isolation from each other'. The author of this comment viewed the separation of the health and social services as failing to recognise this fact - see Barrowclough F (1977), in *'Nursing Mirror'*, op.cit., (reference 109); another article commented that 'people's problems cannot be split neatly into packages to be dealt with by different professional skills and organisations' (Forder A (1981), in *'Social Work Today'*, op.cit., (reference 158)).

168. Dearman G (1979), "Can care be 13 storeys high?" in *'Community Care'*, 12th April 1979, pp24-26.

169. Buckle J (1977) "Health and Welfare - Quality and Welfare 'in the community'" in *'Social Work Today'*, Vol 9 (15), 6th December 1977, p19.

170. Hunt P (1979), "The caring family needs support" in *'Nursing Mirror'*, 2nd August 1979, pp24-25. See also Godber C (1979), in *'Nursing Mirror'*, op.cit., (reference 119) which stated that 'it is clearly vital that every encouragement is given to families to care for their disabled relatives'. A separate article commented that in principle, 'most of the demented should, indeed must, continue to be cared for at home' (Stewart G (1978) in *'Community Care'*, op.cit., (reference 104). One article on the elderly mentally infirm asserted that 'even the most dependent can be cared for at home' (Pasker P, Thomas J P R & Ashley J S A (1976) in *British Medical Journal*, op.cit., (reference 153)); see also the case studies of patients reported in the article by Watt G M (1982) in *'Nursing Times'* op.cit.,' (reference 14).

171. For example; a social work article commented that in terms of after care for the mentally disordered, 'the evidence confirms that we continue to discharge patients to the community without adequate services and support' (Olsen (1979) in *'Social Work Today'*, op.cit., (reference 137); in the same article the author quoted the Earl of Feversham who said 'Doubts are often expressed (about community care) on the grounds that the services in the community are totally inadequate to meet the needs of the mentally disordered', adding that 'in the ensuing years reservations about the wisdom and detrimental effects of community care appeared regularly in the professional journals and the press'; a separate article referred to the fact that the confused elderly 'will be the ones most difficult to maintain in the community' (Muir Gray J A (1976), in *'Community Care'*, op.cit., (reference 116)); it was argued that for the elderly mentally infirm there was 'an enormous lack of provision in all areas' (Robinson W (1977), "Care of the elderly in the community", *'Nursing Mirror'*, 26th May 1977, pp6-9); accommodation for the same people was described as 'at a premium almost everywhere' (Manley R (1982) in *'Nursing Mirror'*, op.cit., (reference 97)). See also Watt G M (1982) in *'Nursing Times'* op.cit., reference 143, which stated that 'there is

an acute shortage of facilities to help there elderly people to remain in the community as long as possible. Another author stated that 'there is no relief for caring professionals in the community nor any respite from the anguish for family, friends or neighbours of grossly demented patients'. The gaps and lacks in provision were 'the cause of much misery'; gaps in services between which the elderly mentally infirm 'will always fall' (Black S & Simon R (1980) "The specialist nurse - support care and the elderly mentally infirm" in *'Nursing Times'*, Community Outlook, 14th February 1980, pp45-46). See also Salvage J (1980), in *'Nursing Times'*, op.cit., (reference 97).

172. Stewart G & Stewart J (1979), in *'Social Work Today'*, op.cit., (reference 97); see also Masters P (1980), "Senile Dementia - Community Support" in *'Nursing Times'*, 12th June 1980, p1065 which added that 'Present attitudes and resources do not offer the facilities and support to which families are entitled'.

173 See Olsen (1979a) in *Social Work Today* op.cit., (reference 137) - in this context the author remarked that community care 'remains in our imagination to inspire future ideals, to support our fancy that we are currently doing is in the best interests of us all, to deaden our anxieties about the hurt this policy may cause patients and their families',,,community care was 'a myth which put more patients at risk than are rehabilitated and more strain on families than they can reasonably be expected to cope with,,,propaganda to make families look after their own - with the concommitant feelings of guilt for those who don't'. A medical article stated that in terms of care at home 'much,,,will depend on the attitudes, willingness and ability of families and relatives to continue to accept much of the responsibility. This raises important issues about the social, economic and psychological cost, both to individuals and to the community of maintaining in their own homes people with extensive nursing needs,,,The major task of caring often devolves on other family members who are themselves elderly and suffer considerable and prolonged strain' (Pasker P, Thomas J P R & Ashley J S A (1976) in *British Medical Journal'*, op.cit., (reference 153)).

174. See Post F (1976) in *'British Medical Journal'*, 18th September 1976, op.cit., (reference 127). One correspondent asked 'I would like to know at what "level" of dementia or risk an old person should be removed from his home or refused to be allowed to return there' - see Turnbull C J (1982), in *'British Medical Journal'*, 3rd April 1982, p1041.

175. See Pasker P, Thomas J P R & Ashley J S A (1976) in *British Medical Journal'*, op.cit., (reference 153).

176. See Webb D (1977) in *'Community Care'*, op.cit., (reference 138).

Appendix 6: Notes and References to Chapter Ten

1. For a discussion as to the distinctions between the various shades of collaborative activity espoused by recent governments, see Wistow G (1982) "Collaboration between Health and Local Authorities: Why is it necessary?", in *'Social Policy and Administration'*, Vol 16(1), Spring 1982, pp44-62.

2. For a similar, but broader, analysis of inter-organisational coordination, see Hardy B, Turrell A and Wistow G (1989a) "Innovations in Management Arrangements: Final Report", Loughborough: Centre for Research in Social Policy, Box 2, p8.

3. See DHSS (1981a), "Report of a Study on Community Care", London: HMSO; DHSS (1981b) "Care in the Community. A Consultative Document on Moving Resources for Care in England", London: DHSS; House of Commons (1985a), "Second Report from the Social Services Committee, Session 1984-85: Community Care with special reference to adult mentally ill and mentally handicapped people", Volume I, Report together with Proceedings of the Committee, House of Commons Paper 13 - I, London: HMSO; House of Commons (1985b), "Second Report from the Social Services Committee, Session 1984-85: Community Care with special reference to adult mentally ill and mentally handicapped people", Volume II, Minutes of Evidence (4 April-3 July 1984), House of Commons Paper 13-II, London: HMSO; House of Commons (1985c), "Second Report from the Social Services Committee, Session 1984-85: Community Care with special reference to adult mentally ill and mentally handicapped people", Volume III, Minutes of Evidence (4 July-21 November 1984) and Appendices, House of Commons Paper 13-III, London: HMSO; Audit Commission for Local Authorities in England and Wales (1986) "Making a reality of community care", London: HMSO; Audit Commission for Local Authorities in England and Wales (1986) "Audit Commission Review: Making a reality of community care", December 1986, London: Audit Commission; House of Commons (1988) "Twenty Sixth Report from the Committee of Public Accounts Session 1987-88. Community Care Developments", London: HMSO; Griffiths R, Sir (1988) "Community Care: Agenda for Action", March 1988, London: HMSO; Department of Health (1989) "Caring for People. Community Care in the next decade and beyond", Cm 849, November 1989, London: HMSO.

4. Audit Commission for Local Authorities in England and Wales (1986) op.cit., p3, p120.

5. Later research which examined joint management arrangements for a range of community care initiatives identified professional barriers as one of five categories barriers to inter-agency co-ordination. The other four barriers were structural, procedural, financial and status/legitimacy barriers (Hardy B, Turrell A and Wistow G (1989a) op.cit., Box 1, p6). This Study suggested that five common issues were significant in determining the robustness of jointly managed community care projects:

- Commitment and shared ownership;
- Minimised vulnerability;
- Clarity of purpose;
- Clarity of responsibility and lines of accountability;
- Organisational learning.

Many of the findings of this Thesis illustrate - in terms of inter-professional collaboration - the relative importance of these issues to collaborative community care initiatives.

6. See, for example, Wistow G (1981) "Incentives for financing community care" in Webb A and Wistow G (1986) 'Planning, Need and Scarcity', London; Allen and Unwin; Wistow G (1983) "Joint finance and community care; have the incentives worked?" in *'Public Money'*, Vol 13(2), pp33-37; Wistow G and Fuller S (1983) "Joint Planning in Perspective", Birmingham; National Association of Health Authorities; Wistow G and Fuller S (1986) "Collaboration since Restructuring", Birmingham; National Association of Health Authorities; Wistow G and Hardy B (1986) "Transferring Care; can financial incentives work?" in Harrison A and Gretton J "Health Care UK', Policy Journals; Hardy B, Turrell A, Webb A and Wistow G (1989b) "Collaboration and Cost-Effectiveness: Final Report", Loughborough; Centre for Research in Social Policy; Wistow G, Hardy B and Turrell A (1990) "Collaboration under Financial Constraint. Health Authorities' spending of Joint Finance", Aldershot; Gower.

Appendix 7: Select Bibliography

This Bibliography primarily lists the sources directly referred to in this Thesis; it is selective in that it does not refer to all the articles and texts consulted in the course of this research (for example, all 1400 articles analysed within the professional journals).

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